AMERICAN HERITAGE LIFE INSURANCE COMPANY (AHL)

1776 AMERICAN HERITAGE LIFE DRIVE
JACKSONVILLE, FLORIDA 32224

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 **Coahoma Community College**	Date Hired	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
		Employee			
		Spouse			

Are you applying for coverage or changing existing coverage due to a qualifying event?

Accident ☐ 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 the following Individual coverage with American Heritage Life Insurance Company (AHL)?

Accident ☐ Yes ☐ No

If you answered "Yes" to the coverage, 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 01/01/2016	**26166**		**MS**

ENROLLMENT FORM
SELECTION OF COVERAGE

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

Accident (GVAP6) (On and Off the Job Accident) ☐ Yes ☐ No	**Base Units** Low Plan 2 High Plan 3	Section 125 ☒ Yes ☐ No	**Home Office Use Only**

Total Monthly Premiums	**Low Plan**	**High Plan**
Employee Only	☐ $13.70	☐ $20.55
Employee+Spouse	☐ $23.68	☐ $35.52
Employee+Child(ren)	☐ $29.12	☐ $43.68
Family	☐ $37.90	☐ $56.85

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

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 ____________________

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

Producer Name	Producer Number	National Producer Number (NPN)	Percentage Credit
Servicing Producer: Debbie Whittington	2M705		100 %
Soliciting Producer:			%
			%
			%
			%

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ELECTRONIC DELIVERY ELECTION (Please check YES or NO)

By checking the "Yes" box, I elect electronic delivery of my certificate(s) of insurance (certificate(s)) and/or my policy(ies), including all documents accompanying my certificate(s) and/or my policies. I also elect electronic delivery of all contractual, regulatory and administrative correspondence (correspondence) regarding my certificate(s) and/or my policy(ies), to include claim correspondence, explanations of benefits, periodic notices (such as privacy notices) and other correspondence. If electronically delivered, I understand that I will be mailed instructions at the last provided residence address and/or email address on how to receive my certificate(s), policy(ies) and correspondence at: www.allstatebenefits.com/mybenefits.

☐ Yes ☐ No

I understand and agree that to receive electronic delivery, I must have a computer with internet access, a web browser that is Microsoft Internet Explorer version 9.0 or greater, an e-mail account, and the ability to download PDF files using Adobe Acrobat Reader version 5.0 or higher and a printer or other device to download and print or save any documents I wish to retain.

I understand and I agree that my consent is valid while I remain covered. 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(s) and/or my policy(ies), 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.

I understand and agree that this election is effective for all certificate(s) and/or policy(ies) applied for and/or enrolled in on the date signed as noted below.

Proposed Insured Name: ______________________________ Date Signed: ______________________________

Owner Printed Name (if other than Insured): ____________________ Account Number (if applicable): ____________________

Owner Social Security Number: ________________________ Account Name (if applicable): ____________________

Owner Signature: ________________________________

AMERICAN HERITAGE LIFE INSURANCE COMPANY
HOME OFFICE:
1776 AMERICAN HERITAGE LIFE DRIVE
JACKSONVILLE, FLORIDA 32224-6688
(904) 992-1776

A Stock Company

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses that result from accidental injury. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when it pays:

- Hospital or medical expenses up to the maximum stated in the policy

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- Hospitalization
- Physician services
- Outpatient prescription drugs if you are enrolled in Medicare Part D
- Other approved items and services

Before You Buy This Insurance

✓ Check the coverage in **all** health insurance policies you already have.
✓ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
✓ For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program (SHIIP).