



**Group Enrollment Form**

Check if custom form

Account No.	Employee ID	Requested Effective Date	First Deduction Date	Account	Location	Situs State
27380						GA
Deduction Mode: <input checked="" type="checkbox"/> Semi-Monthly						
Remarks			AHL home office use only		Dep Code <input type="checkbox"/> E <input type="checkbox"/> S <input type="checkbox"/> C <input type="checkbox"/> F	

**General Information**

*All references to spouse include civil union and domestic partner relationships.*

Employee Name (Last, First, M.I.)	Birth Date	Social Security No.	<input type="checkbox"/> Male <input type="checkbox"/> Female
Residence Street Address		Phone No.	
City, State, Zip	Email Address		
Employer/Association/Union <b>Pinnacle Bank</b>	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 Critical Illness, has the employee used tobacco in the last 12 months? **Employee**  Yes  No  
 If applying for Critical Illness, 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)

**Termination of Current Coverage**

Do you currently have any individual coverages with AHL that you wish to terminate in conjunction with this enrollment for group coverage?  Yes  No

If yes, enter the following information: Effective date of termination  Policy Number

Select the type of coverage:  Accident  Critical Illness

### Group Enrollment Form

## Selection of Coverage

Answer yes or no and complete for each coverage selected.

**Accident (GVAP6)** Do you want this coverage?  Yes  No Section 125

Choose coverage amount:

Total Semi-monthly Deductions	Plan 1
Employee Only	<input type="checkbox"/> \$ 7.61
Employee + Spouse	<input type="checkbox"/> \$17.36
Employee + Child(ren)	<input type="checkbox"/> \$21.27
Family	<input type="checkbox"/> \$27.88

Your coverage will consist of:	Units
Base Coverage	4
<input checked="" type="checkbox"/> Accident Treatment & Urgent Care Rider	4
<input checked="" type="checkbox"/> Emergency Room Services Rider	4
<input checked="" type="checkbox"/> Outpatient Physician's Rider	4
<input checked="" type="checkbox"/> Dislocation/Fracture Rider	4
<input checked="" type="checkbox"/> Benefit Enhancement Rider	4
<input checked="" type="checkbox"/> Accidental Death, Dismemberment & Functional Loss Rider	4

**Critical Illness (GVCIP2)** Do you want this coverage?  Yes  No Section 125

Your coverage will consist of:

Choose basic benefit amount:  \$10,000  \$20,000

- Cancer Critical Illness Option
- Second Event Initial Critical Illness Option
- Wellness Option Units   2
- Supplemental Critical Illness Option II

Semi-monthly Deductions	\$10,000 Basic Benefit Non-Tobacco				\$10,000 Basic Benefit Tobacco			
	Employee Only	Employee + Spouse	Employee + Child(ren)	Family	Employee Only	Employee + Spouse	Employee + Child(ren)	Family
Age								
18-29	<input type="checkbox"/> \$ 2.55	<input type="checkbox"/> \$ 4.14	<input type="checkbox"/> \$ 2.55	<input type="checkbox"/> \$ 4.14	<input type="checkbox"/> \$ 3.71	<input type="checkbox"/> \$ 5.88	<input type="checkbox"/> \$ 3.71	<input type="checkbox"/> \$ 5.88
30-39	<input type="checkbox"/> \$ 4.49	<input type="checkbox"/> \$ 7.05	<input type="checkbox"/> \$ 4.49	<input type="checkbox"/> \$ 7.05	<input type="checkbox"/> \$ 6.93	<input type="checkbox"/> \$10.71	<input type="checkbox"/> \$ 6.93	<input type="checkbox"/> \$10.71
40-49	<input type="checkbox"/> \$ 8.18	<input type="checkbox"/> \$12.57	<input type="checkbox"/> \$ 8.18	<input type="checkbox"/> \$12.57	<input type="checkbox"/> \$14.37	<input type="checkbox"/> \$21.87	<input type="checkbox"/> \$14.37	<input type="checkbox"/> \$21.87
50-59	<input type="checkbox"/> \$14.42	<input type="checkbox"/> \$21.95	<input type="checkbox"/> \$14.42	<input type="checkbox"/> \$21.95	<input type="checkbox"/> \$24.24	<input type="checkbox"/> \$36.67	<input type="checkbox"/> \$24.24	<input type="checkbox"/> \$36.67
60-63	<input type="checkbox"/> \$23.36	<input type="checkbox"/> \$35.36	<input type="checkbox"/> \$23.36	<input type="checkbox"/> \$35.36	<input type="checkbox"/> \$39.90	<input type="checkbox"/> \$60.16	<input type="checkbox"/> \$39.90	<input type="checkbox"/> \$60.16
64+	<input type="checkbox"/> \$30.62	<input type="checkbox"/> \$46.24	<input type="checkbox"/> \$30.62	<input type="checkbox"/> \$46.24	<input type="checkbox"/> \$52.83	<input type="checkbox"/> \$79.56	<input type="checkbox"/> \$52.83	<input type="checkbox"/> \$79.56

  

Semi-monthly Deductions	\$20,000 Basic Benefit Non-Tobacco				\$20,000 Basic Benefit Tobacco			
	Employee Only	Employee + Spouse	Employee + Child(ren)	Family	Employee Only	Employee + Spouse	Employee + Child(ren)	Family
Age								
18-29	<input type="checkbox"/> \$ 4.48	<input type="checkbox"/> \$ 7.03	<input type="checkbox"/> \$ 4.48	<input type="checkbox"/> \$ 7.03	<input type="checkbox"/> \$ 6.81	<input type="checkbox"/> \$ 10.52	<input type="checkbox"/> \$ 6.81	<input type="checkbox"/> \$ 10.52
30-39	<input type="checkbox"/> \$ 8.36	<input type="checkbox"/> \$12.85	<input type="checkbox"/> \$ 8.36	<input type="checkbox"/> \$12.85	<input type="checkbox"/> \$ 13.23	<input type="checkbox"/> \$ 20.16	<input type="checkbox"/> \$ 13.23	<input type="checkbox"/> \$ 20.16
40-49	<input type="checkbox"/> \$15.74	<input type="checkbox"/> \$23.91	<input type="checkbox"/> \$15.74	<input type="checkbox"/> \$23.91	<input type="checkbox"/> \$ 28.12	<input type="checkbox"/> \$ 42.49	<input type="checkbox"/> \$ 28.12	<input type="checkbox"/> \$ 42.49
50-59	<input type="checkbox"/> \$28.23	<input type="checkbox"/> \$42.65	<input type="checkbox"/> \$28.23	<input type="checkbox"/> \$42.65	<input type="checkbox"/> \$ 47.85	<input type="checkbox"/> \$ 72.09	<input type="checkbox"/> \$ 47.85	<input type="checkbox"/> \$ 72.09
60-63	<input type="checkbox"/> \$46.10	<input type="checkbox"/> \$69.46	<input type="checkbox"/> \$46.10	<input type="checkbox"/> \$69.46	<input type="checkbox"/> \$ 79.17	<input type="checkbox"/> \$119.06	<input type="checkbox"/> \$ 79.17	<input type="checkbox"/> \$119.06
64+	<input type="checkbox"/> \$60.62	<input type="checkbox"/> \$91.24	<input type="checkbox"/> \$60.62	<input type="checkbox"/> \$91.24	<input type="checkbox"/> \$105.03	<input type="checkbox"/> \$157.86	<input type="checkbox"/> \$105.03	<input type="checkbox"/> \$157.86

## Group Enrollment Form

### 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.	

**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. **I UNDERSTAND THAT CRITICAL ILLNESS COVERAGE IS CONSIDERED A LIMITED BENEFIT TYPE OF COVERAGE AND IS MEANT TO SUPPLEMENT, NOT BE A SUBSTITUTE OR REPLACEMENT FOR MAJOR MEDICAL INSURANCE.**

Employee Signature \_\_\_\_\_

Date Signed \_\_\_\_\_

**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.

Soliciting Producer Signature \_\_\_\_\_

Soliciting Producer Name Printed \_\_\_\_\_

Home office or producer to complete before issue:

Producer Name	Producer Number	Percentage Credit	Producer Name	Producer Number	Percentage Credit
Servicing Producer			Soliciting Producer		
			Roy Downey	960W6	100



## 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 (SHIP).