AMERICAN HERITAGE LIFE INSURANCE COMPANY (AHL)
1776 AMERICAN HERITAGE LIFE DRIVE
JACKSONVILLE, FL 32224

Allstate. BENEFITS

Group Enrollment Form

☒ Check if custom form

Account No.	Employee ID	Requested Effective Date	First Deduction Date	Account	Location	Situs State
39689						OR

Deduction Mode: ☒ Semi-Monthly

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 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 **Pacific States Marine Fisheries Commission**	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 Critical Illness, has the employee used tobacco in the last 12 months? **Employee** ☐ Yes ☐ No

If applying for 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 ☐ No

Check the qualifying event: ☐ Marriage/Divorce ☐ Birth/Adoption ☐ Spouse New Job/Job Loss ☐ Termination ☐ Work Status Change ☐ Eligible/Ineligible Child ☐ Spouse/Dependent Child Death ☐ Employee Death

Qualifying 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 ☐ No

If yes, enter the following information: Effective date of termination _____ Policy Number _____

Select the type of coverage: ☐ Accident ☐ Critical Illness ☐ Hospital Indemnity

Employee Name _____ Account No. 39689

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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

Choose coverage amount:

Total Semi-Monthly Deductions	Plan 1	Plan 2
Employee Only	☐ $ 9.00	☐ $11.90
Employee + Spouse	☐ $17.72	☐ $23.76
Employee + Child(ren)	☐ $21.39	☐ $28.34
Family	☐ $26.37	☐ $34.78

Your coverage will consist of:	Plan 1	Plan 2
Base Coverage	2	2.5
Benefit Enhancement Rider	1	2

Critical Illness (GVCIP2) Do you want this coverage? ☐ Yes ☐ No

Your coverage will consist of:	☐ Plan 1 $10,000 Basic Benefit Amt.	☐ Plan 2 $20,000 Basic Benefit Amt.
Cancer Critical Illness Option	☒	☒
Second Event Initial Critical Illness Option	N/A	☒
Wellness Option	2 Units	3 Units
Second Event Cancer Critical Illness Option	N/A	☒
Supplemental Critical Illness Option II	☒	☒
Second Evaluation Benefit Rider	N/A	☒

Semi-Monthly Deductions	$10,000 Basic Benefit Non-Tobacco				$10,000 Basic Benefit Tobacco			
Age	Employee Only	Employee + Spouse	Employee + Child(ren)	Family	Employee Only	Employee + Spouse	Employee + Child(ren)	Family
18-35	☐ $ 3.83	☐ $ 5.80	☐ $ 3.83	☐ $ 5.80	☐ $ 5.88	☐ $ 8.88	☐ $ 5.88	☐ $ 8.88
36-50	☐ $ 8.78	☐ $13.23	☐ $ 8.78	☐ $13.23	☐ $14.43	☐ $21.70	☐ $14.43	☐ $21.70
51-60	☐ $17.98	☐ $27.03	☐ $17.98	☐ $27.03	☐ $29.73	☐ $44.65	☐ $29.73	☐ $44.65
61-63	☐ $28.08	☐ $42.18	☐ $28.08	☐ $42.18	☐ $42.98	☐ $64.53	☐ $42.98	☐ $64.53
64+	☐ $41.23	☐ $61.90	☐ $41.23	☐ $61.90	☐ $63.33	☐ $95.05	☐ $63.33	☐ $95.05
Semi-Monthly Deductions	**$20,000 Basic Benefit Non-Tobacco**				**$20,000 Basic Benefit Tobacco**			
Age	Employee Only	Employee + Spouse	Employee + Child(ren)	Family	Employee Only	Employee + Spouse	Employee + Child(ren)	Family
18-35	☐ $ 7.65	☐ $ 11.60	☐ $ 7.65	☐ $ 11.60	☐ $ 11.75	☐ $ 17.75	☐ $ 11.75	☐ $ 17.75
36-50	☐ $17.55	☐ $ 26.45	☐ $17.55	☐ $ 26.45	☐ $ 28.85	☐ $ 43.40	☐ $ 28.85	☐ $ 43.40
51-60	☐ $35.95	☐ $ 54.05	☐ $35.95	☐ $ 54.05	☐ $ 59.45	☐ $ 89.30	☐ $ 59.45	☐ $ 89.30
61-63	☐ $56.15	☐ $ 84.35	☐ $56.15	☐ $ 84.35	☐ $ 85.95	☐ $129.05	☐ $ 85.95	☐ $129.05
64+	☐ $82.45	☐ $123.80	☐ $82.45	☐ $123.80	☐ $126.65	☐ $190.10	☐ $126.65	☐ $190.10

Employee Name _____ Account No. 39689

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Hospital Indemnity (GVSP1) Do you want this coverage? ☐ Yes ☐ No

Your coverage will consist of:	Plan 1	Plan 2
Hospital Related	1	1
Surgery/Inpatient Physician	1	1
Outpatient Related	1	2
Diagnostic/Wellness Option	1	2
Prescription Drug Option	2	2

Semi-Monthly Deductions	Plan 1				Plan 2			
Age	Employee Only	Employee + Spouse	Employee + Child(ren)	Family	Employee Only	Employee + Spouse	Employee + Child(ren)	Family
18-35	☐ $19.10	☐ $37.29	☐ $39.11	☐ $ 55.74	☐ $25.26	☐ $49.62	☐ $50.75	☐ $ 73.99
36-49	☐ $22.17	☐ $43.34	☐ $43.43	☐ $ 64.52	☐ $28.83	☐ $56.66	☐ $57.11	☐ $ 84.27
50-59	☐ $26.18	☐ $51.87	☐ $47.94	☐ $ 73.98	☐ $33.43	☐ $66.36	☐ $62.81	☐ $ 95.46
60-64	☐ $32.13	☐ $64.26	☐ $54.43	☐ $ 85.80	☐ $40.41	☐ $80.82	☐ $71.40	☐ $110.30
65+	☐ $39.16	☐ $78.31	☐ $62.52	☐ $100.78	☐ $48.56	☐ $97.12	☐ $81.77	☐ $128.55

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.	

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.

Employee Signature _____ Date Signed _____

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.

Soliciting Producer Signature _____ Soliciting Producer Name Printed _____

Employee Name _____ Account No. 39689

Group Enrollment Form

Home office or producer to complete before issue:

Producer Name	Producer Number	Percentage Credit	Producer Name	Producer Number	Percentage Credit
Servicing Producer			Soliciting Producer		
Thomas Patrick	**841K0**	**25**	**Benefits Insurance Group**	**3K2A0**	**70**

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 pays a fixed dollar amount, regardless of your expenses, for each day you meet the policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when:

- any expenses or services covered by the policy are also covered by Medicare

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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