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 **San Jose Police Officers Association** / 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

All references to marriage, spouse, etc. include Domestic Partner Relationships.

Last Name	First Name	Relationship	Sex	Date of Birth	Social Security Number	Tobacco Use* (Critical Illness)
		Employee				** ☐ Yes ☐ No
		Spouse				** ☐ Yes ☐ No

***Has any adult (19 and older) person to be insured used tobacco in the last 12 months? (**If applying for Critical Illness.)**

Are you applying for coverage or changing existing coverage due to a qualifying event?
Accident ☐ Yes ☐ No **Cancer/Specified Disease** ☐ Yes ☐ No **Critical Illness** ☐ 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 any of the following Individual coverages with American Heritage Life Insurance Company (AHL)?
Accident ☐ Yes ☐ No Cancer ☐ Yes ☐ No Critical Illness ☐ Yes ☐ No

If you answered "Yes" to any of the coverages, please enter the Policy Number _____

Do you wish to terminate this coverage? ☐ Yes ☐ No If "Yes", please enter effective date of termination _____

Do you currently have comprehensive health benefits from either an insurance policy or an HMO? ☐ Yes ☐ No
If you have answered "No," you may not apply for Cancer/Specified Disease or Critical Illness coverage.

Premium/Billing Mode ☒ Semi-monthly Date of First Deduction _____ Coverage Effective Date _____	Account Number	Employee ID	Situs State
	97972		**CA**

ENROLLMENT FORM

SELECTION OF COVERAGE

(Do you wish to sign up for coverage? Answer Yes or No for each coverage and complete each section answered Yes.)

Accident (GVAP1) (On and Off the Job Accident) ☐ Yes ☐ No	**Base Units** Low Plan 1 High Plan 2	**Total Semi-monthly Premiums** Low Plan / High Plan Employee Only ☐ $40.10 / ☐ $79.12 Family ☐ $46.04 / ☐ $91.00	Section 125 ☐ Yes ☐ No

Low Plan	**Optional Disability Rider for Employee** ☒ On and Off the Job Accident and Sickness	Employee Monthly Salary $ _____	Rider Units 1
High Plan	**Optional Disability Rider for Employee** ☒ On and Off the Job Accident and Sickness	Employee Monthly Salary $ _____	Rider Units 2

Cancer/Specified Disease (GVCP2) ☐ Yes ☐ No	Plan 1	**Total Semi-monthly Premiums** Low Plan / High Plan Employee Only ☐ $ 9.41 / ☐ $15.81 Family ☐ $16.00 / ☐ $27.50	Section 125 ☐ Yes ☐ No	**Home Office Use Only**

Benefits	Hospital	Radiation / Chemotherapy	Surgery Related	Misc.	☒ Cancer Initial Diagnosis Option	☒ Intensive Care Option	☒ Cancer Screening Option
Units Low Plan	1	4	1	1	1	2	1
High Plan	3	4	3	1	5	8	1

ENROLLMENT FORM

SELECTION OF COVERAGE

(Do you wish to sign up for coverage? Answer Yes or No for each coverage and complete each section answered Yes.)

Critical Illness (GVCIP1) (My Lifeline) ☐ Yes ☐ No	Section 125 ☐ Yes ☐ No	**Home Office Use Only**

Basic Benefit Amount ☐ **$5,000 - or -** ☐ **$15,000 - or -** ☐ **$30,000**
If covered, Basic Benefit Amount for spouse or other dependents is 50% of the employee's.

☒ Recurrence Option ☒ Wellness Option Units 4

Semi-monthly Premiums $5,000 Basic Benefit	Age	Employee Only	Employee + Spouse	Employee + Child(ren)	Family
Non-Tobacco	18-35	☐ $ 2.55	☐ $ 4.06	☐ $ 2.60	☐ $ 4.14
	36-49	☐ $ 3.80	☐ $ 5.94	☐ $ 3.88	☐ $ 5.99
	50-59	☐ $ 6.20	☐ $ 9.46	☐ $ 6.25	☐ $ 9.54
	60-64	☐ $ 8.95	☐ $ 13.56	☐ $ 9.03	☐ $ 13.61
	65-69	☐ $11.08	☐ $ 16.71	☐ $11.15	☐ $ 16.79
	70+	☐ $13.05	☐ $ 19.59	☐ $13.10	☐ $ 19.66
Tobacco	18-35	☐ $ 3.08	☐ $ 4.84	☐ $ 3.13	☐ $ 4.91
	36-49	☐ $ 5.48	☐ $ 8.41	☐ $ 5.53	☐ $ 8.46
	50-59	☐ $10.28	☐ $ 15.51	☐ $10.35	☐ $ 15.56
	60-64	☐ $14.05	☐ $ 21.09	☐ $14.10	☐ $ 21.14
	65-69	☐ $16.10	☐ $ 24.11	☐ $16.15	☐ $ 24.16
	70+	☐ $17.98	☐ $ 26.91	☐ $18.05	☐ $ 26.99

Semi-monthly Premiums $15,000 Basic Benefit	Age	Employee Only	Employee + Spouse	Employee + Child(ren)	Family
Non-Tobacco	18-35	☐ $ 3.65	☐ $ 5.66	☐ $ 3.80	☐ $ 5.89
	36-49	☐ $ 7.40	☐ $ 11.29	☐ $ 7.63	☐ $ 11.44
	50-59	☐ $14.60	☐ $ 21.86	☐ $14.75	☐ $ 22.09
	60-64	☐ $22.85	☐ $ 34.16	☐ $23.08	☐ $ 34.31
	65-69	☐ $29.23	☐ $ 43.61	☐ $29.45	☐ $ 43.84
	70+	☐ $35.15	☐ $ 52.24	☐ $35.30	☐ $ 52.46
Tobacco	18-35	☐ $ 5.23	☐ $ 7.99	☐ $ 5.38	☐ $ 8.21
	36-49	☐ $12.43	☐ $ 18.71	☐ $12.58	☐ $ 18.86
	50-59	☐ $26.83	☐ $ 40.01	☐ $27.05	☐ $ 40.16
	60-64	☐ $38.15	☐ $ 56.74	☐ $38.30	☐ $ 56.89
	65-69	☐ $44.30	☐ $ 65.81	☐ $44.45	☐ $ 65.96
	70+	☐ $49.93	☐ $ 74.21	☐ $50.15	☐ $ 74.44

Semi-monthly Premiums $30,000 Basic Benefit	Age	Employee Only	Employee + Spouse	Employee + Child(ren)	Family
Non-Tobacco	18-35	☐ $ 5.30	☐ $ 8.06	☐ $ 5.60	☐ $ 8.51
	36-49	☐ $12.80	☐ $ 19.31	☐ $13.25	☐ $ 19.61
	50-59	☐ $27.20	☐ $ 40.46	☐ $27.50	☐ $ 40.91
	60-64	☐ $43.70	☐ $ 65.06	☐ $44.15	☐ $ 65.36
	65-69	☐ $56.45	☐ $ 83.96	☐ $56.90	☐ $ 84.41
	70+	☐ $68.30	☐ $101.21	☐ $68.60	☐ $101.66
Tobacco	18-35	☐ $ 8.45	☐ $ 12.71	☐ $ 8.75	☐ $ 13.16
	36-49	☐ $22.85	☐ $ 34.16	☐ $23.15	☐ $ 34.46
	50-59	☐ $51.65	☐ $ 76.76	☐ $52.10	☐ $ 77.06
	60-64	☐ $74.30	☐ $110.21	☐ $74.60	☐ $110.51
	65-69	☐ $86.60	☐ $128.36	☐ $86.90	☐ $128.66
	70+	☐ $97.85	☐ $145.16	☐ $98.30	☐ $145.61

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:			%
Soliciting Producer: A. Francois Derendinger Insurance Agency Inc.	3WLT0		%
			%
			%
			%

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).

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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 only when you are treated for one of the specific diseases or health conditions listed in the policy. 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
- hospice
- 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).

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