Step 1: Visit https://allstate.benselect.com/zacbrowncollective

Login using the Employee's login credentials:

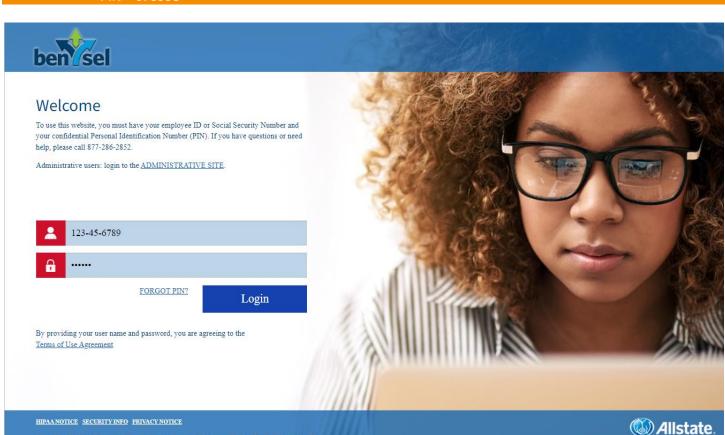
Enter SSN and PIN

PIN = Last four digits of your SSN + last two digits of your birth year

Example: SSN 123-45-6789 Birth Year: 1958

PIN = 678958

Allstate Benefits is the marketing name used by American Heritage Life Insurance Company (Home Office, Jacksonville, FL.), a subsidiary of The Allstate Corporation. © 2022 Allstate Insurance Company., Portions ©Selerix System, Inc.



Step 2: You will see the 'Welcome Screen' - Click 'Next'

 $\textbf{Zac Brown Collective} \ | \ \mathsf{TEST} \ \mathsf{TEST} \ (0) \ | \ \mathsf{Alambrecht@ltc-solutions.com} \ (\ \circleddash \mathsf{Logout} \)$



You & Your Family → My Benefits →

Sign & Submit

Welcome to Your Benefit Enrollment

At Zac Brown Collective, we know that benefit requirements change. That's why we are offering an Universal Life plan with Accelerated Death Benefit for Long Term Care.

For this benefit, Initial Enrollment is the only time of year you can take advantage of the Guaranteed Issue offer.

Group Universal Life Insurance Long Term Care Benefits

When you elect Group Universal Life Insurance coverage from Allstate Benefits, the following Long Term Care benefit riders are automatically included if you are 18-70 years of age.

Accelerated Death Benefit for Long Term Care Rider

This rider can provide an advance of the life insurance benefit as monthly cash payments when an insured person receives qualified long $term\ care\ services.\ The\ insured\ must\ be\ certified\ by\ a\ physician\ as\ chronically\ ill.\ Chronically\ ill\ means\ you\ have\ lost\ the\ ability\ to\ perform$ two (2) or more activities of daily living (bathing, continence, dressing, eating, to ileting or transferring) or are severely cognitively impaired. $Monthly\ premium\ payments\ are\ not\ charged\ while\ the\ insured\ is\ receiving\ benefit\ payments\ under\ this\ rider.\ The\ monthly\ Long\ Term\ Care$ benefit is equal to 4% of the life insurance benefit after a 90-day elimination period and is subject to the pre-existing condition exclusion.

Benefits are not paid for long term care services that are: a result of mental or emotional disorder (except for Alzheimer's Disease, senitity or senile dementia that are of organic origin); a result of alcoholism or drug addiction; a result of illness, treatment or medical conditions due to: act of war, declared or undeclared, service in the armed forces or units auxiliary therebet, participation in a felony, rior or insurrection, suicides or attempt at suicide, or intertionally addictions are all the properties of the declated between co-insurance requirements or other governmental program (except Medicaid), any state or federal workers' compensation, employer's liability or occupational disease law, or motor vehicle no fault law; received outside the United States or its territories.

Group Universal Life Insurance benefits are provided under policy and rider forms GUL23P, GULTC2 or state variations thereof.

This is a brief overview of the benefits available under the group policy underwritten by American Heritage Life Insurance Company (Home Office, Jacksonville, FL). Details of the coverage, including exclusions and limitations are included in the certificates issued. For additional information, you may contact your Allstate Benefits representative.

Benefit enrollment is easy! Just follow these steps.

- First, review and contact HR to update personal information about you or your covered dependents.
- · Review each of your benefit elections and make your choices.
- Sign the Enrollment Confirmation form to complete your enrollment.

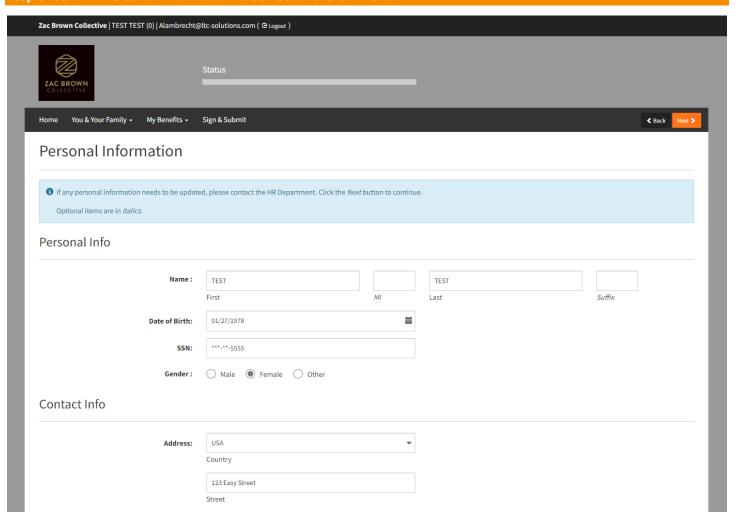
Click Next to begin.

Press Next to review personal information and begin enrollment.

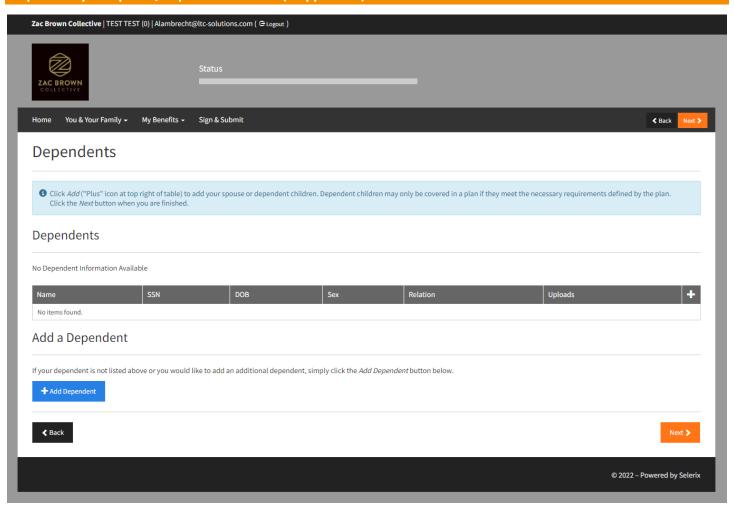
✓ Your Benefit Options

GUL23 with LTC - Max funded premium to age 95

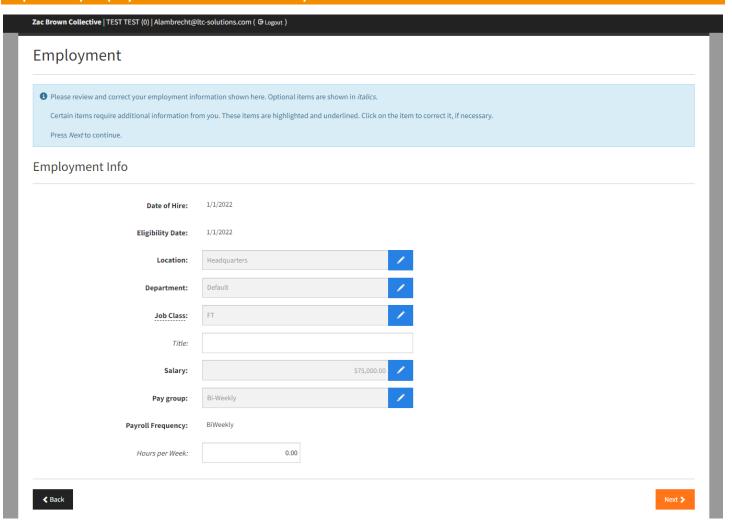
Step 3: Confirm Personal Information is Correct and Click 'Next'



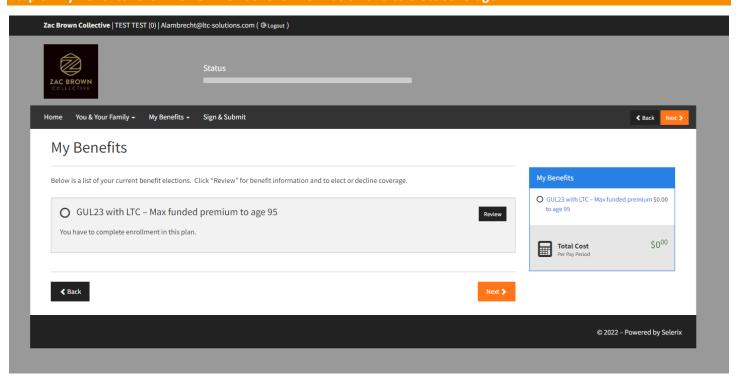
Step 4: Add your Spouse/Dependent Partner (if applicable) and Click 'Next'



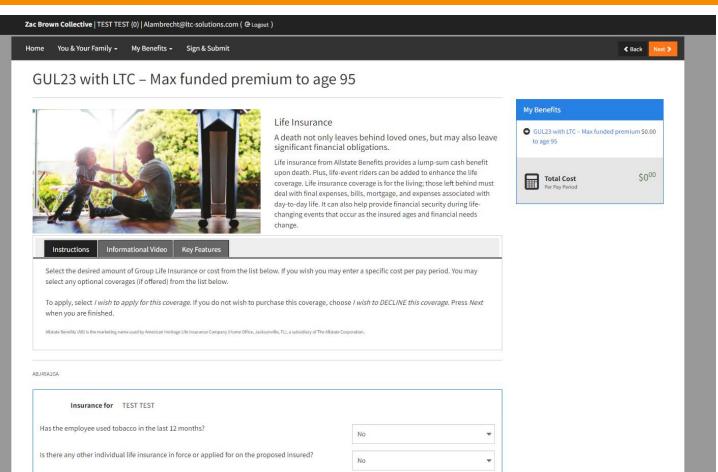
Step 5: Verify Employment Information and Verify Hours Worked and Click 'Next'



Step 6: My Benefits: Click 'Review' for benefit information and to elect coverage



Step 7: Review Plan and Rates – Answer the Questions Related to Tobacco Use and Other Individual Life Insurance and then Select the Desired Benefit Amount



Cost per Pay Period	Benefit Amount
○ <u>\$8.82</u>	10,000
<u>\$16.67</u>	20,000
<u>\$24.51</u>	30,000
<u>\$32.36</u>	40,000
<u>\$40.20</u>	50,000
<u>\$48.05</u>	60,000
<u>\$55.90</u>	70,000
	75,000
○ <u>\$63.74</u>	80,000
<u>\$71.59</u>	90,000
O <u>\$79.44</u>	100,000
<u>\$87.28</u>	110,000
<u>\$95.13</u>	120,000
<u>\$102.97</u>	130,000
<u>\$110.82</u>	140,000
<u>\$118.67</u>	150,000

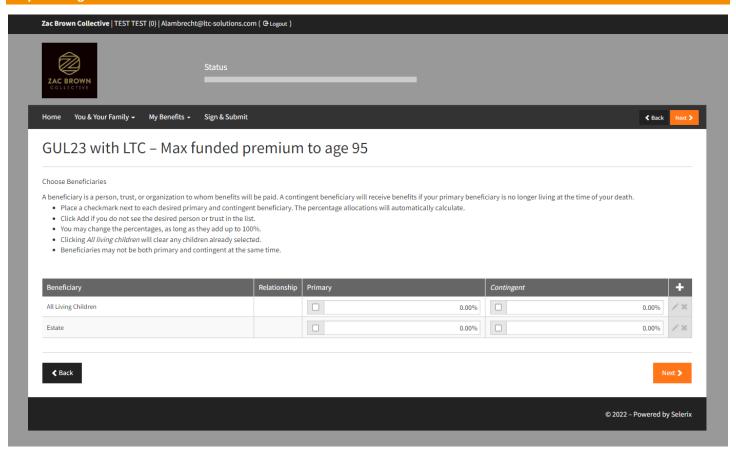
Step 8: Select 'I wish to apply for this coverage' and click 'Next'

I wish to apply for this coverage
 I wish to DECLINE this coverage

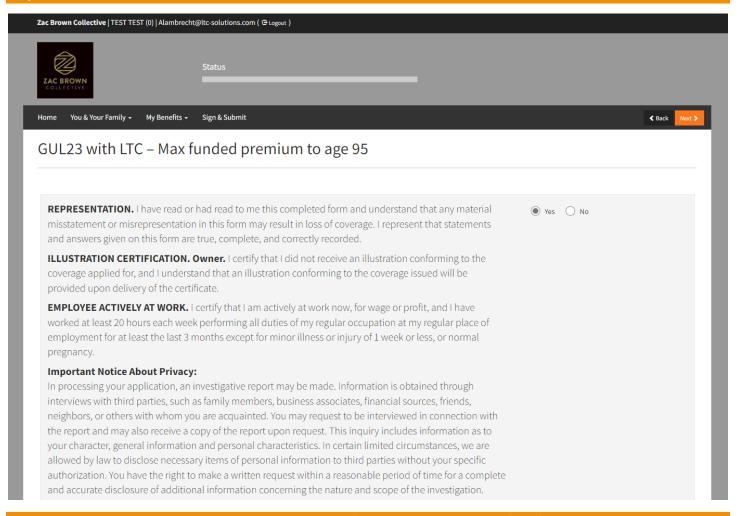
∢ Back

Next >

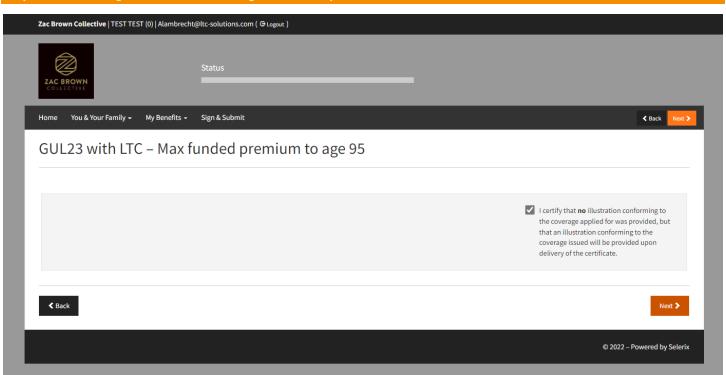
Step 9: Assign Beneficiaries and Click 'Next'



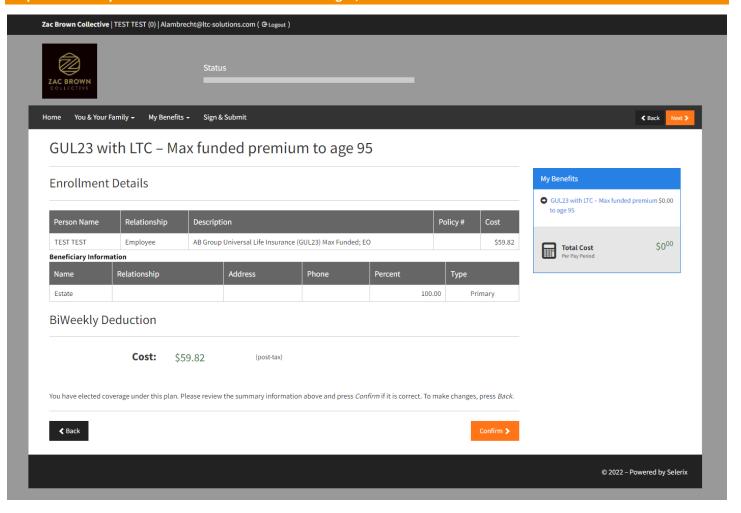
Step 10: Answer Questionnaire and Click 'Next'



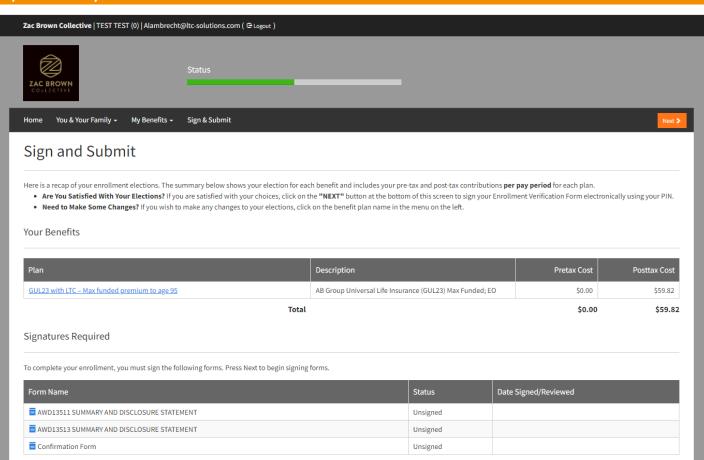
Step 10: Acknowlege Your Understanding on Delievery of an Illustration and Click 'Next'



Step 11: Review your Benefits Section – To make changes, click Back. Click 'Confirm' when finished.

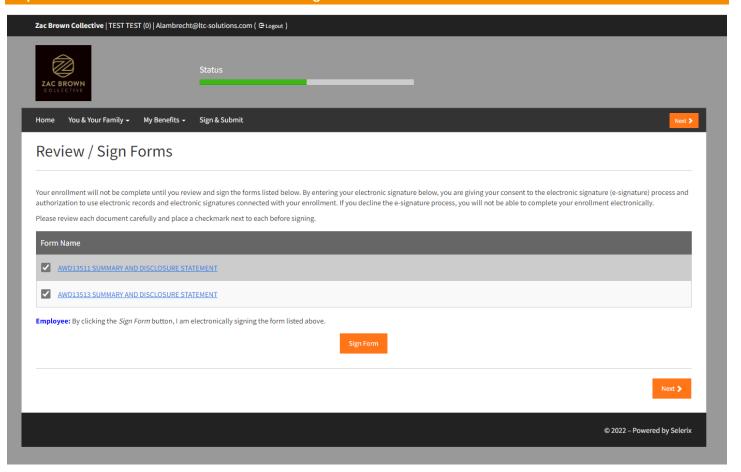


Step 13: Review your Enrollment Forms and Click 'Next'



Next >

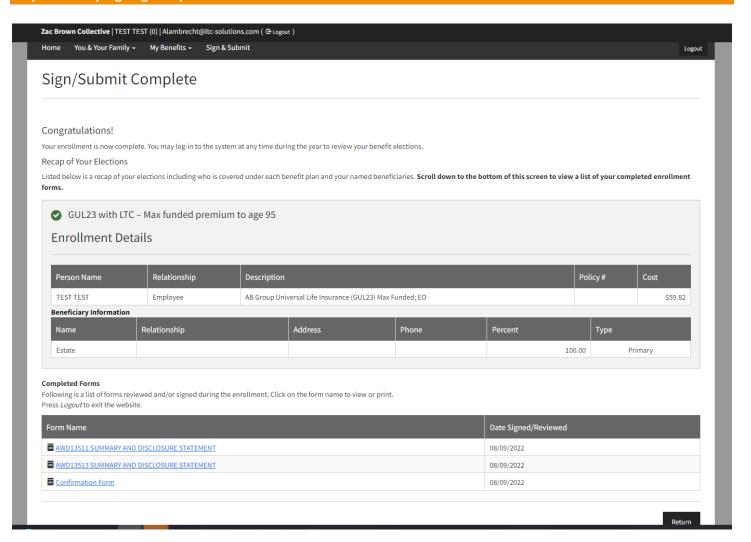
Step 14: Place a check mark next to the forms to sign



Step 15: Click 'Sign Form' – Enter PIN (last four digits of SSN + last two digits of birth year) to Sign

Zac Brown Co	ollective TEST TEST (0) Alambre	cht@ltc-solutions	.com (@ Logout)								
							Total:	0.00	0.00	59.82		1
			Enrollm	ent Agreement /	Payro	Il Deduction A	ıthorizat	ion				-
de	To the best of my knowledge and belief, all statements and answers made on this form and all associated application forms are true, complete, and correct. Upon acceptance by the insurers, I hereby authorize my Group to deduct from my earnings the amounts indicated above. My authorization shall continue thereafter until the earlier of (a) termination of my employment, (b) written notice from me canceling this authorization, or (c) termination of the Payroll Deduction Plan. I understand that it is my responsibility to verify the deduction							Download For	m			
				" to complete your enrol v it carefully before ente N:			s. By enterin		vord, you are elec	tronically signir	ng the Benefit	1
											© 2022 – Powered by Se	elerix

Step 16: Verify Signing Complete



Benefit Verification / Deduction Confirmation

Name	SSN	Employee ID	Date of Hire
TEST TEST	123555555	0	01/01/2022
Location	Department	Job Class	Pay Mode
Headquarters	Default	FT	26
Work Phone	Home Phone	E-mail	

Reason for Completing	Form
Open Enrollment	

Address 123 Easy Street Redmond, WA 98052

Benefit Deduction Summary

Benefit Deduction Summary Benefit Ded. Employer Employee Cost								
L			Benefit		Employer	Employee Cost		
Plan	Product	Cvg	Amount	Cycle	Cost	Pre-tax	Post-tax	
GUL23 with LTC – Max fun	AB Group Universal Life Insur	EO	75,000	26	0.00	0.00	59.82	

Enrollment Agreement / Payroll Deduction Authorization

- To the best of my knowledge and belief, all statements and answers made on this form and all associated application forms are true, complete, and correct.
- I understand that omissions or misrepresentations in the information I have provided may constitute fraud and may result in my coverage being void.
- Pursuant to IRC § 125, 'pre-tax' elections are irrevocable during the
 plan year. No changes to 'pre-tax' elections are allowed during the
 plan year unless you experience a qualified change in status event.
 Qualified change in status events include: change in marital status,
 change in dependent status, change in employment status. You
 have 30 days from the date of the change to contact human
 resources to change your benefit elections.
- Upon acceptance by the insurers, I hereby authorize my Group to deduct from my earnings the amounts indicated above.
- My authorization shall continue thereafter until the earlier of (a) termination of my employment, (b) written notice from me canceling this authorization, or (c) termination of the Payroll Deduction Plan.
- I understand that it is my responsibility to verify the deduction amounts from my paycheck and to notify my Employer immediately of any discrepancies.
- I understand any unused balance in a Dependent Care or Health Care Reimbursement account in which I am enrolled will be forfeited under the "Use It or Lose It" rule. Expenses must be incurred during the plan year for which the election amount was redirected.

Your total deductions per pay period...

Total Deductions				
\$	59.82			

[******] Electronic Signature on File	08/09/2022
Employee Signature	Date