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 **GreenState Credit Union**	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				** ☐ Yes ☐ No
		Spouse				** ☐ Yes ☐ No

*Has any adult (19 and older) person to be insured used tobacco in the last 12 months? (**If applying for Critical Illness.)

Are you applying for coverage or changing existing coverage due to a qualifying event?
Accident ☐ Yes ☐ No **Critical Illness** ☐ Yes ☐ No **Indemnity Medical** ☐ Yes ☐ No
If "Yes", check the qualifying event:

☐ Marriage ☐ Spouse/Dependent Child Death ☐ Newly Eligible
☐ Divorce ☐ Eligible/Ineligible Child ☐ Termination
☐ Birth/Adoption ☐ Spouse New Job/Job Loss ☐ 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 Hospital Indemnity ☐ 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 **IA**

SELECTION OF COVERAGE

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

Accident (GVAP1)
(On and Off the Job Accident)
☐ Yes ☐ No

Semi-monthly Premiums	Low Plan	High Plan
Employee Only	☐ $ 9.00	☐ $12.34
Employee+Spouse	☐ $16.93	☐ $23.61
Employee+Child(ren)	☐ $18.42	☐ $25.84
Family	☐ $22.45	☐ $31.73

Section 125 ☒ Yes ☐ No

Home Office Use Only

Low Plan	High Plan
Base Units 2 ☒ Benefit Enhancement Rider Units 1	Base Units 3 ☒ Benefit Enhancement Rider Units 1

ENROLLMENT FORM

SELECTION OF COVERAGE

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

Critical Illness (GVCIP2) ☐ Yes ☐ No	Section 125 ☒ Yes ☐ No	**Home Office Use Only**

Basic Benefit Amount ☐ **$10,000 - or -** ☐ **$20,000**

☒ 2nd Event Cancer Critical Illness Option	☒ Supplemental Critical Illness Option II	☒ Wellness Option Units 4	☒ Cancer Critical Illness Option	☒ 2nd Event Initial Critical Illness Option

Semi-monthly Premiums $10,000 Basic Benefit	Age	Employee Only	Employee + Spouse	Employee + Child(ren)	Family
Non-Tobacco	18-29	☐ $ 7.16	☐ $ 12.00	☐ $ 7.16	☐ $ 12.00
	30-35	☐ $ 7.18	☐ $ 12.03	☐ $ 7.18	☐ $ 12.03
	36-39	☐ $ 13.78	☐ $ 21.93	☐ $ 13.78	☐ $ 21.93
	40-50	☐ $ 13.94	☐ $ 22.17	☐ $ 13.94	☐ $ 22.17
	51-54	☐ $ 26.81	☐ $ 41.47	☐ $ 26.81	☐ $ 41.47
	55-60	☐ $ 27.31	☐ $ 42.23	☐ $ 27.31	☐ $ 42.23
	61-63	☐ $ 42.07	☐ $ 64.36	☐ $ 42.07	☐ $ 64.36
	64-70	☐ $ 62.04	☐ $ 94.32	☐ $ 62.04	☐ $ 94.32
	71+	☐ $ 63.14	☐ $ 95.97	☐ $ 63.14	☐ $ 95.97
Tobacco	18-29	☐ $ 9.97	☐ $ 16.21	☐ $ 9.97	☐ $ 16.21
	30-35	☐ $ 10.01	☐ $ 16.27	☐ $ 10.01	☐ $ 16.27
	36-39	☐ $ 21.47	☐ $ 33.46	☐ $ 21.47	☐ $ 33.46
	40-50	☐ $ 21.74	☐ $ 33.86	☐ $ 21.74	☐ $ 33.86
	51-54	☐ $ 43.28	☐ $ 66.18	☐ $ 43.28	☐ $ 66.18
	55-60	☐ $ 44.14	☐ $ 67.46	☐ $ 44.14	☐ $ 67.46
	61-63	☐ $ 63.75	☐ $ 96.89	☐ $ 63.75	☐ $ 96.89
	64-70	☐ $ 94.80	☐ $143.45	☐ $ 94.80	☐ $143.45
	71+	☐ $ 96.56	☐ $146.10	☐ $ 96.56	☐ $146.10

Semi-monthly Premiums $20,000 Basic Benefit	Age	Employee Only	Employee + Spouse	Employee + Child(ren)	Family
Non-Tobacco	18-29	☐ $ 10.80	☐ $ 17.45	☐ $ 10.80	☐ $ 17.45
	30-35	☐ $ 10.84	☐ $ 17.52	☐ $ 10.84	☐ $ 17.52
	36-39	☐ $ 24.04	☐ $ 37.32	☐ $ 24.04	☐ $ 37.32
	40-50	☐ $ 24.34	☐ $ 37.78	☐ $ 24.34	☐ $ 37.78
	51-54	☐ $ 50.08	☐ $ 76.39	☐ $ 50.08	☐ $ 76.39
	55-60	☐ $ 51.10	☐ $ 77.91	☐ $ 51.10	☐ $ 77.91
	61-63	☐ $ 80.61	☐ $122.18	☐ $ 80.61	☐ $122.18
	64-70	☐ $120.55	☐ $182.09	☐ $120.55	☐ $182.09
	71+	☐ $122.75	☐ $185.39	☐ $122.75	☐ $185.39
Tobacco	18-29	☐ $ 16.41	☐ $ 22.87	☐ $ 16.41	☐ $ 22.87
	30-35	☐ $ 16.48	☐ $ 25.99	☐ $ 16.48	☐ $ 25.99
	36-39	☐ $ 39.41	☐ $ 60.38	☐ $ 39.41	☐ $ 60.38
	40-50	☐ $ 39.96	☐ $ 61.19	☐ $ 39.96	☐ $ 61.19
	51-54	☐ $ 83.02	☐ $125.80	☐ $ 83.02	☐ $125.80
	55-60	☐ $ 84.75	☐ $128.38	☐ $ 84.75	☐ $128.38
	61-63	☐ $123.98	☐ $187.23	☐ $123.98	☐ $187.23
	64-70	☐ $186.07	☐ $280.36	☐ $186.07	☐ $280.36
	71+	☐ $189.61	☐ $285.67	☐ $189.61	☐ $285.67

ENROLLMENT FORM

SELECTION OF COVERAGE

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

For AHL Home Office use only

Group No.	Account	Location	Dep Code	Smoker	Issue State	Effective Date
			E S C F	EE **Y** or **N** SP **Y** or **N**		

Indemnity Medical II **(GIM2)** (New Generation) ☐ Yes ☐ No	**Semi-monthly Premiums**	**Low Plan**	**High Plan**	Section 125 ☒ Yes ☐ No	**Home Office Use Only**
	Employee Only	☐ $10.92	☐ $17.68		
	Employee+Spouse	☐ $28.15	☐ $48.75		
	Employee+Child(ren)	☐ $18.85	☐ $30.62		
	Family	☐ $30.68	☐ $52.39		

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: **Rhonda Pape**	**4PCH0**		%
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).

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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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