AMERICAN HERITAGE LIFE INSURANCE COMPANY (AHL)

1776 AMERICAN HERITAGE LIFE DRIVE
JACKSONVILLE, FLORIDA 32224

Allstate Benefits

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: **Manatt's Inc.** / Date Hired or Re-hire date	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

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

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	Account Number	Employee ID	Situs State
☒ Monthly Date of First Deduction _____ Coverage Effective Date _____	**30078**		**IA**

ENROLLMENT FORM

SELECTION OF COVERAGE

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

Accident (GVAP6)	Base Units	Total Monthly Premiums		Section 125	Home Office Use Only
Off the Job Accident		Employee Only	☐ $ 8.48	☒ Yes ☐ No	
☐ Yes ☐ No	2	Employee+Spouse	☐ $19.50		
		Employee+Child(ren)	☐ $24.51		
		Family	☐ $31.61		

☒ Accident Treatment & Urgent Care Rider	**Units** 3	☒ Dislocation/Fracture Rider	**Units** 3
☒ Emergency Room Services Rider	**Units** 2	☒ Benefit Enhancement Rider	**Units** 2
☒ Outpatient Physician's Rider	**Units** 2	☒ Accidental Death, Dismemberment and Functional Loss Rider	**Units** 2

Critical Illness (GVCIP2)	Basic Benefit Amount	Section 125	Home Office Use Only
☐ Yes ☐ No	☐ **$10,000 - or -** ☐ **$20,000**	☒ Yes ☐ No	
☒ 2nd Event Cancer Critical Illness Option	☒ Wellness Option Units 2	☒ Cancer Critical Illness Option	☒ 2nd Event Initial Critical Illness Option

Monthly Premiums $10,000 Basic Benefit	Age	Employee Only	Employee + Spouse	Employee + Child(ren)	Family
Non-Tobacco	18-29	☐ $ 5.09	☐ $ 8.26	☐ $ 5.09	☐ $ 8.26
	30-39	☐ $ 8.68	☐ $ 13.64	☐ $ 8.68	☐ $ 13.64
	40-49	☐ $ 16.02	☐ $ 24.65	☐ $ 16.02	☐ $ 24.65
	50-59	☐ $ 27.84	☐ $ 42.39	☐ $ 27.84	☐ $ 42.39
	60-63	☐ $ 45.10	☐ $ 68.28	☐ $ 45.10	☐ $ 68.28
	64+	☐ $ 58.52	☐ $ 88.40	☐ $ 58.52	☐ $ 88.40
Tobacco	18-29	☐ $ 7.57	☐ $ 11.98	☐ $ 7.57	☐ $ 11.98
	30-39	☐ $ 13.82	☐ $ 21.35	☐ $ 13.82	☐ $ 21.35
	40-49	☐ $ 29.06	☐ $ 44.21	☐ $ 29.06	☐ $ 44.21
	50-59	☐ $ 48.44	☐ $ 73.28	☐ $ 48.44	☐ $ 73.28
	60-63	☐ $ 79.75	☐ $120.26	☐ $ 79.75	☐ $120.26
	64+	☐ $104.92	☐ $158.02	☐ $104.92	☐ $158.02

Monthly Premiums $20,000 Basic Benefit	Age	Employee Only	Employee + Spouse	Employee + Child(ren)	Family
Non-Tobacco	18-29	☐ $ 8.93	☐ $ 14.02	☐ $ 8.93	☐ $ 14.02
	30-39	☐ $ 16.12	☐ $ 24.80	☐ $ 16.12	☐ $ 24.80
	40-49	☐ $ 30.82	☐ $ 46.84	☐ $ 30.82	☐ $ 46.84
	50-59	☐ $ 54.46	☐ $ 82.30	☐ $ 54.46	☐ $ 82.30
	60-63	☐ $ 88.97	☐ $134.07	☐ $ 88.97	☐ $134.07
	64+	☐ $115.80	☐ $174.32	☐ $115.80	☐ $174.32
Tobacco	18-29	☐ $ 13.91	☐ $ 21.48	☐ $ 13.91	☐ $ 21.48
	30-39	☐ $ 26.38	☐ $ 40.20	☐ $ 26.38	☐ $ 40.20
	40-49	☐ $ 56.86	☐ $ 85.92	☐ $ 56.86	☐ $ 85.92
	50-59	☐ $ 95.61	☐ $144.05	☐ $ 95.61	☐ $144.05
	60-63	☐ $158.27	☐ $238.02	☐ $158.27	☐ $238.02
	64+	☐ $208.60	☐ $313.52	☐ $208.60	☐ $313.52

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 Stacey Krings

To be completed by home office or producer, prior to issue:

Producer Name	Producer Number	National Producer Number (NPN)	Percentage Credit
Servicing Producer: Stacey Krings	3T0A2		100 %
Soliciting Producer: Stacey Krings			%
			%
			%
			%