

AMERICAN HERITAGE LIFE INSURANCE COMPANY (AHL)

1776 AMERICAN HERITAGE LIFE DRIVE
JACKSONVILLE, FLORIDA 32224



ENROLLMENT FORM

Check appropriate box(es)

- Short-Term Disability
- Heritage Choice Dental
- AHL minimedical®
- Critical Illness
- Life

This Box for AHL Home Office use only		
Group No.	Account	Location
82227		
Dep Code	Smoker	Issue State
E S C F	EE Y or N SP Y or N	FL
EFFECTIVE DATE		

This box for AHL Home Office use only

GENERAL INFORMATION SECTION

(Please complete entire section for all coverages)

Please print with black ink

EMPLOYEE'S NAME Last (Sr, Jr, etc.)		First	M.I.	<input type="checkbox"/> M <input type="checkbox"/> F	SOCIAL SECURITY NUMBER	<input type="checkbox"/> Married <input type="checkbox"/> Single
HOME ADDRESS (Street or P.O. Box)				CITY	STATE	ZIP
BIRTHDATE (MM/DD/YEAR)	HOME PHONE NUMBER	EMPLOYER First Financial Employee Leasing		DATE HIRED (MM/DD/YEAR)		
OCCUPATION			PLANT OR DIVISION			
BENEFICIARY'S NAME (Last, First, M.I.)				RELATIONSHIP		

Are you adding any coverage or changing any of your existing coverage due to marriage, birth, adoption, employment status change, etc.?

- | | | | |
|------------------------------|--|-------------------------------|--|
| Short-Term Disability | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heritage Choice Dental | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| AHL minimedical® | <input type="checkbox"/> Yes <input type="checkbox"/> No | Critical Illness | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Life | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |

If "yes", indicate type of change: _____

Date of change _____ Current Certificate Number _____

DEPENDENT COVERAGE SECTION

(Please complete if dependent coverage elected. Use additional paper if needed.)

Abbreviations: Med-Medical Den-Dental CI-Critical Illness

Choose Plans: Med Life Den CI	Dependent's Name (Last, First, M.I.)	Relationship	Sex	Date of Birth (MM/DD/YEAR)	Social Security Number

Short-Term Disability <input type="checkbox"/> Yes <input type="checkbox"/> No	Benefit Amount	Premium	AHL Home Office Use Only SET ID/PLAN ID ACTIV/STD _____ and/or EMPLR/STD _____ and/or (other)_____
	per month \$ 650		

ENROLLMENT FORM

SELECTION OF COVERAGE SECTION

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

Heritage Choice Dental <input type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Plan 1	<input type="checkbox"/> Employee Only <input type="checkbox"/> Employee + Spouse	<input type="checkbox"/> Employee + Child <input type="checkbox"/> Family	Section 125 <input type="checkbox"/> Yes <input type="checkbox"/> No	Total Mode Premium \$ _____
Were you covered under your Employer's prior Dental Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", please enter the date coverage effective _____			Home Office Use Only SET ID ACTIV or EMPLR or _____ PLAN ID P1NG1 P1NG2 P1NG3		

AHL minimedical® <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Low <input type="checkbox"/> High	<input type="checkbox"/> Employee Only <input type="checkbox"/> Employee + Spouse <input type="checkbox"/> Employee + Child <input type="checkbox"/> Family	Section 125 <input type="checkbox"/> Yes <input type="checkbox"/> No	Home Office Use Only SET ID _____
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If you did not elect MEDICAL coverage, is this because of other health coverage? Yes No

Notice of Preexisting Conditions Exclusion: This plan imposes a Preexisting Conditions Exclusion. This means that if you have a medical condition before coming to our plan, you might have to wait a certain period of time before the plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis, care or treatment was recommended or received within a 6-month period. Generally, this 6-month period ends the day before your coverage becomes effective. However, if you were in a waiting period for coverage, the 6-month period ends on the day before the waiting period begins. The preexisting condition exclusion does not apply to pregnancy or to a child who is enrolled in the plan within 30 days after birth, adoption, or placement for adoption. This exclusion may last up to 12 months (18 months if you are a late enrollee) from your first day of coverage, or, if you were in a waiting period, from the first day of your waiting period. However, you can reduce the length of this exclusion period by the number of days of your prior "creditable coverage". Most prior health coverage is considered creditable coverage and can be used to reduce the preexisting condition exclusion if you have not experienced a break in coverage of at least 63 days. To reduce the 12-month (or 18-month) exclusion period by your creditable coverage, you should give us a copy of any certificates of creditable coverage you have. If you do not have a certificate, but you do have prior health coverage, we will help you obtain one from your prior plan or issuer. There are also other ways that you can show you have creditable coverage. Please contact us if you need help demonstrating creditable coverage. All questions about the preexisting condition exclusion and creditable coverage should be directed to our Customer Service Department at 1-800-937-7039.

Life <input type="checkbox"/> Yes <input type="checkbox"/> No	Benefit Amount \$ 10,000	Premium	AHL Home Office Use Only SET ID/PLAN ID ACTIV/AD&D _____ LIFE _____ and/or EMPLR/AD&D _____ LIFE _____ and/or (other) _____
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Dependent Coverage (If Applicable)

Spouse <input type="checkbox"/> Yes <input type="checkbox"/> No	Benefit Amount (Cannot exceed 50% of Employee Amount) \$ 5,000	AHL Home Office Use Only SET ID/PLAN ID ACTIV/AD&D _____ LIFE _____ and/or EMPLR/AD&D _____ LIFE _____ and/or (other) _____
Child(ren) <input type="checkbox"/> Yes <input type="checkbox"/> No	Benefit Amount (Cannot exceed 50% of Employee Amount) \$ 5,000	AHL Home Office Use Only SET ID ACTIV or EMPLR or (other) _____ PLAN ID OPTA / OPTB / OPTC / OPTD / OPTE

Has any person to be insured used tobacco in any form in the last 12 months? Yes No
If so, who and what type? _____

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SELECTION OF COVERAGE SECTION

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

Critical Illness <input type="checkbox"/> Yes <input type="checkbox"/> No	New Generation	<input type="checkbox"/> Employee Only <input type="checkbox"/> Employee+Spouse <input type="checkbox"/> Employee+Child(ren) <input type="checkbox"/> Family	Section 125 <input type="checkbox"/> Yes <input type="checkbox"/> No	Total Mode Premium \$ _____	Home Office Use Only SET ID _____
Basic Benefit Amount \$ 5,000 _____ If requesting coverage for spouse or dependents, the basic benefit amount is 50% of the employee.				Critical Illness Cancer Option <input type="checkbox"/>	
Has any person to be insured used tobacco in any form in the last 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, who and what type? _____					
Do you currently have an individual Critical Illness product with AHL? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", please enter the Policy Number _____					
Do you wish to terminate this coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", please enter the effective date of termination _____					

ELECTRONIC ACCEPTANCE (Please check YES or NO)

By checking the "Yes" box below, I agree to electronic delivery of my certificate of insurance, describing my coverage under the group policy ("my Certificate"), and all future correspondence regarding my Certificate, to include claim correspondence, explanations of benefit, periodic notices (such as privacy notices) and certificate administration correspondence. If electronically delivered, I will be provided instructions on how to receive my Certificate and correspondence regarding my Certificate via the following address: www.allstateatwork.com/mybenefits.

My consent is valid while I am covered under the group policy. 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, 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.

- YES, I agree to receive my Certificate and all correspondence regarding my Certificate electronically via the internet.
- NO, I prefer to receive paper copies of my Certificate and all correspondence regarding my Certificate.

ACCEPTANCE: I hereby request all coverage 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 earnings any contributions required of me for the payment of premiums for such coverage. · **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: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Date _____ Employee's
 Signed _____ Signature _____