AMERICAN HERITAGE LIFE INSURANCE COMPANY (AHL)
1776 AMERICAN HERITAGE LIFE DRIVE
JACKSONVILLE, FLORIDA 32224

ENROLLMENT FORM

☐ New Certificate ☐ Change/Increase Certificate # ________

Remarks: CUSTOM FORM	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: Salida School District	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 ________	D8942		CO

(Salida School District)
(EF L70PA)
(2016)

ABJ4580CO7

ENROLLMENT FORM

SELECTION OF COVERAGE

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

Accident (GVAP6) Off the Job Accident	Base Units	Total Monthly Premiums		Section 125	Home Office Use Only
☐ Yes ☐ No	3	Employee Only	☐ $ 9.06	☐ Yes ☐ No	
		Employee+Spouse	☐ $20.19		
		Employee+Child(ren)	☐ $24.88		
		Family	☐ $32.33		

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

FRAUD NOTICE: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

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:			%
Soliciting Producer: Willis of Colorado Inc.	441P0		100 %
			%
			%
			%

(Salida School District)
(EF L70PA)
(2016)

Allstate.
Benefits

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).