AMERICAN HERITAGE LIFE INSURANCE COMPANY (AHL)
1776 AMERICAN HERITAGE LIFE DRIVE
JACKSONVILLE, FL 32224

Allstate. BENEFITS

Group Enrollment Form

☒ Check if custom form

Account No.	Employee ID	Requested Effective Date	First Deduction Date	Account	Location	Situs State
31468						**FL**

Deduction Mode: ☒ Bi-Weekly

Remarks	*AHL home office use only*	Dep Code ☐ **E** ☐ **S** ☐ **C** ☐ **F**

General Information

All references to spouse include domestic partner relationships.

Employee Name *(Last, First, M.I.)*	Birth Date	Social Security No.	☐ Male ☐ Female
Residence Street Address		Phone No.	
City, State, Zip	Email Address		
Employer/Association/Union **Hillsborough County Clerk of Courts**	Hire Date	Occupation*	

**Occupation with the employer in the General Information section.*

Complete for all other persons you (the employee) are requesting to be insured

Last Name	First Name	Relationship	Gender	Birth Date	Social Security No.

Tobacco Use

If applying for Life or Critical Illness, has the employee used tobacco in the last 12 months? **Employee** ☐ Yes ☐ No

If applying for Life or Critical Illness, has the employee's spouse used tobacco in the last 12 months? **Spouse** ☐ Yes ☐ No

Qualifying Life Event

Are you applying for coverage or changing existing coverage due to a qualifying event? ☐ Yes ☐ No

Check the qualifying event: ☐ Marriage/Divorce ☐ Birth/Adoption ☐ Spouse New Job/Job Loss ☐ Termination ☐ Work Status Change ☐ Eligible/Ineligible Child ☐ Spouse/Dependent Child Death ☐ Employee Death

Qualifying event date _____ Current certificate number(s) _____

Termination of Current Coverage

Do you currently have any individual coverages with AHL that you wish to terminate in conjunction with this enrollment for group coverage? ☐ Yes ☐ No

If yes, enter the following information: Effective date of termination _____ Policy Number _____

Select the type of coverage: ☐ Accident ☐ Cancer ☐ Critical Illness ☐ Hospital Indemnity

Employee Name _____ Account No. 31468

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Selection of Coverage

Answer yes or no and complete for each coverage selected.

Accident (GVAP1 On and Off the Job Accident) **Do you want this coverage?** ☐ Yes ☐ No

Who do you want to cover?

- ☐ Employee Only
- ☐ Employee + Spouse
- ☐ Employee + Child(ren)
- ☐ Family

Total Deduction

Your coverage will consist of:	Units
Base Coverage	**2**
☒ Benefit Enhancement Rider	**2**

Cancer/Specified Disease (GVCP2) **Do you want this coverage?** ☐ Yes ☐ No

Who do you want to cover?

- ☐ Employee Only
- ☐ Family

Plan _____

Total Deduction

Your coverage will consist of:	Units
Hospital	**2**
Radiation/Chemotherapy	**4**
Surgery Related	**1**
Miscellaneous	**1**
☒ Cancer Initial Diagnosis Option	**5**
☒ Intensive Care Option	**2**
☒ Cancer Screening Option	**4**

Critical Illness (GVCIP2) **Do you want this coverage?** ☐ Yes ☐ No

Who do you want to cover?

- ☐ Employee Only
- ☐ Employee + Spouse
- ☐ Employee + Child(ren)
- ☐ Family

Total Deduction

Your coverage will consist of:

- ☒ Second Event Initial Critical Illness Option
- ☒ Wellness Option Units **4**
- ☒ Supplemental Critical Illness Option II

Basic Benefit Amount: $ **15,000**

Hospital Indemnity (GVSP1) **Do you want this coverage?** ☐ Yes ☐ No

Who do you want to cover?

- ☐ Employee Only
- ☐ Employee + Spouse
- ☐ Employee + Child(ren)
- ☐ Family

Total Deduction

Your coverage will consist of:	Units
Hospital Related	**2**
Surgery/Inpatient Physician	**1**
Outpatient Related	**1**

Employee Name _____ Account No. 31468

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Life **Do you want this coverage?** ☐ Yes ☐ No ☒ *Guaranteed Issue*

Life product being offered: ☒ Term Life

Requested Face Amount $ _____

Employee Annual Base Salary $ _____

Total Deduction

Riders being applied for: Units/Amt.

GTLCLBR	
GTLCPWP	

If you are requesting rider coverage for your spouse or child(ren) and his/her contact information is different from yours, provide his/her name, address, and phone number below.

Replacement and Existing Insurance *(Must answer)*

1a. Replacement. Proposed Insured. Is this insurance to replace or change any existing life coverage? ☐ Yes ☐ No

If yes, indicate product being replaced or changed and complete replacement form provided by your agent (producer), if required by your state.

1b. Agent (Producer). To your knowledge, is change or replacement involved? ☐ Yes ☐ No

2a. Existing Insurance. Proposed Insured. Is there any other (not listed in Question 1a.) life insurance in force or applied for on the proposed insured? If yes, list company name, policy number, year issued, type of coverage, and amount of benefit. ☐ Yes ☐ No

2b. Agent (Producer). To your knowledge, does the proposed insured have existing coverage in force? ☐ Yes ☐ No

Illustration Regulation Certification for Term Life

OWNER. The owner must select one of the following statements.

☐ I certify that I have received an illustration conforming to the coverage applied for. I will complete the applicable illustration certification form provided, if required in my state.

☐ I certify that I did **not** receive an illustration conforming to the coverage applied for. I understand that an illustration conforming to the coverage issued will be provided upon delivery of the certificate.

Agent (Producer). The agent (producer) must select one of the following statements.

☐ I certify that an illustration conforming to the coverage applied for was provided. I will complete the applicable illustration certification form provided, if required.

☐ I certify that **no** illustration conforming to the coverage applied for was provided, but that an illustration conforming to the coverage issued will be provided upon delivery of the certificate.

Employee Name _____ Account No. 31468

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Beneficiary Designation

Your beneficiary designations will apply to all coverages and riders applied for, including designations for a spouse or covered dependent. For additional beneficiary designation options, complete form ABJ040.

Primary Beneficiary Name *(Last, First, M.I.)*		Social Security No.
Residence Address	Birth Date	Relationship
City, State, Zip	Phone No.	
Contingent Beneficiary Name *(Last, First, M.I.)*		Social Security No.
Residence Address	Birth Date	Relationship
City, State, Zip	Phone No.	

Eligibility Question

GI -- Guaranteed Issue

Answer each question for the coverages for which you are applying.

Employee answer for the following: GI Life

Employee Actively At Work. Is the employee actively at work now, for wage or profit, and has he/she worked at least 20 hours each week performing all duties of his/her regular occupation at his/her regular place of employment for at least the last 3 months except for minor illness or injury of 1 week or less, or normal pregnancy?

Employee ☐ Yes ☐ No

ACCEPTANCE/AUTHORIZATION. I hereby request all coverage(s) selected for which I am or may become eligible under the group coverages issued by AHL. **I AUTHORIZE** my employer to deduct from my salary or wages, if applicable, the necessary premium for the coverages requested. **EFFECTIVE DATE:** I understand that the "effective date" of my elected coverages will be the effective date recorded on my Certificate, not the date this Enrollment is signed. **WAIVER/DECLINATION:** I understand that if I refuse any coverage for which I am eligible, satisfactory proof of insurability may be required, at my own expense, should I desire to apply for it at a later date. Any such form may be declined on the basis of such proof.

FRAUD NOTICE: Any person who knowingly and with intent to injure, defraud or deceive any insurer, files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

_____ _____

Employee Signature Date Signed

Agent's (Producer's) Statement. I certify that to the best of my knowledge and belief the information on this form is complete, accurate and correctly recorded.

_____ _____

Soliciting Florida Agent (Producer) Signature Soliciting Agent (Producer) Name Printed

Florida Agent License Number _____

Home office or agent (producer) to complete before issue:

Agent (Producer) Name	Agent (Producer) Number	Percentage Credit	Agent (Producer) Name	Agent (Producer) Number	Percentage Credit
Servicing Agent (Producer)			Soliciting Agent (Producer)		
Benecom	**4T1G0**		**Amber Hoadley**	**801N0**	

AMERICAN HERITAGE LIFE INSURANCE COMPANY
HOME OFFICE:
1776 AMERICAN HERITAGE LIFE DRIVE
JACKSONVILLE, FLORIDA 32224-6688
(904) 992-1776

A Stock Company

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses that result from accidental injury. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when it pays:

- Hospital or medical expenses up to the maximum stated in the policy

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- Hospitalization
- Physician services
- Outpatient prescription drugs if you are enrolled in Medicare Part D
- Other approved items and services

Before You Buy This Insurance

✓ Check the coverage in **all** health insurance policies you already have.
✓ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
✓ For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program (SHIIP).

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This is not Medicare Supplement Insurance

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses only when you are treated for one of the specific diseases or health conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when it pays:

- hospital or medical expenses up to the maximum stated in the policy

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- outpatient prescription drugs if you are enrolled in Medicare Part D
- other approved items and services

Before You Buy This Insurance

- ✓ Check the coverage in **all** health insurance policies you already have.
- ✓ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- ✓ For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program (SHIIP).

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THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance pays a fixed dollar amount, regardless of your expenses, for each day you meet the policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when:

- any expenses or services covered by the policy are also covered by Medicare

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- outpatient prescription drugs if you are enrolled in Medicare Part D
- other approved items and services

Before You Buy This Insurance

- ✓ Check the coverage in **all** health insurance policies you already have.
- ✓ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
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