AMERICAN HERITAGE LIFE INSURANCE COMPANY (AHL)

1776 AMERICAN HERITAGE LIFE DRIVE
JACKSONVILLE, FLORIDA 32224

ENROLLMENT FORM

☐ New Certificate ☐ Change/Increase Certificate # _____

Remarks:	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 **Valley Center USD 262** / 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*
		Employee				** ☐ Yes ☐ No
		Spouse/ Domestic Partner				** ☐ Yes ☐ No

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

Are you changing any existing coverage due to a qualifying event such as marriage, birth, or adoption?

Accident ☐ Yes ☐ No **Critical Illness** ☐ Yes ☐ No

Cancer/Specified Disease ☐ Yes ☐ No

If "Yes", please complete the following: Qualifying Event _____

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 Cancer ☐ 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 ☒ Semi-monthly Date of First Deduction _____ Coverage Effective Date _____	Account Number	Employee ID	Situs State
	20216		**KS**

ENROLLMENT FORM
SELECTION OF COVERAGE

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

Accident (GVAP2) (Off the Job Accident) ☐ Yes ☐ No	**Total Semi-monthly Premiums**	**Low Plan**	**High Plan**	Section 125 ☐ Yes ☐ No	**Home Office Use Only**
	Employee Only	☐ $ 5.64	☐ $ 8.46		
	Employee+Spouse	☐ $ 8.46	☐ $12.69		
	Employee+Child(ren)	☐ $11.28	☐ $16.92		
	Family	☐ $14.10	☐ $21.15		

Low Plan	Base Units 2	☒ Benefit Enhancement Rider Units 2
High Plan	Base Units 3	☒ Benefit Enhancement Rider Units 3

Cancer/Specified Disease (GVCP3) ☐ Yes ☐ No	**Total Semi-monthly Premiums**	**Low Plan**	**High Plan**	Section 125 ☐ Yes ☐ No	**Home Office Use Only**
	Employee Only	☐ $11.67	☐ $17.49		
	Employee+Spouse	☐ $18.08	☐ $27.06		
	Employee+Child(ren)	☐ $16.26	☐ $24.74		
	Family	☐ $22.66	☐ $34.31		

Benefits	Hospital	Radiation / Chemotherapy	Surgery Related	Misc.	☒ Cancer Initial Diagnosis Option	☒ Wellness Option
Units Low Plan	2	4	2	1	2	4
High Plan	3	6	3	1	5	4

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** If covered, Basic Benefit amount for spouse or other dependents is 50% of the employee's.	Section 125 ☐ Yes ☐ No	**Home Office Use Only**

☒ 2nd Event Initial Critical Illness Option	☒ Supplemental Critical Illness Option II	☒ Wellness Option Units 2

Semi-monthly Premiums **Low Plan**	Age	Employee Only	Employee + Spouse	Employee + Child(ren)	Family
Non-Tobacco	18-29	☐ $ 1.37	☐ $ 2.36	☐ $ 1.37	☐ $ 2.36
	30-39	☐ $ 2.41	☐ $ 3.92	☐ $ 2.41	☐ $ 3.92
	40-49	☐ $ 4.02	☐ $ 6.34	☐ $ 4.02	☐ $ 6.34
	50-59	☐ $ 7.10	☐ $10.97	☐ $ 7.10	☐ $10.97
	60-63	☐ $11.94	☐ $18.23	☐ $11.94	☐ $18.23
	64+	☐ $16.58	☐ $25.18	☐ $16.58	☐ $25.18
Tobacco	18-29	☐ $ 1.76	☐ $ 2.95	☐ $ 1.76	☐ $ 2.95
	30-39	☐ $ 3.41	☐ $ 5.42	☐ $ 3.41	☐ $ 5.42
	40-49	☐ $ 6.55	☐ $10.14	☐ $ 6.55	☐ $10.14
	50-59	☐ $11.28	☐ $17.22	☐ $11.28	☐ $17.22
	60-63	☐ $19.50	☐ $29.56	☐ $19.50	☐ $29.56
	64+	☐ $27.47	☐ $41.53	☐ $27.47	☐ $41.53

☒ Cancer Critical Illness Option	☒ 2nd Event Initial Critical Illness Option	☒ Supplemental Critical Illness Option II	☒ Wellness Option Units 2

Semi-monthly Premiums **High Plan**	Age	Employee Only	Employee + Spouse	Employee + Child(ren)	Family
Non-Tobacco	18-29	☐ $ 2.54	☐ $ 4.12	☐ $ 2.54	☐ $ 4.12
	30-39	☐ $ 4.47	☐ $ 7.01	☐ $ 4.47	☐ $ 7.01
	40-49	☐ $ 8.07	☐ $12.41	☐ $ 8.07	☐ $12.41
	50-59	☐ $14.15	☐ $21.54	☐ $14.15	☐ $21.54
	60-63	☐ $22.83	☐ $34.56	☐ $22.83	☐ $34.56
	64+	☐ $29.63	☐ $44.76	☐ $29.63	☐ $44.76
Tobacco	18-29	☐ $ 3.70	☐ $ 5.86	☐ $ 3.70	☐ $ 5.86
	30-39	☐ $ 6.89	☐ $10.64	☐ $ 6.89	☐ $10.64
	40-49	☐ $14.16	☐ $21.56	☐ $14.16	☐ $21.56
	50-59	☐ $23.78	☐ $35.97	☐ $23.78	☐ $35.97
	60-63	☐ $38.98	☐ $58.79	☐ $38.98	☐ $58.79
	64+	☐ $51.10	☐ $76.97	☐ $51.10	☐ $76.97

ENROLLMENT FORM

SELECTION OF COVERAGE

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

Critical Illness (GVCIP2) ☐ Yes ☐ No	**Basic Benefit Amount $15,000** If covered, Basic Benefit amount for spouse or other dependents is 50% of the employee's.	Section 125 ☐ Yes ☐ No	**Home Office Use Only**

☒ 2nd Event Initial Critical Illness Option	☒ Supplemental Critical Illness Option II	☒ Wellness Option Units 2

Semi-monthly Premiums **Low Plan**	Age	Employee Only	Employee + Spouse	Employee + Child(ren)	Family
Non-Tobacco	18-29	☐ $ 1.73	☐ $ 2.91	☐ $ 1.73	☐ $ 2.91
	30-39	☐ $ 3.30	☐ $ 5.26	☐ $ 3.30	☐ $ 5.26
	40-49	☐ $ 5.71	☐ $ 8.88	☐ $ 5.71	☐ $ 8.88
	50-59	☐ $10.34	☐ $15.83	☐ $10.34	☐ $ 15.83
	60-63	☐ $17.61	☐ $26.73	☐ $17.61	☐ $ 26.73
	64+	☐ $24.55	☐ $37.14	☐ $24.55	☐ $ 37.14
Tobacco	18-29	☐ $ 2.33	☐ $ 3.81	☐ $ 2.33	☐ $ 3.81
	30-39	☐ $ 4.79	☐ $ 7.49	☐ $ 4.79	☐ $ 7.49
	40-49	☐ $ 9.51	☐ $14.58	☐ $ 9.51	☐ $ 14.58
	50-59	☐ $16.60	☐ $25.21	☐ $16.60	☐ $ 25.21
	60-63	☐ $28.94	☐ $43.72	☐ $28.94	☐ $ 43.72
	64+	☐ $40.90	☐ $61.66	☐ $40.90	☐ $ 61.66

☒ Cancer Critical Illness Option	☒ 2nd Event Initial Critical Illness Option	☒ Supplemental Critical Illness Option II	☒ Wellness Option Units 2

Semi-monthly Premiums **High Plan**	Age	Employee Only	Employee + Spouse	Employee + Child(ren)	Family
Non-Tobacco	18-29	☐ $ 3.49	☐ $ 5.55	☐ $ 3.49	☐ $ 5.55
	30-39	☐ $ 6.39	☐ $ 9.90	☐ $ 6.39	☐ $ 9.90
	40-49	☐ $11.79	☐ $ 17.99	☐ $11.79	☐ $ 17.99
	50-59	☐ $20.92	☐ $ 31.69	☐ $20.92	☐ $ 31.69
	60-63	☐ $33.94	☐ $ 51.22	☐ $33.94	☐ $ 51.22
	64+	☐ $44.13	☐ $ 66.51	☐ $44.13	☐ $ 66.51
Tobacco	18-29	☐ $ 5.24	☐ $ 8.17	☐ $ 5.24	☐ $ 8.17
	30-39	☐ $10.01	☐ $ 15.33	☐ $10.01	☐ $ 15.33
	40-49	☐ $20.94	☐ $ 31.71	☐ $20.94	☐ $ 31.71
	50-59	☐ $35.35	☐ $ 53.34	☐ $35.35	☐ $ 53.34
	60-63	☐ $58.17	☐ $ 87.56	☐ $58.17	☐ $ 87.56
	64+	☐ $76.35	☐ $114.83	☐ $76.35	☐ $114.83

ELECTRONIC ACCEPTANCE (Please check YES or NO)

By checking the "Yes" box, I elect electronic delivery of my certificate(s) of insurance, including all documents accompanying my certificate(s) of insurance. If electronically delivered, I understand that I will receive instructions at the email address I have provided on how to receive my certificate and accompanying documents at: www.allstatebenefits.com/mybenefits.

☐ Yes ☐ No

By checking the "Yes" box, I elect electronic delivery of all contractual, regulatory and administrative correspondence (correspondence) regarding my certificate(s) of insurance, to include claim correspondence, explanations of benefits, periodic notices (such as privacy notices) and other correspondence. If electronically delivered, I understand that I will receive instructions at the last email address I have provided on how to receive correspondence at: www.allstatebenefits.com/mybenefits**.**

☐ Yes ☐ No

I understand and agree that to receive electronic delivery, I must have a computer with internet access, a web browser that is Microsoft Internet Explorer version 5.0 or greater, an e-mail account, and the ability to download PDF files using Adobe Acrobat Reader version 5.0 or higher and a printer or other device to download and print or save any documents I wish to retain.

I understand and I agree that my consent is valid while I remain covered. At any time, I may withdraw my consent for any reason and receive future correspondence in paper to include a paper copy of my certificate(s) of insurance, free of charge, by calling toll-free: 1-800-521-3535; or by writing to: Customer Care Center, American Heritage Life Insurance Company, 1776 American Heritage Life Drive, Jacksonville, Florida, 32224.

REPRESENTATION. I have read or had read to me the completed application and understand that any misstatement or misrepresentation in the application may result in loss of coverage. I represent that statements and answers given on this application are true, complete, and correctly recorded. **UNDERSTANDING**. I understand that: if premiums for the coverage(s) is (are) to be paid by payroll deductions, these deductions may start before the "effective date" of coverage(s) and that this does not change the effective date of coverage; and the “effective date” for health insurance coverages will be the date recorded on the policy/certificate/benefit statement, not the date the application is signed. If the coverage(s) is (are) not issued, American Heritage Life will refund any deductions it receives. I also understand that no producer (agent) has authority to waive any answer or otherwise modify this application, or to bind AHL in any way by making any promise or representation that is not set out in writing in this application. 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 application may be declined on the basis of such proof. **PREMIUM DEDUCTION AUTHORIZATION. I AUTHORIZE** my employer to deduct from my salary or wages, if applicable, the necessary premium for the coverages requested. **AUTHORIZATION TO OBTAIN AND DISCLOSE CERTAIN DATA (FOR CRITICAL ILLNESS)**. I authorize any physician, medical practitioner, hospital, clinic or other medical facility, Pharmacy Benefit Managers, insurance company, the Medical Information Bureau (MIB, Inc.) or other organization, institution or person, that has records or knowledge of me or my health including my prescription medication history to give to AHL, its subsidiaries or its reinsurers any information. I also authorize AHL, or its reinsurers, to make a brief report of my health information to MIB, Inc. I understand that there is a possibility of redisclosure of any information disclosed pursuant to this authorization and that information, once disclosed, may no longer be protected by federal rules governing privacy and confidentiality. I acknowledge receipt of the Important Notice About Privacy and MIB Notice form. A copy of this authorization is as valid as the original. This authorization applies to any dependent on whom insurance is requested. This authorization is valid for 24 months from the date signed. I understand that I may revoke this authorization at any time by notifying AHL in writing of my desire to do so.

Signed at: City/State _____ Date Signed _____

Signature of Proposed Insured _____

Signature of Owner, if other than Insured N/A

Signature of Employee/Payor, if not Insured or Owner N/A

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:	**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 (SHIIP).

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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 only when you are treated for one of the specific diseases or health conditions listed in the policy. 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
- hospice
- 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).

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