Allstate Benefits

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 **Tennessee State Employees Association** / 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 or Critical Illness.)

Premium/Billing Mode	Account Number	Employee ID	Situs State
☒ Monthly Date of First Deduction_____ Coverage Effective Date _____	CG255		TN

SELECTION OF COVERAGE

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

Critical Illness (GVCIP2) ☐ Yes ☐ No	☐ Employee Only ☐ Employee+Spouse ☐ Employee+Child(ren) ☐ Family	Section 125 ☐ Yes ☒ No	Total Monthly Premium $_____	**Home Office Use Only**

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

☒ No Pre-Existing Option	☒ 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

ENROLLMENT FORM
SELECTION OF COVERAGE

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

Disability (Short-Term) (GVDIP) (My Lifeline) ☐ Yes ☐ No	Monthly Salary $_____	Monthly Benefit $_____	Section 125 ☐ Yes ☒ No	Total Monthly Premium $_____	**Home Office Use Only**

☐ Elimination Period	Days Acc. 14	Days Sick. 14	Benefit Period	Months 6
☐ Elimination Period	Days Acc. 14	Days Sick. 14	Benefit Period	Months 12
☐ Elimination Period	Days Acc. 30	Days Sick. 30	Benefit Period	Months 6
☐ Elimination Period	Days Acc. 30	Days Sick. 30	Benefit Period	Months 12
☐ Elimination Period	Days Acc. 90	Days Sick. 90	Benefit Period	Months 24

A. Is this insurance to replace any existing disability coverage? ☐ Yes ☐ No

If yes, provide the Company Name _____

B. Is there any other disability insurance in force or applied for that will continue after the effective date of this coverage? ☐ Yes ☐ No

If yes, complete the following:

Company Name _____ Year Issued _____

Monthly Benefit $_____ Elimination Period _____ Benefit Period _____

Eligibility Question		**EMPLOYEE**
Disability	Is the employee actively at work now, for wage or profit, and has he/she worked at least 20 hours each week performing all duties of his/her regular occupation at his/her regular place of employment for at least the last 3 months except for minor illness or injury of 1 week or less, or normal pregnancy?	☐ Yes ☐ No

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.

FRAUD NOTICE: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

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: Federated Marketing	**1TE30**		**100** %
Soliciting Producer:			%
			%
			%
			%