

**AMERICAN HERITAGE LIFE INSURANCE COMPANY (AHL)**4920 SAN PABLO ROAD S, SUITE 200C
JACKSONVILLE, FL 32224-1844**Group Enrollment Form**☒ Check if custom form

Account No.	Employee ID	Requested Effective Date	First Deduction Date	Account	Location	Situs State
W2359				Union County		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 (Payor/Owner/Certificate holder) 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 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 ☐ 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 ☐ Critical Illness ☐ Disability

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

Total Deduction**Choose coverage:**

Base Coverage

- ☐ Employee Off-the-Job Accident Disability Rider
- ☐ Employee On and Off-the-Job Accident Disability Rider
- ☐ Employee Off-the-Job Accident/Sickness Disability Rider
- ☐ Employee On and Off-the-Job Accident/Sickness Disability Rider
- ☐ Spouse On and Off-the-Job Accident Disability Rider*
- ☐ Spouse On and Off-the-Job Accident/Sickness Disability Rider*
- ☐ Benefit Enhancement Rider

Units

Provide for disability riders:

Employee Monthly Earnings \$ _____

Spouse Monthly Earnings \$ _____

*Available only when Employee + Spouse or Family coverage is selected and the insured spouse has worked 20 hours per week for 3 or more consecutive months.

Accident (GVAP2 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

Total Deduction**Choose coverage:**

Base Coverage

- ☐ Benefit Enhancement Option
- ☐ Outpatient Physician's Rider

Units

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:**

Base Coverage

- ☒ Accident Treatment & Urgent Care Rider
- ☒ Emergency Room Services Rider
- ☒ Outpatient Physician's Rider
- ☒ Dislocation/Fracture Rider
- ☒ Benefit Enhancement Rider
- ☒ Accidental Death, Dismemberment & Functional Loss Rider

Units

4

4

4

2

4

4

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

Total Deduction

- ☐ Cancer Critical Illness Option
- ☐ Second Event Initial Critical Illness Option
- ☐ Wellness Option Units _____
- ☐ Second Event Cancer Critical Illness Option
- ☐ Supplemental Critical Illness Option I (HIV)
- ☐ Supplemental Critical Illness Option II
- ☐ Second Evaluation Benefit Rider

Basic Benefit Amount: \$ _____

10K or 20K

Employee Name _____

Account No. _____

Group Enrollment Form**Critical Illness** (GVCIP4) My Lifeline Do you want this coverage? ☐ Yes ☐ NoSection 125 ☐**Who do you want to cover?**☐ Employee + Child(ren)☐ Family**Total Deduction**

- ☒ 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

Basic Benefit Amount: \$ _____

Disability (GVDIP Short-Term) My Lifeline Do you want this coverage? ☐ Yes ☐ NoSection 125 ☐

Provide: Monthly Earnings* \$ _____ Monthly Benefit \$ _____

*Taxable (gross) monthly earnings from your occupation with the employer listed on the first page of this form.

Choose elimination and benefit periods:

Elimination Period: _____ Days Accident _____ Days Sickness Benefit Period: _____ Months

Total DeductionA. Is this insurance to replace any existing disability coverage? ☐ Yes ☐ No If yes, provide the company name: _____B. Is there any other disability insurance in force or applied for that will continue after the effective date of this coverage? ☐ Yes ☐ No

If yes, provide the following: Company Name _____ Year Issued _____

Monthly Benefit \$ _____ Elimination Period _____ Benefit Period _____

Life Do you want this coverage? ☐ Yes ☐ No☒ Guaranteed IssueLife product being offered: ☒ Whole Life

Requested Face Amount \$ _____

Employee Annual Base Salary \$ _____

Total Deduction

Riders being applied for: Units/Amt.

Group Enrollment Form**If the proposed insured is your spouse, provide the following for that proposed insured.**☐ Spouse

Proposed Insured Name (<i>Last, First, M.I.</i>)		Social Security No.	☐ Male ☐ Female
Residence Street Address		Birth Date	
City, State, Zip	Phone No.	Email Address	
Employer of Proposed Insured	Annual Salary	Occupation	

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*)**1. 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 producer, if required by your state.

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2. 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

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Accelerated Death Benefit for Long Term Care Rider (*Must answer*)**1. Secondary Addressee Designation.** Protection against unintended lapse: I understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of this long term care insurance rider for nonpayment of premium. I understand that notice will not be given until 30 days after a premium is due and unpaid. Would you like to designate at least one additional person to receive notification of a possible lapse or termination of coverage? If yes, please provide full name and mailing address.☐ Yes ☐ No

Name (<i>Last, First, M.I.</i>)	
Residence Street Address	City, State, Zip

2. Replacement. Is this rider to replace or change any existing accident and health or long term care coverage? If yes, please indicate product being replaced or changed and complete replacement form provided by your producer, if required by your state.☐ Yes ☐ No

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3a. Existing Insurance. Is there any other long term care insurance in force (including health care service contract or health maintenance organization contract) on the proposed insured? If yes, list company name, policy number, year issued, type of coverage, and amount of benefit.☐ Yes ☐ No

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3b. Has there been any other long term care insurance in force during the last 12 months on the proposed insured? If yes, list company name, policy number, year issued, type of coverage, and amount of benefit. If that insurance lapsed, state when it lapsed.☐ Yes ☐ No

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3c. Are you covered by Medicaid?☐ Yes ☐ No

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 Questions

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

Employee answer for the following: Disability, 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

Spouse answer for the following: Life

Spouse Actively At Work. Is the employee's spouse 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? **Spouse** ☐ 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.

Caution: If your answers on this application are incorrect or untrue, AHL has the right to deny benefits or rescind your Accelerated Death Benefit for Long Term Care coverage, if applied for.

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 _____

Home office or producer to complete before issue:

Producer Name	Producer Number	Percentage Credit	Producer Name	Producer Number	Percentage Credit
Servicing Producer					

AMERICAN HERITAGE LIFE INSURANCE COMPANY

HOME OFFICE:

4920 SAN PABLO ROAD S, SUITE 200C

JACKSONVILLE, FL 32224-1844

800.521.3535

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).