AMERICAN HERITAGE LIFE INSURANCE COMPANY (AHL)

1776 AMERICAN HERITAGE LIFE DRIVE
JACKSONVILLE, FLORIDA 32224

ENROLLMENT FORM

☐ New Certificate ☐ Change/Increase Certificate # _____

Remarks: **Please return the completed enrollment form to your HR/Benefits Department.**	This box for AHL Home Office use only

GENERAL INFORMATION

Employee's Name (Last, First, M.I.)	☐ M ☐ F	Social Security Number	
Residence Address	City	State	Zip
Date of Birth / Phone Number		Email	
Employer/Association/Union **Metro** / Date Hired		Occupation / Badge Number	
Primary Beneficiary's Full Name and Address / City / State / Zip		Relationship	
Phone Number / Date of Birth / Social Security Number			
Contingent Beneficiary's Full Name and Address / City / State / Zip		Relationship	
Phone Number / Date of Birth / Social Security Number			

COMPLETE THIS SECTION FOR PERSONS TO BE INSURED

Last Name	First Name	Relationship	Sex	Date of Birth	Social Security Number	Tobacco Use*
		Employee				** ☐ Yes ☐ No
		Spouse				** ☐ Yes ☐ No

***Has anyone to be insured used tobacco in the last 12 months? (**If applying for Critical Illness.)**

Premium/Billing Mode ☒ Weekly Coverage Effective Date _____	Account Number	Employee ID	Situs State **MO**

SELECTION OF COVERAGE

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

Accident (GVAP2) (Off the Job Accident) ☐ Yes ☐ No	Base Units 1	**Total Weekly Premiums** Employee Only ☐ $1.59; Employee+Spouse ☐ $2.41; Employee+Child(ren) ☐ $3.68; Family ☐ $4.61	Section 125 ☐ Yes ☒ No	**Home Office Use Only**

☒ Benefit Enhancement Rider Units 1	☒ Enhanced Family Fracture Option	☒ Outpatient Physician's Rider Units 2

ENROLLMENT FORM

SELECTION OF COVERAGE

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

Critical Illness (GVCIP2) ☐ Yes ☐ No	**Basic Benefit Amount** ☐ **$10,000 - or -** ☐ **$20,000** If covered, Basic Benefit amount for spouse or other dependents is 50% of the employee's.	Section 125 ☐ Yes ☒ No	**Home Office Use Only**

☒ Cancer Critical Illness Option	☒ 2nd Event Initial Critical Illness Option	☒ 2nd Event Cancer Critical Illness Option	☒ Supplemental Critical Illness Option II	☒ No Pre-Existing Option	☒ Wellness Option Units 2

Weekly Premiums $10,000 Basic Benefit	Age	Employee Only	Employee + Spouse	Employee + Child(ren)	Family
Non-Tobacco	18-29	☐ $ 1.24	☐ $ 2.00	☐ $ 1.24	☐ $ 2.00
	30-39	☐ $ 2.16	☐ $ 3.38	☐ $ 2.16	☐ $ 3.38
	40-49	☐ $ 3.94	☐ $ 6.05	☐ $ 3.94	☐ $ 6.05
	50-59	☐ $ 6.94	☐ $10.56	☐ $ 6.94	☐ $10.56
	60-63	☐ $11.25	☐ $17.01	☐ $11.25	☐ $17.01
	64+	☐ $14.70	☐ $22.19	☐ $14.70	☐ $22.19
Tobacco	18-29	☐ $ 1.81	☐ $ 2.85	☐ $ 1.81	☐ $ 2.85
	30-39	☐ $ 3.35	☐ $ 5.16	☐ $ 3.35	☐ $ 5.16
	40-49	☐ $ 6.95	☐ $10.57	☐ $ 6.95	☐ $10.57
	50-59	☐ $11.70	☐ $17.69	☐ $11.70	☐ $17.69
	60-63	☐ $19.24	☐ $29.01	☐ $19.24	☐ $29.01
	64+	☐ $25.41	☐ $38.26	☐ $25.41	☐ $38.26

Weekly Premiums $20,000 Basic Benefit	Age	Employee Only	Employee + Spouse	Employee + Child(ren)	Family
Non-Tobacco	18-29	☐ $ 2.18	☐ $ 3.41	☐ $ 2.18	☐ $ 3.41
	30-39	☐ $ 4.04	☐ $ 6.19	☐ $ 4.04	☐ $ 6.19
	40-49	☐ $ 7.60	☐ $11.54	☐ $ 7.60	☐ $11.54
	50-59	☐ $13.60	☐ $20.54	☐ $13.60	☐ $20.54
	60-63	☐ $22.20	☐ $33.45	☐ $22.20	☐ $33.45
	64+	☐ $29.11	☐ $43.81	☐ $29.11	☐ $43.81
Tobacco	18-29	☐ $ 3.33	☐ $ 5.13	☐ $ 3.33	☐ $ 5.13
	30-39	☐ $ 6.40	☐ $ 9.75	☐ $ 6.40	☐ $ 9.75
	40-49	☐ $13.61	☐ $20.56	☐ $13.61	☐ $20.56
	50-59	☐ $23.10	☐ $34.79	☐ $23.10	☐ $34.79
	60-63	☐ $38.20	☐ $57.44	☐ $38.20	☐ $57.44
	64+	☐ $50.53	☐ $75.93	☐ $50.53	☐ $75.93

ACCEPTANCE/AUTHORIZATION: I hereby request all coverage(s) 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 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 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 _____

To be completed by home office or producer, prior to issue:

Producer Name	**Producer Number**	**National Producer Number (NPN)**	**Percentage Credit**
Servicing Producer:			%
Soliciting Producer:			%
			%
			%
			%

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).