

Instructions for Application Mini Medical Plan

If you want to enroll in the mini medical program, you need to complete the following application and return it to SBS. You can fax it to 614-793-8663 or scan and email it to IHCPUbenefits@gmail.com. Please make sure the form is filled out in its entirety. Remember that the forms must be returned to SBS no later than the 15th of the month to be effective by the first of the following month.

AMERICAN HERITAGE LIFE INSURANCE COMPANY (AHL)

1776 AMERICAN HERITAGE LIFE DRIVE
JACKSONVILLE, FLORIDA 32224



Allstate

Workplace Division

ENROLLMENT FORM

This Box for AHL Home Office use only		
Group No.	Account	Location
Dep Code	Smoker	Issue State
E S C F	EE Y or N SP Y or N	
EFFECTIVE DATE		

GENERAL INFORMATION SECTION

Please print with black ink

(Please complete entire section for all coverages)

EMPLOYEE'S NAME Last (Sr, Jr, etc.)		First	M.I.	<input type="checkbox"/> M <input type="checkbox"/> F	SOCIAL SECURITY NUMBER	<input type="checkbox"/> Married <input type="checkbox"/> Single
HOME ADDRESS (Street or P.O. Box)				CITY	STATE	ZIP
BIRTHDATE (MM/DD/YEAR)	HOME PHONE NUMBER	EMPLOYER Independent Home Care Providers			DATE HIRED (MM/DD/YEAR)	
OCCUPATION	PLANT OR DIVISION		CURRENT EARNINGS \$ _____ (also check appropriate box)			
BENEFICIARY'S NAME (Last, First, M.I.)		RELATIONSHIP		<input type="checkbox"/> Hourly <input type="checkbox"/> Bi-weekly (26)	<input type="checkbox"/> Weekly <input type="checkbox"/> Semi-monthly (24)	<input type="checkbox"/> Monthly <input type="checkbox"/> Annually
Are you adding any coverage or changing any of your existing coverage due to marriage, birth, adoption, employment status change, etc.? <input type="checkbox"/> Yes <input type="checkbox"/> No						
If "yes", indicate type of change: _____						
Date of change _____ Current Certificate Number _____						

DEPENDENT COVERAGE SECTION

(Please complete if dependent coverage elected. Use additional paper if needed.)

Dependent's Name (Last, First, M.I.)	Relationship	Sex	Date of Birth (MM/DD/YEAR)	Social Security Number

AHL minimedical® <input type="checkbox"/> Yes <input type="checkbox"/> No	Essential	<input type="checkbox"/> Employee Only <input type="checkbox"/> Employee+ Spouse <input type="checkbox"/> Employee+ Child <input type="checkbox"/> Family	Section 125 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Home Office Use Only SET ID _____
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If you did not elect MEDICAL coverage, is this because of other health coverage? Yes No

Notice of Preexisting Conditions Exclusion: This plan imposes a Preexisting Conditions Exclusion. This means that if you have a medical condition before coming to our plan, you might have to wait a certain period of time before the plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis, care or treatment was recommended or received within a 6-month period. Generally, this 6-month period ends the day before your coverage becomes effective. However, if you were in a waiting period for coverage, the 6-month period ends on the day before the waiting period begins. The preexisting condition exclusion does not apply to pregnancy or to a child who is enrolled in the plan within 30 days after birth, adoption, or placement for adoption. This exclusion may last up to 12 months (18 months if you are a late enrollee) from your first day of coverage, or, if you were in a waiting period, from the first day of your waiting period. However, you can reduce the length of this exclusion period by the number of days of your prior "creditable coverage". Most prior health coverage is considered creditable coverage and can be used to reduce the preexisting condition exclusion if you have not experienced a break in coverage of at least 63 days. To reduce the 12-month (or 18-month) exclusion period by your creditable coverage, you should give us a copy of any certificates of creditable coverage you have. If you do not have a certificate, but you do have prior health coverage, we will help you obtain one from your prior plan or issuer. There are also other ways that you can show you have creditable coverage. Please contact us if you need help demonstrating creditable coverage. All questions about the preexisting condition exclusion and creditable coverage should be directed to our Customer Service Department at 1-800-937-7039.

ENROLLMENT FORM

ELECTRONIC ACCEPTANCE

By checking the "Yes" box below, I agree to electronic delivery of my certificate of insurance, describing my coverage under the group policy, and its accompanying notices ("my Certificates"). If electronically delivered, I will be provided instructions on how to receive my Certificate via the following address: www.allstateatwork.com/mybenefits.

To electronically receive my Certificate, I must use a computer that meets the following minimum requirements: (1) Operating system with a minimum of: (a) Pentium or higher processor, (b) 16 MB random access memory (RAM), (c) 20 MB of free hard drive space; (2) Operating system Windows® XP or higher or Windows® 2000 or higher; (3) Microsoft® Internet Explorer 6.x or greater; (4) Adobe® Reader 6.x or greater; (5) Internet connection.

My consent is valid while I am covered under the group policy. At any time, I may withdraw my consent for any reason and receive a paper copy of my Certificate, 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.

- YES, I agree to receive the Certificate and Notices electronically via the internet.
- NO, I prefer to receive paper copies of the Certificate and Notices.

ACCEPTANCE: I hereby request all coverage 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 earnings any contributions required of me for the payment of premiums for such coverage. **FRAUD NOTICE: Any person who with intent to defraud or knowing that he is facilitating fraud against an insurer, submits an application or files a claim containing false or deceptive statement is guilty of insurance fraud.** · 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" for each coverage not wanted), 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 _____ Employee's
Signed _____ Signature _____