

**AMERICAN HERITAGE LIFE INSURANCE COMPANY (AHL)**

1776 AMERICAN HERITAGE LIFE DRIVE

JACKSONVILLE, FL 32224

Group Enrollment Form Check if custom form

Account No.	Employee ID	Requested Effective Date	First Deduction Date	Account	Location	Situs State
35725						FL
Deduction Mode: <input checked="" type="checkbox"/> Bi-Weekly						
Remarks			AHL home office use only		Dep Code <input type="checkbox"/> E <input type="checkbox"/> S <input type="checkbox"/> C <input type="checkbox"/> F	

General Information*All references to spouse include domestic partner relationships.*

Employee (Payor/Owner/Certificate holder) Name (Last, First, M.I.)		Birth Date	Social Security No.	<input type="checkbox"/> Male <input type="checkbox"/> Female
Residence Street Address			Phone No.	
City, State, Zip		Email Address		
Employer/Association/Union Children's Board of Hillsborough County		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 NoIf yes, enter the following information: Effective date of termination Policy Number Select the type of coverage: Accident Cancer Critical Illness Hospital Indemnity

Group Enrollment Form

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 Section 125

Who do you want to cover?

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

Your coverage will consist of:

	Units
Base Coverage	<u>2</u>
<input checked="" type="checkbox"/> Benefit Enhancement Rider	<u>2</u>

Total Deduction

Cancer/Specified Disease (GVCP2) Do you want this coverage? Yes No Section 125

Who do you want to cover?

- Employee Only
- Family

Plan _____

Your coverage will consist of:

	Units
Hospital	<u>2</u>
Radiation/Chemotherapy	<u>4</u>
Surgery Related	<u>1</u>
Miscellaneous	<u>1</u>
<input checked="" type="checkbox"/> Cancer Initial Diagnosis Option	<u>5</u>
<input checked="" type="checkbox"/> Intensive Care Option	<u>2</u>
<input checked="" type="checkbox"/> Cancer Screening Option	<u>4</u>

Total Deduction

Critical Illness (GVCIP2) Do you want this coverage? Yes No Section 125

Who do you want to cover?

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

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

Total Deduction

Hospital Indemnity (GVSP1) Do you want this coverage? Yes No Section 125

Who do you want to cover?

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

Your coverage will consist of:

	Units
Hospital Related	<u>2</u>
Surgery/Inpatient Physician	<u>1</u>
Outpatient Related	<u>1</u>

Total Deduction

Group Enrollment Form

Life Do you want this coverage? Yes No

Guaranteed Issue

Life product being offered: Term Life

Riders being applied for: Units/Amt.

Requested Face Amount \$ _____

Employee Annual Base Salary \$ _____

GTLWP	
GTLBR	

Total Deduction

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.

Group Enrollment Form**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)		
Amber Hoadley	801N0		Benecom	4T1G0	



AMERICAN HERITAGE LIFE INSURANCE COMPANY

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

A Stock Company

<p>IMPORTANT NOTICE TO PERSONS ON MEDICARE THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS</p>
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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 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

<p>Before You Buy This Insurance</p>

- ✓ 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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(AWDPKG1)



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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

<p>Before You Buy This Insurance</p>

- ✓ 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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AWD3431-1



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<p>IMPORTANT NOTICE TO PERSONS ON MEDICARE THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS</p>
--

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

<p>Before You Buy This Insurance</p>

- ✓ 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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