AMERICAN HERITAGE LIFE INSURANCE COMPANY (AHL)

Jacksonville, Florida

CUSTOMER AGREEMENT

For Home Office use only
Group/Account No. ________
Master Account No. ________
____
Effective Date ________

I. Proposed Account

A. Name ______________________ (Legal Name) **B.** ________ (Situs State) **C.** NAIC/SIC code ________

D. Fed. I.D. No. ________ **E.** Type of Busines ________ **F.** Years in Business ________

G. Total Eligibles ________

H. Address* ______________________
(Street) (City) (State) (Zip)

I. ______________________
(P.O. Box, If any) (City) (State) (Zip)

*For group products, address must be based on situs state of group policy.

Contact Person(s):

1. Responsible Officer & Title ________ Phone: (   ) ________
2. Administrative Contact ________ Phone: (   ) ________ Fax: (   ) ________
3. Administrative Contact Email ________

II. Group Insurance *(This section pertains to Group Products only.)*

A. Subsidiaries to be included in coverage:

Name	Address (Street, City, State, Zip)	Number of Employees	Wholly-owned Subsidiary of Policyholder? YES	NO*
			☐	☐
			☐	☐
			☐	☐

*If the "subsidiary" is *not owned* by the Policyholder, please describe the relationship under Item VI, "Comments".

B. Will this replace similar group coverage? ☐ Yes ☐ No If yes, please provide:
Termination date of similar plan ________
Name of similar insurer ________ (attach copy of Certificate or SPD)

C. Requested Effective Date for Plan year ________ to ________ . First Payroll Deduction Date ________

D. Most Group Plans underwritten by AHL (with the exception of Disability and Life) are subject to COBRA. AHL offers and pays for administration of its COBRA plans through COBRAGuard. If you want to utilize COBRAGuard, please complete the COBRAGuard User Service Order Form, ABJ13007. **NOTE: AHL does not pay for administration of COBRA for products not underwritten by AHL.**

E. Will the AHL insurance be part of an Employee Welfare Benefit Plan (ERISA)? ☐ Yes ☐ No
If yes for group insurance, should AHL include a Summary Plan Description (SPD) in the Certificates of Coverage?
☐ Yes ☐ No
If yes, complete the following as it appears on the most recent Form 5500 or ***AS IT WILL APPEAR*** *on the first form 5500 for a new plan.*
ERISA Plan No. ________ Plan Year: From ________ through ________ each year
Plan Name ________ Address: ________ (If different than G. above)
If no, the SPD will be the Policyholder's responsibility.

III. Proposed Insureds

A. Eligible Employees.

1. Total number of employees eligible for coverage: ________
2. Eligible Employees are: (check all that apply)
   - ☐ Full-time employees who work 25 or more hours per week.
   - ☐ Full-time employees who work 30 or more hours per week.
   - ☐ Regular part-time employees who work 20 or more hours per week.
   - ☐ Full-time employees who work 20 or more hours per week.
   - ☐ Other (explain): ________
3. Describe any class of employees to be excluded: ________

B. Eligible Association / Union Members (applies to Cancer/Specified Disease (GVCP3), Accident, SHOP, Indemnity Medical, Critical Illness, Vision, Universal Life, and Disability (GVDI))

1. Total number of members eligible for coverage: ________
2. Eligible Members are: (check all that apply)
   - ☐ Full-time members who work 25 or more hours per week.
   - ☐ Full-time members who work 30 or more hours per week.

III. Proposed Insureds (continued)

☐ Regular part-time members who work 20 or more hours per week.
☐ Full-time members who work 20 or more hours per week.
☐ Other (explain): ____________________

3. Describe any class of members to be excluded: ____________________

C. New-Hire Waiting Period is ________ days after hire date.
New-Hire Enrollment Period includes the 31 days following the New-Hire Waiting Period.
Coverage for New-Hires begins: ☐ On the first day of the month following enrollment - or - ☐ the Next Day.

D. Eligible Individuals in the Waiting Period on the policy effective date will:
☐ Complete Waiting Period - or - ☐ Be eligible immediately.

E. Annual Enrollment Period is:
☐ The Calendar Month before the Policy Anniversary Date - or - ☐ Other (explain) ____________________
(*Only applicable to Disability (GVD-4000) and Term Life (GVL - 4000)*)

F. Individuals first eligible after the policy effective date may enroll (Applies to AHL Products ONLY):
☐ within 31 days of eligibility - or - ☐ only at the next Annual Enrollment Period

G. Rehired Employees (Only applies to Group PPO Dental):
More than 31 days after termination considered a new employee? ☐ Yes ☐ No If No, explain: ____________________

____

IV. Billing Information (For both Group and Individual Products)

A. Account Name ____________________ Account Number ____________________

B. Billing Address ____________________
(Street)

____
(City) (State) (Zip)

C. Billing Contact ____________________
Telephone ____________________ Fax ____________________
Email ____________________

D. Billing Method
☐ Bill to Employer
☐ Credit Union (complete form ABJ445)
☐ Third Party Administrator Name of Third Party: ____________________
☐ Account's Own Service Provider ____________________
(Name)

E. Initial Billing Date ____________________

F. Employees will be identified by ☐ Social Security Number - or - ☐ Employee ID

G. Bill will be sorted by ☐ Employee Name ☐ Social Security Number ☐ Employee ID

H. Billing Frequency - Please select billing frequency

☐ Monthly*	☐ Quarterly
☐ Semi-Monthly*	☐ Semi-Annually
☐ Weekly*	☐ Annually
☐ Bi-weekly*	☐ Ninthly
☐ Tenthly	☐ Forty-Eighthly

***Available billing frequency for the following products: EyeMed, GAP, GIM, Group PPO Dental, GCIP3, GVCIP1 (New Generation), GVDI (New Generation), LTD, STD, Term Life & Vision.**

I. Combined Billing: ☐ Yes ☐ No (For Products on Multiple Admin Systems)

V. Product Offerings

Select products

Please mark each product with an "X"		
GROUP PRODUCTS (Please complete attached addendum.)	**INDIVIDUAL PRODUCTS**	**NON-INSURANCE PRODUCTS** (Please complete attached addendum.)
☐ Group Accident (GVAP1) (p.1)	☐ Accident (AP2)	☐ Mayo Clinic Services Option (p.9)
☐ Group Accident (GVAP2) (p.1)	☐ Accident (AP3)	☐ Roadside Assistance (p.9)
☐ Group Accident (GVAP6) (p.1)	☐ Cancer (CP10)	
☐ Group Critical Illness (GVCIP1) (p.2)	☐ Critical Illness (CILP1)	
☐ Group Critical Illness (GVCIP2) (p.2)	☐ Disability (DI5)	
☐ Group Critical Illness (GCIP3) (p.2)	☐ Heart/Stroke (HSP2)	
☐ Group Cancer/Specified Disease (GVCP2) (p.3)	☐ Hospital Indemnity (SHOP)	
☐ Group Cancer/Specified Disease (GVCP3) (p.3)	☐ Universal Life (UL20)	
☐ Group Universal Life (GUL22) (p.3)	☐ Universal Life (UL21)	
☐ Group Term to 100 Life (GPTL) (p.3)	☐ 20 Year Term (20YT)	
☐ Group Term Life Insurance (GVL-4000 Only) (p.4)		
☐ Long Term Disability (p.4)		
☐ Group Voluntary Disability Income (GVDI) (p.5)		
☐ Short Term Disability (GVD-4000) (p.5)		
☐ Group SHOP (GVSP1) (p.6)		
☐ Group Indemnity Medical I (GIM I) (p.6)		
☐ Group Indemnity Medical II (GIM II) (p.7)		
☐ Guardian Group PPO Dental Plan (p.8)		
☐ EyeMed Vision Care (p.8)		
☐ The Major Medical Complement (p.9)		

VI. Comments

ITEM #	ADDITIONAL INFORMATION

VII. Account Agreement

A. Electronic Acceptance of American Heritage Life Insurance Company (Group Products Only)

By checking the "Yes" box below, you agree to electronic delivery of the certificate of insurance and its accompanying notices (“the Certificates”). If electronically delivered, insureds will be provided instructions on how to receive their Certificate via the following address: www.allstatebenefits.com/mybenefits.

To electronically receive their Certificate, insureds will need a personal computer with internet access and appropriate browser software, and Adobe Acrobat Reader®.

☐ YES, I agree to have insureds receive their Certificate electronically via the internet.
☐ NO, I prefer for insureds to receive paper copies of their Certificate.

B. Additional Services

May we contact your employees to offer them:

a) The Good Hands[SM] Roadside Assistance Plan? ☐ Yes ☐ No
b) A no obligation auto insurance quote? ☐ Yes ☐ No

C. Effective Date

If issued, the coverage selected as indicated on the attached addendum(s) will become effective on the date stated in the Policy(ies). The Policy(ies) issued and any amendments, riders, and/or endorsements thereto, along with the application, will constitute the entire contract.

D. Acceptance of Voluntary Insurance

Upon the approval of American Heritage Life Insurance Company, the Account agrees to establish a voluntary insurance program for the benefit of its employees/members. For each employee/member who executes a payroll deduction request, we will withhold the amount authorized. We will forward this money either: (i) directly to AHL upon notice of the premium due from each employee/member, or (ii) to the credit union if named in item IV, “Billing Information”.

We may, upon written notice to AHL and to our employees/members, discontinue our participation in AHL’s Insurance Program. In such event, the continued payment of premiums will be a matter directly between each employee/member and AHL.

We assume no responsibility for forwarding premiums from anyone other than current employees/members.

We understand that AHL does not disclose personal information about our employees/members to companies or organizations not affiliated with AHL that would use the information to market their own products and services. However, AHL may share with us personal information about our employees/members, and other persons, in order to carry out the purpose of AHL’s Insurance Program. Personal Information includes all personally identifiable health information and other information about a person that:

- a person provides to AHL to obtain insurance,
- results from an insurance transaction, or
- is otherwise obtained in connection with providing insurance.

We agree not to disclose or use this personal information except as necessary for our participation in AHL’s Insurance Program. We may be provided access to this information in electronic form and are responsible for limiting this access to those necessary for our participation.

Agent Of Record For Account is: ______________________

Authorized Officer Printed Name ______________________

Authorized Officer Signature ______________________ Date Signed ______________

E. Producer Signature

By signing below, I affirm that I have personally met with the Account, verified all of the above information and the Account is ready to be processed.

	Agent Number	Agent Name	Signature	Date Signed
Agent of Record				
Servicing Agent				

AOR Sales Channel (check one):

☐ Allstate (EA/EFS) ☐ Independent Agent