



AMERICAN HERITAGE LIFE INSURANCE COMPANY (AHL)

**1776 AMERICAN HERITAGE LIFE DRIVE
JACKSONVILLE, FLORIDA 32224**

ENROLLMENT FORM

New Certificate Change/Increase Certificate # _____

| | |
|-----------------------------|---------------------------------------|
| Remarks: CUSTOM FORM | This box for AHL Home Office use only |
|-----------------------------|---------------------------------------|

GENERAL INFORMATION

| | | | | |
|--|---------------|--|------------------------|-------------------|
| Employee's Name (Last, First, M.I.) | | <input type="checkbox"/> M <input type="checkbox"/> F | Social Security Number | |
| Residence Address | | City | State | Zip |
| Date of Birth | Phone Number | Email | | |
| Employer/Association/Union USD 261 Haysville Schools | | Date Hired | Occupation | Plant Or Division |
| 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* (Critical Illness) |
|-----------|------------|--------------|-----|---------------|------------------------|---|
| | | Employee | | | | ** <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | Spouse | | | | ** <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | | | | | |
| | | | | | | |

***Has any adult (19 and older) person to be insured used tobacco in the last 12 months? (**If applying for Critical Illness. For Critical Illness, tobacco rating applies to all covered persons if either the employee or the employee's spouse answers "Yes" to Tobacco Use.)**

Are you applying for coverage or changing existing coverage due to a qualifying event?
Accident Yes No **Critical Illness** Yes No

If "Yes," check the qualifying event:

| | | |
|---|---|---|
| <input type="checkbox"/> Marriage | <input type="checkbox"/> Spouse/Dependent Child Death | <input type="checkbox"/> Newly Eligible |
| <input type="checkbox"/> Divorce | <input type="checkbox"/> Eligible/Ineligible Child | <input type="checkbox"/> Termination |
| <input type="checkbox"/> Birth/Adoption | <input type="checkbox"/> Spouse New Job/Job Loss | <input type="checkbox"/> Employee Death |

Date of Qualifying Event _____ Current Certificate Number(s) _____

Do you currently have any of the following Individual coverages with American Heritage Life Insurance Company (AHL)?
 Accident Yes No Critical Illness Yes No

If you answered "Yes" to any of the coverages, please enter the Policy Number _____

Do you wish to terminate this coverage? Yes No If "Yes," please enter effective date of termination _____

| | | | |
|--|----------------|-------------|-------------|
| Premium/Billing Mode <input checked="" type="checkbox"/> Monthly | Account Number | Employee ID | Situs State |
| Date of First Deduction _____ Coverage Effective Date _____ | 25203 | | KS |

ENROLLMENT FORM

SELECTION OF COVERAGE

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

| | | | | |
|---|----------------------------|--|--|-----------------------------|
| Accident (GVAP2) (Off the Job Accident) <input type="checkbox"/> Yes <input type="checkbox"/> No | Base Units <u>2</u> | Total Monthly Premiums Employee Only <input type="checkbox"/> \$10.40 Employee+Spouse <input type="checkbox"/> \$16.65 Employee+Child(ren) <input type="checkbox"/> \$24.75 Family <input type="checkbox"/> \$31.00 | Section 125 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | Home Office Use Only |
| <input checked="" type="checkbox"/> Benefit Enhancement Option Units <u>1</u> | | <input checked="" type="checkbox"/> Family Fracture Option | | |

| | | | | | |
|--|--|---|-----------------------------------|-----------------------------------|-----------------------------------|
| Critical Illness (GVCIP2) <input type="checkbox"/> Yes <input type="checkbox"/> No | Section 125 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | Home Office Use Only | | | |
| Basic Benefit Amount <input type="checkbox"/> \$10,000 - or - <input type="checkbox"/> \$20,000 | | | | | |
| <input checked="" type="checkbox"/> Supplemental Critical Illness Option II | <input checked="" type="checkbox"/> Wellness Option Units <u>3</u> | <input checked="" type="checkbox"/> 2 nd Event Initial Critical Illness Option | | | |
| Monthly Premiums \$10,000 Basic Benefit | Age | Employee Only | Employee + Spouse | Employee + Child(ren) | Family |
| Non-Tobacco | 18-29 | <input type="checkbox"/> \$ 3.59 | <input type="checkbox"/> \$ 6.43 | <input type="checkbox"/> \$ 3.59 | <input type="checkbox"/> \$ 6.43 |
| | 30-39 | <input type="checkbox"/> \$ 5.68 | <input type="checkbox"/> \$ 9.57 | <input type="checkbox"/> \$ 5.68 | <input type="checkbox"/> \$ 9.57 |
| | 40-49 | <input type="checkbox"/> \$ 8.98 | <input type="checkbox"/> \$ 14.51 | <input type="checkbox"/> \$ 8.98 | <input type="checkbox"/> \$ 14.51 |
| | 50-59 | <input type="checkbox"/> \$ 15.31 | <input type="checkbox"/> \$ 24.02 | <input type="checkbox"/> \$ 15.31 | <input type="checkbox"/> \$ 24.02 |
| | 60-63 | <input type="checkbox"/> \$ 25.27 | <input type="checkbox"/> \$ 38.96 | <input type="checkbox"/> \$ 25.27 | <input type="checkbox"/> \$ 38.96 |
| | 64+ | <input type="checkbox"/> \$ 35.07 | <input type="checkbox"/> \$ 53.65 | <input type="checkbox"/> \$ 35.07 | <input type="checkbox"/> \$ 53.65 |
| Tobacco | 18-29 | <input type="checkbox"/> \$ 4.39 | <input type="checkbox"/> \$ 7.63 | <input type="checkbox"/> \$ 4.39 | <input type="checkbox"/> \$ 7.63 |
| | 30-39 | <input type="checkbox"/> \$ 7.69 | <input type="checkbox"/> \$ 12.58 | <input type="checkbox"/> \$ 7.69 | <input type="checkbox"/> \$ 12.58 |
| | 40-49 | <input type="checkbox"/> \$ 14.12 | <input type="checkbox"/> \$ 22.23 | <input type="checkbox"/> \$ 14.12 | <input type="checkbox"/> \$ 22.23 |
| | 50-59 | <input type="checkbox"/> \$ 23.82 | <input type="checkbox"/> \$ 36.78 | <input type="checkbox"/> \$ 23.82 | <input type="checkbox"/> \$ 36.78 |
| | 60-63 | <input type="checkbox"/> \$ 40.72 | <input type="checkbox"/> \$ 62.14 | <input type="checkbox"/> \$ 40.72 | <input type="checkbox"/> \$ 62.14 |
| | 64+ | <input type="checkbox"/> \$ 57.59 | <input type="checkbox"/> \$ 87.44 | <input type="checkbox"/> \$ 57.59 | <input type="checkbox"/> \$ 87.44 |
| Monthly Premiums \$20,000 Basic Benefit | Age | Employee Only | Employee + Spouse | Employee + Child(ren) | Family |
| Non-Tobacco | 18-29 | <input type="checkbox"/> \$ 5.08 | <input type="checkbox"/> \$ 8.67 | <input type="checkbox"/> \$ 5.08 | <input type="checkbox"/> \$ 8.67 |
| | 30-39 | <input type="checkbox"/> \$ 9.27 | <input type="checkbox"/> \$ 14.95 | <input type="checkbox"/> \$ 9.27 | <input type="checkbox"/> \$ 14.95 |
| | 40-49 | <input type="checkbox"/> \$ 15.87 | <input type="checkbox"/> \$ 24.85 | <input type="checkbox"/> \$ 15.87 | <input type="checkbox"/> \$ 24.85 |
| | 50-59 | <input type="checkbox"/> \$ 28.54 | <input type="checkbox"/> \$ 43.85 | <input type="checkbox"/> \$ 28.54 | <input type="checkbox"/> \$ 43.85 |
| | 60-63 | <input type="checkbox"/> \$ 48.45 | <input type="checkbox"/> \$ 73.72 | <input type="checkbox"/> \$ 48.45 | <input type="checkbox"/> \$ 73.72 |
| | 64+ | <input type="checkbox"/> \$ 68.03 | <input type="checkbox"/> \$103.10 | <input type="checkbox"/> \$ 68.03 | <input type="checkbox"/> \$103.10 |
| Tobacco | 18-29 | <input type="checkbox"/> \$ 6.69 | <input type="checkbox"/> \$ 11.08 | <input type="checkbox"/> \$ 6.69 | <input type="checkbox"/> \$ 11.08 |
| | 30-39 | <input type="checkbox"/> \$ 13.28 | <input type="checkbox"/> \$ 20.97 | <input type="checkbox"/> \$ 13.28 | <input type="checkbox"/> \$ 20.97 |
| | 40-49 | <input type="checkbox"/> \$ 26.15 | <input type="checkbox"/> \$ 40.27 | <input type="checkbox"/> \$ 26.15 | <input type="checkbox"/> \$ 40.27 |
| | 50-59 | <input type="checkbox"/> \$ 45.53 | <input type="checkbox"/> \$ 69.35 | <input type="checkbox"/> \$ 45.53 | <input type="checkbox"/> \$ 69.35 |
| | 60-63 | <input type="checkbox"/> \$ 79.35 | <input type="checkbox"/> \$120.07 | <input type="checkbox"/> \$ 79.35 | <input type="checkbox"/> \$120.07 |
| | 64+ | <input type="checkbox"/> \$113.08 | <input type="checkbox"/> \$170.67 | <input type="checkbox"/> \$113.08 | <input type="checkbox"/> \$170.67 |

ENROLLMENT FORM

SELECTION OF COVERAGE

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

| | | | | | | |
|--|---|--|--|-----------------------------------|---|--|
| Critical Illness (GVCIP2) <input type="checkbox"/> Yes <input type="checkbox"/> No | | | Section 125 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | Monthly Premiums | |
| <input checked="" type="checkbox"/> 2 nd Event Cancer Critical Illness Option | <input checked="" type="checkbox"/> Supplemental Critical Illness Option II | <input checked="" type="checkbox"/> Wellness Option Units <u>3</u> | <input checked="" type="checkbox"/> Cancer Critical Illness Option | | <input checked="" type="checkbox"/> 2 nd Event Initial Critical Illness Option | |
| Plan 3 \$10,000 Basic Benefit | Age | Employee Only | Employee + Spouse | Employee + Child(ren) | Family | |
| Non-Tobacco | 18-29 | <input type="checkbox"/> \$ 6.19 | <input type="checkbox"/> \$ 10.33 | <input type="checkbox"/> \$ 6.19 | <input type="checkbox"/> \$ 10.33 | |
| | 30-39 | <input type="checkbox"/> \$ 10.20 | <input type="checkbox"/> \$ 16.35 | <input type="checkbox"/> \$ 10.20 | <input type="checkbox"/> \$ 16.35 | |
| | 40-49 | <input type="checkbox"/> \$ 17.92 | <input type="checkbox"/> \$ 27.92 | <input type="checkbox"/> \$ 17.92 | <input type="checkbox"/> \$ 27.92 | |
| | 50-59 | <input type="checkbox"/> \$ 30.92 | <input type="checkbox"/> \$ 47.44 | <input type="checkbox"/> \$ 30.92 | <input type="checkbox"/> \$ 47.44 | |
| | 60-63 | <input type="checkbox"/> \$ 49.57 | <input type="checkbox"/> \$ 75.41 | <input type="checkbox"/> \$ 49.57 | <input type="checkbox"/> \$ 75.41 | |
| | 64+ | <input type="checkbox"/> \$ 64.54 | <input type="checkbox"/> \$ 97.85 | <input type="checkbox"/> \$ 64.54 | <input type="checkbox"/> \$ 97.85 | |
| Tobacco | 18-29 | <input type="checkbox"/> \$ 8.67 | <input type="checkbox"/> \$ 14.05 | <input type="checkbox"/> \$ 8.67 | <input type="checkbox"/> \$ 14.05 | |
| | 30-39 | <input type="checkbox"/> \$ 15.34 | <input type="checkbox"/> \$ 24.06 | <input type="checkbox"/> \$ 15.34 | <input type="checkbox"/> \$ 24.06 | |
| | 40-49 | <input type="checkbox"/> \$ 30.96 | <input type="checkbox"/> \$ 47.48 | <input type="checkbox"/> \$ 30.96 | <input type="checkbox"/> \$ 47.48 | |
| | 50-59 | <input type="checkbox"/> \$ 51.52 | <input type="checkbox"/> \$ 78.33 | <input type="checkbox"/> \$ 51.52 | <input type="checkbox"/> \$ 78.33 | |
| | 60-63 | <input type="checkbox"/> \$ 84.22 | <input type="checkbox"/> \$127.39 | <input type="checkbox"/> \$ 84.22 | <input type="checkbox"/> \$127.39 | |
| | 64+ | <input type="checkbox"/> \$110.94 | <input type="checkbox"/> \$167.47 | <input type="checkbox"/> \$110.94 | <input type="checkbox"/> \$167.47 | |
| Plan 4 \$20,000 Basic Benefit | Age | Employee Only | Employee + Spouse | Employee + Child(ren) | Family | |
| Non-Tobacco | 18-29 | <input type="checkbox"/> \$ 10.28 | <input type="checkbox"/> \$ 16.47 | <input type="checkbox"/> \$ 10.28 | <input type="checkbox"/> \$ 16.47 | |
| | 30-39 | <input type="checkbox"/> \$ 18.32 | <input type="checkbox"/> \$ 28.52 | <input type="checkbox"/> \$ 18.32 | <input type="checkbox"/> \$ 28.52 | |
| | 40-49 | <input type="checkbox"/> \$ 33.77 | <input type="checkbox"/> \$ 51.69 | <input type="checkbox"/> \$ 33.77 | <input type="checkbox"/> \$ 51.69 | |
| | 50-59 | <input type="checkbox"/> \$ 59.78 | <input type="checkbox"/> \$ 90.70 | <input type="checkbox"/> \$ 59.78 | <input type="checkbox"/> \$ 90.70 | |
| | 60-63 | <input type="checkbox"/> \$ 97.05 | <input type="checkbox"/> \$146.62 | <input type="checkbox"/> \$ 97.05 | <input type="checkbox"/> \$146.62 | |
| | 64+ | <input type="checkbox"/> \$126.98 | <input type="checkbox"/> \$191.52 | <input type="checkbox"/> \$126.98 | <input type="checkbox"/> \$191.52 | |
| Tobacco | 18-29 | <input type="checkbox"/> \$ 15.26 | <input type="checkbox"/> \$ 23.93 | <input type="checkbox"/> \$ 15.26 | <input type="checkbox"/> \$ 23.93 | |
| | 30-39 | <input type="checkbox"/> \$ 28.58 | <input type="checkbox"/> \$ 43.92 | <input type="checkbox"/> \$ 28.58 | <input type="checkbox"/> \$ 43.92 | |
| | 40-49 | <input type="checkbox"/> \$ 59.81 | <input type="checkbox"/> \$ 90.77 | <input type="checkbox"/> \$ 59.81 | <input type="checkbox"/> \$ 90.77 | |
| | 50-59 | <input type="checkbox"/> \$100.93 | <input type="checkbox"/> \$152.45 | <input type="checkbox"/> \$100.93 | <input type="checkbox"/> \$152.45 | |
| | 60-63 | <input type="checkbox"/> \$166.35 | <input type="checkbox"/> \$250.57 | <input type="checkbox"/> \$166.35 | <input type="checkbox"/> \$250.57 | |
| | 64+ | <input type="checkbox"/> \$219.78 | <input type="checkbox"/> \$330.72 | <input type="checkbox"/> \$219.78 | <input type="checkbox"/> \$330.72 | |

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 _____

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.

Signature of Soliciting Producer _____ Print Soliciting Producer Name _____

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: Hays Companies | 8BPX1 | | 100 % |
| | | | % |
| | | | % |
| | | | % |



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 (SHIP).