

**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
48942						FL
Deduction Mode (choose one): <input type="checkbox"/> Monthly <input checked="" type="checkbox"/> Semi-Monthly <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-Weekly <input type="checkbox"/> Other _____						
Remarks			AHL home office use only			

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 Pasco County Supervisor of Elections		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 ☐ NoCheck the qualifying event: ☐ Marriage/Divorce ☐ Birth/Adoption ☐ Spouse New Job/Job Loss ☐ Termination
☐ Work Status Change ☐ Eligible/Ineligible Child ☐ Spouse/Dependent Child Death ☐ Employee DeathQualifying 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 (GVAP6) Do you want this coverage? ☐ Yes ☐ No

Section 125 ☐

Choose coverage amount:

Total Semi-Monthly Deductions	
Employee Only	<input type="checkbox"/> \$ 9.37
Employee + Spouse	<input type="checkbox"/> \$16.21
Employee + Child(ren)	<input type="checkbox"/> \$19.58
Family	<input type="checkbox"/> \$26.22

Your coverage will consist of:

Units

Base Coverage	3
Accident Treatment & Urgent Care Rider	3
Emergency Room Services Rider	2.5
Outpatient Physician's Rider	1.5
Dislocation/Fracture Rider	2
Benefit Enhancement Rider	3.5
Accidental Death, Dismemberment & Functional Loss Rider	2

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

Section 125 ☐

Choose coverage amount:

Total Semi-Monthly Deductions	
Employee Only	<input type="checkbox"/> \$11.64
Family	<input type="checkbox"/> \$19.96

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	3

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

Section 125 ☐

Basic Benefit Amount: \$ 20,000

Your coverage will consist of:

- ☒ Second Event Initial Critical Illness Option
- ☒ Wellness Option Units 3
- ☒ Supplemental Critical Illness Option II

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	<input type="checkbox"/> \$ 2.78	<input type="checkbox"/> \$ 4.23	<input type="checkbox"/> \$ 2.78	<input type="checkbox"/> \$ 4.23	<input type="checkbox"/> \$ 3.34	<input type="checkbox"/> \$ 5.05	<input type="checkbox"/> \$ 3.34	<input type="checkbox"/> \$ 5.05
25-29	<input type="checkbox"/> \$ 2.96	<input type="checkbox"/> \$ 4.59	<input type="checkbox"/> \$ 2.96	<input type="checkbox"/> \$ 4.59	<input type="checkbox"/> \$ 3.52	<input type="checkbox"/> \$ 5.41	<input type="checkbox"/> \$ 3.52	<input type="checkbox"/> \$ 5.41
30-35	<input type="checkbox"/> \$ 3.71	<input type="checkbox"/> \$ 5.71	<input type="checkbox"/> \$ 3.71	<input type="checkbox"/> \$ 5.71	<input type="checkbox"/> \$ 4.57	<input type="checkbox"/> \$ 6.99	<input type="checkbox"/> \$ 4.57	<input type="checkbox"/> \$ 6.99
36-39	<input type="checkbox"/> \$ 4.61	<input type="checkbox"/> \$ 7.17	<input type="checkbox"/> \$ 4.61	<input type="checkbox"/> \$ 7.17	<input type="checkbox"/> \$ 6.22	<input type="checkbox"/> \$ 9.53	<input type="checkbox"/> \$ 6.22	<input type="checkbox"/> \$ 9.53
40-44	<input type="checkbox"/> \$ 5.82	<input type="checkbox"/> \$ 8.98	<input type="checkbox"/> \$ 5.82	<input type="checkbox"/> \$ 8.98	<input type="checkbox"/> \$ 8.12	<input type="checkbox"/> \$12.41	<input type="checkbox"/> \$ 8.12	<input type="checkbox"/> \$12.41
45-50	<input type="checkbox"/> \$ 7.76	<input type="checkbox"/> \$11.84	<input type="checkbox"/> \$ 7.76	<input type="checkbox"/> \$11.84	<input type="checkbox"/> \$11.31	<input type="checkbox"/> \$17.10	<input type="checkbox"/> \$11.31	<input type="checkbox"/> \$17.10
51-54	<input type="checkbox"/> \$10.25	<input type="checkbox"/> \$15.52	<input type="checkbox"/> \$10.25	<input type="checkbox"/> \$15.52	<input type="checkbox"/> \$15.03	<input type="checkbox"/> \$22.56	<input type="checkbox"/> \$15.03	<input type="checkbox"/> \$22.56
55-60	<input type="checkbox"/> \$13.45	<input type="checkbox"/> \$20.29	<input type="checkbox"/> \$13.45	<input type="checkbox"/> \$20.29	<input type="checkbox"/> \$20.75	<input type="checkbox"/> \$31.10	<input type="checkbox"/> \$20.75	<input type="checkbox"/> \$31.10
61-70	<input type="checkbox"/> \$18.01	<input type="checkbox"/> \$26.98	<input type="checkbox"/> \$18.01	<input type="checkbox"/> \$26.98	<input type="checkbox"/> \$26.22	<input type="checkbox"/> \$39.17	<input type="checkbox"/> \$26.22	<input type="checkbox"/> \$39.17
71+	<input type="checkbox"/> \$29.00	<input type="checkbox"/> \$43.38	<input type="checkbox"/> \$29.00	<input type="checkbox"/> \$43.38	<input type="checkbox"/> \$39.65	<input type="checkbox"/> \$60.08	<input type="checkbox"/> \$39.65	<input type="checkbox"/> \$60.08

Group Enrollment Form

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

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

Semi-Monthly Deductions				
Age	Employee Only	Employee + Spouse	Employee + Child(ren)	Family
18-35	<input type="checkbox"/> \$15.98	<input type="checkbox"/> \$30.15	<input type="checkbox"/> \$25.81	<input type="checkbox"/> \$39.43
36-49	<input type="checkbox"/> \$18.72	<input type="checkbox"/> \$35.46	<input type="checkbox"/> \$29.81	<input type="checkbox"/> \$45.97
50-59	<input type="checkbox"/> \$23.31	<input type="checkbox"/> \$45.63	<input type="checkbox"/> \$34.15	<input type="checkbox"/> \$55.83
60-64	<input type="checkbox"/> \$31.14	<input type="checkbox"/> \$62.28	<input type="checkbox"/> \$41.22	<input type="checkbox"/> \$71.61
65+	<input type="checkbox"/> \$41.72	<input type="checkbox"/> \$83.43	<input type="checkbox"/> \$51.84	<input type="checkbox"/> \$92.67

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 <i>(Last, First, M.I.)</i>		Social Security No.	
Residence Address		Birth Date	Relationship
City, State, Zip		Phone No.	
Contingent Beneficiary Name <i>(Last, First, M.I.)</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.

Employee Signature _____	Date Signed _____
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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 _____
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Florida Agent License Number _____	
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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 Benecom - Brad Shattuck (Producer)	4T1G0	90	Soliciting Agent Amber Hoadley (Producer)	801N0	10



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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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 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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IMPORTANT NOTICE TO PERSONS ON MEDICARE 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.
- ✓ For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program (SHIIP).