**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 |
|---|---|---|---|---|---|---|
| 41380 | | 10-01-2019 | | | | FL |

Deduction Mode *(choose one)*: ☒ Semi-Monthly

| *Remarks* | *AHL home office use only* |
|---|---|
| | |

## 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 **City of Zephyrhills** | 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 Critical Illness, has the employee used tobacco in the last 12 months? **Employee** ☐ Yes ☐ No

If applying for 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. _____

# Group Enrollment Form

## Selection of Coverage

*Answer yes or no and complete for each coverage selected.*

### Accident (GVAP6)

**Do you want this coverage?** ☐ Yes ☐ No

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**Choose coverage amount:**

| Total Semi-Monthly Deductions | Plan 1 | Plan 2 |
|---|---|---|
| Employee Only | ☐ $ 9.37 | ☐ $11.93 |
| Employee + Spouse | ☐ $16.21 | ☐ $20.63 |
| Employee + Child(ren) | ☐ $19.58 | ☐ $24.90 |
| Family | ☐ $26.22 | ☐ $32.86 |

| Your coverage will consist of: | Plan 1 | Plan 2 |
|---|---|---|
| Base Coverage | 3 | 4 |
| Accident Treatment & Urgent Care Rider | 3 | 3.5 |
| Emergency Room Services Rider | 2.5 | 3.5 |
| Outpatient Physician's Rider | 1.5 | 2 |
| Dislocation/Fracture Rider | 2 | 2.5 |
| Benefit Enhancement Rider | 3.5 | 4 |
| Accidental Death, Dismemberment & Functional Loss Rider | 2 | 3.5 |

### Cancer/Specified Disease (GVCP2)

**Do you want this coverage?** ☐ Yes ☐ No

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**Choose coverage amount:**

| Total Semi-Monthly Deductions | Plan 1 |
|---|---|
| Employee Only | ☐ 11.14 |
| Family | ☐ 19.07 |

| Choose coverage: | Units |
|---|---|
| Hospital | 2 |
| Radiation/Chemotherapy | 4 |
| Surgery Related | 1 |
| Miscellaneous | 1 |
| ☐ Cancer Initial Diagnosis Option | 5 |
| ☐ Intensive Care Option | 2 |
| ☐ Cancer Screening Option | 4 |

Employee Name _____ Account No. _____

# Group Enrollment Form

## Critical Illness (GVCIP2)

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**Do you want this coverage?** ☐ Yes ☐ No

| **Your coverage will consist of:** | ☐ Plan 1 $15,000 Basic Benefit Amt. | ☒ Plan 2 $20,000 Basic Benefit Amt. |
|---|---|---|
| Second Event Initial Critical Illness Option | ☒ | ☒ |
| Wellness Option | 3 Units | 3 Units |
| Supplemental Critical Illness Option II | ☒ | ☒ |

| **Semi-Monthly Deductions** | **$15,000 Basic Benefit Non-Tobacco** | | | | **$15,000 Basic Benefit Tobacco** | | | |
|---|---|---|---|---|---|---|---|---|
| Age | Employee Only | Employee + Spouse | Employee + Child(ren) | Family | Employee Only | Employee + Spouse | Employee + Child(ren) | Family |
| 18-24 | ☐ $ 2.41 | ☐ $ 3.70 | ☐ $ 2.41 | ☐ $ 3.70 | ☐ $ 2.83 | ☐ $ 4.31 | ☐ $ 2.83 | ☐ $ 4.31 |
| 25-29 | ☐ $ 2.59 | ☐ $ 4.06 | ☐ $ 2.59 | ☐ $ 4.06 | ☐ $ 3.01 | ☐ $ 4.67 | ☐ $ 3.01 | ☐ $ 4.67 |
| 30-35 | ☐ $ 3.19 | ☐ $ 4.97 | ☐ $ 3.19 | ☐ $ 4.97 | ☐ $ 3.83 | ☐ $ 5.93 | ☐ $ 3.83 | ☐ $ 5.93 |
| 36-39 | ☐ $ 3.88 | ☐ $ 6.10 | ☐ $ 3.88 | ☐ $ 6.10 | ☐ $ 5.08 | ☐ $ 7.87 | ☐ $ 5.08 | ☐ $ 7.87 |
| 40-44 | ☐ $ 4.80 | ☐ $ 7.49 | ☐ $ 4.80 | ☐ $ 7.49 | ☐ $ 6.53 | ☐ $10.06 | ☐ $ 6.53 | ☐ $10.06 |
| 45-50 | ☐ $ 6.26 | ☐ $ 9.63 | ☐ $ 6.26 | ☐ $ 9.63 | ☐ $ 8.93 | ☐ $13.59 | ☐ $ 8.93 | ☐ $13.59 |
| 51-54 | ☐ $ 8.12 | ☐ $12.37 | ☐ $ 8.12 | ☐ $12.37 | ☐ $11.70 | ☐ $17.65 | ☐ $11.70 | ☐ $17.65 |
| 55-60 | ☐ $10.50 | ☐ $15.93 | ☐ $10.50 | ☐ $15.93 | ☐ $15.97 | ☐ $24.03 | ☐ $15.97 | ☐ $24.03 |
| 61-70 | ☐ $13.90 | ☐ $20.90 | ☐ $13.90 | ☐ $20.90 | ☐ $20.06 | ☐ $30.05 | ☐ $20.06 | ☐ $30.05 |
| 71+ | ☐ $22.14 | ☐ $33.19 | ☐ $22.14 | ☐ $33.19 | ☐ $30.13 | ☐ $45.71 | ☐ $30.13 | ☐ $45.71 |

| **Semi-Monthly Deductions** | **$20,000 Basic Benefit Non-Tobacco** | | | | **$20,000 Basic Benefit Tobacco** | | | |
|---|---|---|---|---|---|---|---|---|
| Age | Employee Only | Employee + Spouse | Employee + Child(ren) | Family | Employee Only | Employee + Spouse | Employee + Child(ren) | Family |
| 18-24 | ☐ $ 2.78 | ☐ $ 4.23 | ☐ $ 2.78 | ☐ $ 4.23 | ☐ $ 3.34 | ☐ $ 5.05 | ☐ $ 3.34 | ☐ $ 5.05 |
| 25-29 | ☐ $ 2.96 | ☐ $ 4.59 | ☐ $ 2.96 | ☐ $ 4.59 | ☐ $ 3.52 | ☐ $ 5.41 | ☐ $ 3.52 | ☐ $ 5.41 |
| 30-35 | ☐ $ 3.71 | ☐ $ 5.71 | ☐ $ 3.71 | ☐ $ 5.71 | ☐ $ 4.57 | ☐ $ 6.99 | ☐ $ 4.57 | ☐ $ 6.99 |
| 36-39 | ☐ $ 4.61 | ☐ $ 7.17 | ☐ $ 4.61 | ☐ $ 7.17 | ☐ $ 6.22 | ☐ $ 9.53 | ☐ $ 6.22 | ☐ $ 9.53 |
| 40-44 | ☐ $ 5.82 | ☐ $ 8.98 | ☐ $ 5.82 | ☐ $ 8.98 | ☐ $ 8.12 | ☐ $12.41 | ☐ $ 8.12 | ☐ $12.41 |
| 45-50 | ☐ $ 7.76 | ☐ $11.84 | ☐ $ 7.76 | ☐ $11.84 | ☐ $11.31 | ☐ $17.10 | ☐ $11.31 | ☐ $17.10 |
| 51-54 | ☐ $10.25 | ☐ $15.52 | ☐ $10.25 | ☐ $15.52 | ☐ $15.03 | ☐ $22.56 | ☐ $15.03 | ☐ $22.56 |
| 55-60 | ☐ $13.45 | ☐ $20.29 | ☐ $13.45 | ☐ $20.29 | ☐ $20.75 | ☐ $31.10 | ☐ $20.75 | ☐ $31.10 |
| 61-70 | ☐ $18.01 | ☐ $26.98 | ☐ $18.01 | ☐ $26.98 | ☐ $26.22 | ☐ $39.17 | ☐ $26.22 | ☐ $39.17 |
| 71+ | ☐ $29.00 | ☐ $43.38 | ☐ $29.00 | ☐ $43.38 | ☐ $39.65 | ☐ $60.08 | ☐ $39.65 | ☐ $60.08 |

Employee Name _____ Account No. _____

# Group Enrollment Form

## Hospital Indemnity (GVSP1)

**Do you want this coverage?** ☐ Yes ☐ No

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| Semi-monthly Premiums | | | | |
|---|---|---|---|---|
| Age | Employee Only | Employee + Spouse | Employee + Child(ren) | Family |
| 18-35 | ☐ $15.98 | ☐ $30.15 | ☐ $25.81 | ☐ $39.43 |
| 36-49 | ☐ $18.72 | ☐ $35.46 | ☐ $29.81 | ☐ $45.97 |
| 50-59 | ☐ $23.31 | ☐ $45.63 | ☐ $34.15 | ☐ $55.83 |
| 60-64 | ☐ $31.14 | ☐ $62.28 | ☐ $41.22 | ☐ $71.61 |
| 65+ | ☐ $41.72 | ☐ $83.43 | ☐ $51.84 | ☐ $92.67 |

| Coverage: | Units |
|---|---|
| Hospital Related | 2 |
| Surgery/Inpatient Physician | 1 |
| Outpatient Related | 1 |

## 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. | |

**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.**

X
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 _____

BeneCom℠
Florida Agency License # L093047
Florida Producer License # A239806
20620 Nolen Road
Land O' Lakes, Florida 34638
813-996-2525

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) | | |
| **Amber Hoadley** | **801N0** | | **Benecom** | **4T1G0** | |
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