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
57505		10/22/2021				WA

Deduction Mode: ☒ 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 (Payor/Owner/Certificate holder) 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 Simple Solutions Insurance Services	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 Life, has the employee used tobacco in the last 12 months? Employee ☐ Yes ☐ No

If applying for Life, 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) _____

Employee Name _____ Account No. 57505

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Selection of Coverage

Answer yes or no and complete for each coverage selected.

Life Do you want this coverage? ☐ Yes ☐ No ☒ *Guaranteed Issue*

Life product being offered: ☒ Whole Life

Requested Face Amount $ _____

Employee Annual Base Salary $ _____

Total Deduction

Riders being applied for:	Units/Amt.
Accelerated Death Benefit for Long Term Care (GWCLTC)	
Accelerated Death Benefit for Terminal Illness or Condition (GWCTI)	

If the proposed insured is your spouse, provide the following for that proposed insured. ☐ Spouse

Proposed Insured Name *(Last, First, M.I.)*		Social Security No.	☐ Male ☐ Female
Residence Street Address		Birth Date	
City, State, Zip	Phone No.	Email Address	
Employer of Proposed Insured	Annual Salary	Occupation	

If you are requesting rider coverage for your spouse or child(ren) and his/her contact information is different from yours, provide his/her name, address, and phone number below.

Accelerated Death Benefit for Long Term Care Rider *(Must answer)*

1. **Secondary Addressee Designation.** Protection against unintended lapse: I understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of this long term care insurance rider for nonpayment of premium. I understand that notice will not be given until 30 days after a premium is due and unpaid. Would you like to designate at least one additional person to receive notification of a possible lapse or termination of coverage? If yes, please provide full name and mailing address. ☐ Yes ☐ No

Name *(Last, First, M.I.)*	
Residence Street Address	City, State, Zip

2. Are you covered by Medicaid? ☐ Yes ☐ No

Employee Name _____ Account No. 57505

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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.	

Eligibility Questions

Answer each question for the coverages for which you are applying.

Employee answer for the following: Life

Employee Actively At Work. 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? Employee ☐ Yes ☐ No

Spouse answer for the following: Life

Spouse Actively At Work. Is the employee's spouse 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? Spouse ☐ Yes ☐ 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.

Caution: If your answers on this application are incorrect or untrue, AHL has the right to deny benefits or rescind your Accelerated Death Benefit for Long Term Care coverage, if applied for.

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.

Employee Signature _____ Date Signed _____

Home office or producer to complete before issue:

Producer Name	Producer Number	Percentage Credit	Producer Name	Producer Number	Percentage Credit
Servicing Producer					
			Long Term Care Solution, Inc.	2P2Y0	