AMERICAN HERITAGE LIFE INSURANCE COMPANY (AHL)

1776 AMERICAN HERITAGE LIFE DRIVE
JACKSONVILLE, FLORIDA 32224

Allstate.

Workplace Division

ENROLLMENT FORM

Check appropriate box(es)

☐ **Heritage Choice Dental**
☐ **Critical Illness**
☐ **Cancer/Specified Disease**
☐ **Accident**
☐ **Hospital Indemnity**

For AHL Home Office use only

Notes

GENERAL INFORMATION SECTION

Please print with black ink

(Please complete entire section for all coverages)

EMPLOYEE'S NAME Last (Sr, Jr, etc) First M.I.	☐ M ☐ F	SOCIAL SECURITY NUMBER	☐ Married ☐ Single
HOME ADDRESS (Street or P.O. Box)	CITY	STATE	ZIP
BIRTHDATE (MM/DD/YEAR)	HOME PHONE NUMBER	EMPLOYER	DATE HIRED (MM/DD/YEAR)
OCCUPATION	PLANT OR DIVISION	CURRENT EARNINGS $________ (also check appropriate box)	
BENEFICIARY'S NAME (Last, First, M.I.)	RELATIONSHIP	☐ Hourly ☐ Weekly ☐ Monthly ☐ Bi-weekly (26) ☐ Semi-monthly (24) ☐ Annually	

Are you adding any coverage or changing any of your existing coverage due to marriage, birth, adoption, employment status change, etc.?

Critical Illness	☐ Yes ☐ No	**Hospital Indemnity**	☐ Yes ☐ No
Cancer/Specified Disease	☐ Yes ☐ No	**Heritage Choice Dental**	☐ Yes ☐ No
Accident	☐ Yes ☐ No		

If "yes", indicate type of change: ____________________

Date of change ________ Current Certificate Number ____________________

DEPENDENT COVERAGE SECTION

(Please complete if dependent coverage elected. Use additional paper if needed.)

Abbreviations: Den-Dental Can-Cancer Acc-Accident Hosp-Hospital CI-Critical Illness

Choose Plans: Den	Can	Acc	Hosp	CI	Dependent's Name (Last, First, M.I.)	Relationship	Sex	Date of Birth (MM/DD/YEAR)	Social Security Number

ENROLLMENT FORM

SELECTION OF COVERAGE SECTION

(Answer Yes or No and complete for each coverage selected)

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Heritage Choice Dental ☐ Yes ☐ No	☐ Plan 1 ☐ Plan 4 ☐ Plan 2 ☐ Plan 5 ☐ Plan 3	☐ Employee Only ☐ Employee + Child ☐ Employee + Spouse ☐ Family	Section 125 ☐ Yes ☐ No	Total Mode Premium $________
Were you covered under your Employer's prior Dental Plan? ☐ Yes ☐ No If "Yes", please enter the date coverage effective________			**AHL Home Office Use Only** SET ID **ACTIV** or **EMPLR** or ________ PLAN ID **P1NG1** **P1NG2** **P1NG3**	

Critical Illness ☐ Yes ☐ No	☒ My Lifeline	☐ Employee Only ☐ Employee+Spouse ☐ Employee+Child(ren) ☐ Family	Section 125 ☐ Yes ☐ No	Total Mode Premium $________	**Home Office Use Only** SET ID________
Basic Benefit Amount $________ If requesting coverage for spouse or dependents, the basic benefit amount is 50% of the employee.		Critical Illness Cancer Option ☐	Recurrence Option ☐	Wellness Option ☐ Units ________	

Has any person to be insured used tobacco in any form in the last 12 months? ☐ Yes ☐ No
If so, who and what type? ________

Do you currently have an individual Critical Illness product with AHL? ☐ Yes ☐ No
If "Yes", please enter the Policy Number________
Do you wish to terminate this coverage? ☐ Yes ☐ No If "Yes", please enter the effective date of termination________

Cancer/Specified Disease ☐ Yes ☐ No	Plan ________	☐ Employee Only ☐ Family	Section 125 ☐ Yes ☐ No	Total Mode Premium $________

Benefits	Hospital	Radiation / Chemotherapy	Surgery Related	Misc.	Initial Diagnosis Option ☐	Intensive Care Option ☐	Cancer Screening Option ☐
Units				1			

Do you currently have an individual Cancer product with AHL? ☐ Yes ☐ No
If "Yes", please enter the Policy Number________
Do you wish to terminate this coverage? ☐ Yes ☐ No If "Yes", please enter the effective date of termination________

Accident ☐ Yes ☐ No	Base Units ________	☐ Employee Only ☐ Family	Section 125 ☐ Yes ☐ No	Total Mode Premium $________

Optional Disability Riders for Employee
- ☐ Off the Job Accident
- ☐ On and Off the Job Accident
- ☐ Off the Job Accident and Sickness
- ☐ On and Off the Job Accident and Sickness

Optional Disability Riders for Spouse
- ☐ On and Off the Job Accident for Insured Spouse*
- ☐ On and Off the Job Accident and Sickness for Insured Spouse*

Disability Rider Units
Employee ________
Spouse ________

***Available only when family coverage is selected and the insured spouse has worked 25 hours per week for 3 or more consecutive months.**

Do you currently have an individual Accident product with AHL? ☐ Yes ☐ No
If "Yes", please enter the Policy Number________
Do you wish to terminate this coverage? ☐ Yes ☐ No If "Yes", please enter the effective date of termination________

ENROLLMENT FORM

SELECTION OF COVERAGE SECTION

(Answer Yes or No and complete for each coverage selected)

Hospital Indemnity ☐ Yes ☐ No	Plan ______	☐ Employee Only ☐ Employee+Child(ren) ☐ Employee+Spouse ☐ Family	Section 125 ☐ Yes ☐ No	Total Mode Premium $ ______

Benefits	Hospital Related	Surgery / Inpatient Physician	Outpatient Related	Diagnostic / Wellness Option ☐	Prescription Drug Option ☐	Disability Rider ☐	Life Rider ☐
Units							

Do you currently have an individual Hospital Indemnity product with AHL? ☐ Yes ☐ No
If "Yes", please enter the Policy Number ______________________
Do you wish to terminate this coverage? ☐ Yes ☐ No If "Yes", please enter the effective date of termination ______

Premium/Billing Mode ☐ Monthly ☐ Semi-monthly ☐ Bi-weekly ☐ Weekly ☐ Other______ Issue Date ______ Cash With Application ______	Case Number	Producer/ Agent Number	Percentage Credit
	Employee ID		
	Situs State		

ACCEPTANCE: I hereby request all coverage checked "yes" above for which I am or may become eligible under the group coverages issued by AHL. I authorize my employer to deduct from my earnings any contributions required of me for the payment of premiums for such coverage. **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 materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. · **I UNDERSTAND** that the "effective date" of my elected coverages will be the effective date recorded on my Certificate, not the date this Enrollment form is signed. · **WAIVER/DECLINATION**: I understand that if I refuse any coverage for which I am eligible (by checking "no" above), satisfactory proof of insurability may be required, at my own expense, should I desire to apply for it at a later date. Any such application may be declined on the basis of such proof.

Date Signed ______________________ Employee's Signature ______________________