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
W2359				Union County	Auditors Office	OH

Deduction Mode: *(choose one)*: ☒ Monthly ☐ Semi-Monthly ☐ Weekly ☐ Bi-Weekly ☐ Other _____

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

General Information

All references to spouse include civil union and 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	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 ☐ Critical Illness

Employee Name _____ Account No. W2359

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 ☒

Who do you want to cover?

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

Total Deduction

Choose coverage:	Units
Base Coverage	4
☒ Accident Treatment & Urgent Care Rider	4
☒ Emergency Room Services Rider	4
☒ Outpatient Physician's Rider	4
☒ Dislocation/Fracture Rider	2
☒ Benefit Enhancement Rider	4
☒ Accidental Death, Dismemberment & Functional Loss Rider	4

Critical Illness (GVCIP4) My Lifeline

Do you want this coverage? ☐ Yes ☐ No Section 125 ☒

Who do you want to cover?

- ☐ Employee + Child(ren)
- ☐ Family

Total Deduction

Choose coverage:

Basic Benefit Amount: $ _____

- ☒ Cancer Critical Illness Option
- ☒ Reoccurrence of Critical Illness Option
- ☒ Second Evaluation, Transportation & Lodging Rider
- ☒ Reoccurrence of Cancer Critical Illness Option
- ☐ Supplemental Critical Illness Rider with HIV
- ☒ Supplemental Critical Illness Rider without HIV
- ☐ Wellness Rider - Fixed Units _____
- ☒ Wellness Rider - Variable Units 1
- ☒ Skin Cancer Rider
- ☒ Cardiopulmonary Enhancement Rider
- ☒ Specified Chronic Illness Rider
- ☒ Specified Chronic Illness or Injury Rider
- ☐ Lifestyle Enhancement Rider

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.	

Employee Name _____ Account No. _____

Group Enrollment Form

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 defraud any insurance company or other person, files an application for insurance or statement of claim containing any false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent act, which is a crime and subjects such person to criminal and civil penalties.

Employee Signature _____ Date Signed _____

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 Producer Signature _____ Soliciting Producer Name Printed Thomas W Boston

Home office or producer to complete before issue:

Producer Name	Producer Number	Percentage Credit	Producer Name	Producer Number	Percentage Credit
Servicing Producer Thomas W Boston	6XNM0		Soliciting Producer		
Eugene Hudock	4XRK0				
Linda Lee Boston	7GNR0				