



Workplace Division

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

New Certificate  
 Change/Increase Certificate # \_\_\_\_\_

**ENROLLMENT FORM**

Remarks

**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.	SEX	SOCIAL SECURITY NUMBER	<input type="checkbox"/> Married <input type="checkbox"/> Single
RESIDENT ADDRESS (Street or P.O. Box)			CITY	STATE	ZIP
BIRTHDATE (MM/DD/YEAR)	RESIDENT PHONE NUMBER	EMPLOYER		DATE HIRED (MM/DD/YEAR)	
JOB TITLE		PLANT OR DIVISION		REHIRE DATE (MM/DD/YEAR)	
BENEFICIARY'S NAME (Last, First, M.I.)			RELATIONSHIP		

Are you adding any coverage or changing any of your existing coverage due to marriage, birth, adoption, employment status change, etc.?

**Critical Illness**  Yes  No    
 **Hospital Indemnity**  Yes  No  
**Cancer/Specified Disease**  Yes  No    
 **Heritage Choice Dental**  Yes  No  
**Accident**  Yes  No

If "yes", indicate type of change: \_\_\_\_\_

Date of change \_\_\_\_\_ Current Certificate Number \_\_\_\_\_

Do you currently have any of the following individual products with AHL?

Cancer  Yes  No   
 Accident  Yes  No   
 Hospital Indemnity  Yes  No   
 Critical Illness  Yes  No

If you answered "Yes" to any of the products, please enter the Policy Number \_\_\_\_\_

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

**DEPENDENT COVERAGE SECTION**

(Please complete if dependent coverage elected. Use additional paper if needed.)  
 Abbreviations: Den-Dental CI-Critical Illness Can-Cancer Acc-Accident Hosp-Hospital

Choose Plan(s):					Dependent's Name (Last, First, M.I.)	Relationship	Sex	Date of Birth (MM/DD/YEAR)
Den	CI	Can	Acc	Hosp				

# ENROLLMENT FORM

## SELECTION OF COVERAGE SECTION

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

<b>Heritage Choice Dental</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Plan 1 <input type="checkbox"/> Plan 4 <input type="checkbox"/> Plan 2 <input type="checkbox"/> Plan 5 <input type="checkbox"/> Plan 3	<input type="checkbox"/> Employee Only <input type="checkbox"/> Employee + One <input type="checkbox"/> Family	Section 125 <input type="checkbox"/> Yes <input type="checkbox"/> No	Total Mode Premium \$ _____
Were you covered under your Employer's prior Dental Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", please enter the date coverage effective _____		<b>AHL Home Office Use Only</b> SET ID <b>ACTIV</b> or <b>EMPLR</b> or _____ PLAN ID <b>P1NG1</b> <b>P1NG2</b> <b>P1NG3</b>		

<b>Critical Illness</b> (My Lifeline) <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Employee Only <input type="checkbox"/> Employee+Spouse <input type="checkbox"/> Employee+Child(ren) <input type="checkbox"/> Family	Section 125 <input type="checkbox"/> Yes <input type="checkbox"/> No	Total Mode Premium \$ _____	<b>Home Office Use Only</b> SET ID _____
<b>Basic Benefit Amount \$</b> _____ <small>If requesting coverage for spouse or dependents, the basic benefit amount is 50% of the employee.</small>		Critical Illness Cancer Option <input type="checkbox"/>	Recurrence Option <input type="checkbox"/>	Wellness Option <input type="checkbox"/> Units _____
Has any person to be insured used tobacco in any form in the last 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, who and what type? _____				

<b>Cancer/Specified Disease</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Employee Only <input type="checkbox"/> Employee+Spouse <input type="checkbox"/> Employee+Child(ren) <input type="checkbox"/> Family	Section 125 <input type="checkbox"/> Yes <input type="checkbox"/> No	Total Mode Premium \$ _____				
<b>Benefits</b>	Hospital	Radiation / Chemotherapy	Surgery Related	Misc.	Cancer Initial Diagnosis Option <input type="checkbox"/>	Intensive Care Option <input type="checkbox"/>	Wellness Benefit Option <input type="checkbox"/>
<b>Units</b>				1			

<b>Accident</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	Base Units _____	<input type="checkbox"/> Employee Only <input type="checkbox"/> Employee+Spouse <input type="checkbox"/> Employee+Child(ren) <input type="checkbox"/> Family	Section 125 <input type="checkbox"/> Yes <input type="checkbox"/> No	Total Mode Premium \$ _____
<b>Optional Disability Riders for Employee</b> <input type="checkbox"/> Off the Job Accident <input type="checkbox"/> Off the Job Accident and Sickness <input type="checkbox"/> On and Off the Job Accident <input type="checkbox"/> On and Off the Job Accident and Sickness			Employee Monthly Salary \$ _____	Rider Units _____
<b>Optional Disability Riders for Spouse</b> <input type="checkbox"/> On and Off the Job Accident for Insured Spouse* <input type="checkbox"/> On and Off the Job Accident and Sickness for Insured Spouse* <small>*Available only when Employee + Spouse or Family coverage is selected and the insured spouse has worked 25 hours per week for 3 or more consecutive months.</small>			Spouse Monthly Salary \$ _____	Rider Units _____

# ENROLLMENT FORM

## SELECTION OF COVERAGE SECTION

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

<b>Hospital Indemnity</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		Plan _____	<input type="checkbox"/> Employee Only <input type="checkbox"/> Employee+Child(ren) <input type="checkbox"/> Employee+Spouse <input type="checkbox"/> Family		Section 125 <input type="checkbox"/> Yes <input type="checkbox"/> No	Total Mode Premium \$ _____	
<b>Benefits</b>	Hospital Related	Surgery / Inpatient Physician	Outpatient Related	Diagnostic / Wellness Option <input type="checkbox"/>	Prescription Drug Option <input type="checkbox"/>	Disability Rider <input type="checkbox"/>	Life Rider <input type="checkbox"/>
<b>Units</b>							

<b>Premium/Billing Mode</b> <input type="checkbox"/> Monthly <input type="checkbox"/> Semi-monthly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Weekly <input type="checkbox"/> Other _____	Case Number	Agent Number	Percentage Credit
Date of Issue _____	Employee ID		
	Situs State		

**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. · **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 \_\_\_\_\_ Employee's  
Signed \_\_\_\_\_ Signature \_\_\_\_\_