aetna℠

American Heritage Life Insurance Company (AHL)
PO Box 41226 Jacksonville, FL 32224
877-750-0472
aetnasupport@allstate.com

☐ New Certificate
☐ Change/Increase
Certificate # _____

Group Critical Illness and Accident Plans Enrollment Form

Insured by American Heritage Life Insurance Company (the Company), a subsidiary of The Allstate Corporation*

Please print with black ink.

Remarks

General Information Section (Please complete entire section for all coverages)

Employee's Name/Last (Sr, Jr, etc.) First M.I.		Gender ☐ Male ☐ Female	Social Security Number	☐ Married ☐ Single
Resident Address (Street or PO Box)		City	State	ZIP
Birthdate (MM/DD/YYYY) / /	Resident Phone Number ( )	Employer	Date Hired (MM/DD/YYYY) / /	
Job Title		Plant or Division	Rehire Date (MM/DD/YYYY) / /	
Employee's E-mail	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.?
Critical Illness ☐ Yes ☐ No
Accident ☐ Yes ☐ No
If "Yes", indicate type of change: _____
Date of change _____ Current Certificate Number _____

Do you currently have either of the following individual products with AHL?
Critical Illness ☐ Yes ☐ No
Accident ☐ Yes ☐ No
If you answered "Yes" to either of the products, please enter the Policy Number _____
Do you wish to terminate this coverage? ☐ Yes ☐ No If "Yes", please enter effective date of termination _____

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

Choose Plan(s): Critical Illness	Accident	**Dependent's Name** (Last, First, M.I.)	**Relationship**	**Gender**	**Date of Birth** (MM/DD/YYYY)	**Social Security Number**
☐	☐					
☐	☐					
☐	☐					
☐	☐					
☐	☐					

Premium/Billing Mode	Case Number	Agent Number	Percentage Credit
☐ Monthly ☐ Semi-monthly ☐ Bi-weekly ☐ Weekly ☐ Other _____ Date of Issue _____	Employee ID	Situs State	

Selection of Coverage Section (Answer Yes or No and complete for each coverage selected)

Critical Illness ☐ Yes ☐ No	☐ Employee Only ☐ Employee & Spouse ☐ Employee & Child(ren) ☐ Family	Section 125 ☐ Yes ☐ No	☐ Low Option ☐ High Option If requesting coverage for spouse or dependents, the basic benefit amount is 50% of the employee.
☐ Cancer Critical Illness Option	☐ Wellness Option		Total Mode Premium $
Has any person to be insured (employee or spouse) used tobacco in any form in the last 12 months? ☐ Yes ☐ No			

Accident ☐ Yes ☐ No	☐ Employee Only ☐ Employee & Spouse ☐ Employee & Child(ren) ☐ Family	Section 125 ☐ Yes ☐ No	☐ Low Option ☐ High Option	☐ Benefit Enhancement Rider	Total Mode Premium $

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.aetnavoluntarybenefits.com.

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: 1-877-750-0472; 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.

Employee's Signature	Date Signed

*The Group Critical Illness and Accident Plans are limited benefit insurance policies and are underwritten by American Heritage Life Insurance Company (headquarters: Jacksonville, Florida). Eligible claims for this plan are the sole financial responsibility of American Heritage Life Insurance Company.