AMERICAN HERITAGE LIFE INSURANCE COMPANY (AHL)

1776 AMERICAN HERITAGE LIFE DRIVE
JACKSONVILLE, FLORIDA 32224

ENROLLMENT FORM

For AHL Home Office use only ☐ New Certificate ☐ Change/Increase Certificate #________

Group No.	Account	Location	Dep Code	Smoker	Issue State	Effective Date
			E S C F	EE **Y** or **N** SP **Y** or **N**		

GENERAL INFORMATION

Employee's (Certificateholder) Name (Last, First, M.I.)	☐ M ☐ F	Social Security Number

Residence Address	City	State	Zip

Date of Birth	Phone Number	Email

Employer/Association/Union	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	Tobacco Use* (Life or 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 Life or Critical Illness. For Critical Illness, tobacco rating applies to all covered persons if either the employee or the employee's spouse answers "Yes" to Tobacco Use.)**

SAMPLE

Are you applying for coverage or changing existing coverage due to a qualifying event?

Critical Illness ☐ Yes ☐ No
Dental ☐ Yes ☐ No
Disability (STD) ☐ Yes ☐ No
Disability (LTD) ☐ Yes ☐ No
Indemnity Medical ☐ Yes ☐ No
Life/Accidental Death & Dismemberment ☐ Yes ☐ No

If "Yes," check the qualifying event:

☐ Marriage
☐ Divorce
☐ Birth/Adoption
☐ Spouse/Dependent Child Death
☐ Eligible/Ineligible Child
☐ Spouse New Job/Job Loss
☐ Newly Eligible
☐ Termination
☐ 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)?
Critical Illness ☐ Yes ☐ No Disability ☐ Yes ☐ No Hospital Indemnity ☐ 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 ________

ENROLLMENT FORM

SELECTION OF COVERAGE

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

Critical Illness (GVCIP1) (New Generation) ☐ Yes ☐ No	☐ Employee Only ☐ Employee+Spouse ☐ Employee+Child(ren) ☐ Family	Section 125 ☐ Yes ☐ No	Total Mode Premium $________	**Home Office Use Only**
☐ **Plan 1** **Basic Benefit Amount $________** If covered, Basic Benefit Amount for spouse is 50% of employee benefit; other dependents are 25% of employee benefit.		☐ **Plan 2** **Basic Benefit Amount $________** If covered, Basic Benefit Amount for spouse is 50% of employee benefit; other dependents are 25% of employee benefit.		

Critical Illness (GCIP3) (New Generation) ☐ Yes ☐ No	☐ Employee Only ☐ Employee+Spouse ☐ Employee+Child(ren) ☐ Family	Total Mode Premium $________
☐ **Plan 1** **Basic Benefit Amount $________** If covered, Basic Benefit Amount for spouse or other dependents is 50% of the employee's.	☐ **Plan 2** **Basic Benefit Amount $________** If covered, Basic Benefit Amount for spouse or other dependents is 50% of the employee's.	**Home Office Use Only**

Disability (Short-Term) (GVDIP) (New Generation) ☐ Yes ☐ No	Monthly Salary $______	Monthly Benefit $______	Section 125 ☐ Yes ☐ No	☐ Plan 1 ☐ Plan 2	Total Mode Premium $ ______	**Home Office Use Only**

A. Is this insurance to replace any existing disability coverage? ☐ Yes ☐ No

If yes, provide the Company Name ____________________

B. Is there any other disability insurance in force or applied for that will continue after the effective date of this coverage? ☐ Yes ☐ No

If yes, complete the following:

Company Name ____________________ Year Issued ____________

Monthly Benefit $____________ Elimination Period ____________ Benefit Period ____________

Short-Term Disability (GVD4000 STD) ☐ Yes ☐ No	Monthly Salary $________	Monthly Benefit $________	Total Mode Premium $________	**Home Office Use Only** SET ID/PLAN ID **ACTIV/STD** ______ and/or **EMPLR/STD** ______ and/or (other) ____________

Long-Term Disability (GVD4000 LTD) ☐ Yes ☐ No	Monthly Salary $ ________	Monthly Benefit $________	Total Mode Premium $________	**Home Office Use Only** SET ID/PLAN ID **ACTIV/LTD** ______ and/or **EMPLR/LTD** ______ and/or (other) ____________

Heritage Choice Dental ☐ Yes ☐ No	☐ Plan 1 ☐ Plan 4 ☐ Plan 2 ☐ Plan 5 ☐ Plan 3	☐ Employee Only ☐ Employee+Spouse ☐ Employee+One Child ☐ Family	Section 125 ☐ Yes ☐ No	Total Mode Premium $________
Were you covered under your Employer's prior Dental Plan? ☐ Yes ☐ No If "Yes," please enter the date coverage effective ____________		**Home Office Use Only** SET ID **ACTIV** or **EMPLR** or PLAN ID **P1NG1** **P1NG2** **P1NG3** ________		

SAMPLE

ENROLLMENT FORM

SELECTION OF COVERAGE

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

Indemnity Medical II **(GIM2)** (New Generation) ☐ Yes ☐ No	☐ Employee Only ☐ Employee+Spouse ☐ Employee+Child(ren) ☐ Family	Section 125 ☐ Yes ☐ No	☐ Plan 1 ☐ Plan 2	Total Mode Premium $_______	**Home Office Use Only**

Indemnity Medical I **(GIM1)** ☐ Yes ☐ No	☐ Employee Only ☐ Employee+Spouse ☐ Employee+Child(ren) ☐ Family	Section 125 ☐ Yes ☐ No	☐ Plan 1 ☐ Plan 2	Total Mode Premium $_______

Riders (only available if the Employer chooses to offer) ☐ Disability ☐ Life

Buy Up Options (only available if the Employer chooses to offer)

☐ **EyeMed Vision Care**
(Underwritten by Fidelity Security Life Insurance Company, Kansas City, MO 64111)

☐ **Dental -** PLAN 1

☐ **Accident - Base Units: 1 Unit**

☐ **New Generation Critical Illness - Basic Benefit Amount** **$5,000**
(Includes additional Critical Illness Cancer Benefit)

Home Office Use Only

Plan 1 Units	**Plan 2** Units
SHOP 1 ______	SHOP 1 ______
SHOP 2 ______	SHOP 2 ______
SHOP 3 ______	SHOP 3 ______
SHOP 4 ______	SHOP 4 ______
SHOP 5 ______	SHOP 5 ______
SHOP 6 ______	SHOP 6 ______
SHOP 7 ______	SHOP 7 ______

Group Term Life with/without Accidental Death & Dismemberment (ICC16GTLP) or (GVL4000)

Employee Basic Life
☐ Yes ☐ No

Home Office Use Only
SET ID/PLAN ID **ACTIV/AD&D** _____ **LIFE** _____
and/or **EMPLR/AD&D** _____ **LIFE** _____
and/or (other) ____________________

Spouse Basic Life
☐ Yes ☐ No

Life Benefit
☐ Fixed Amount $__________

Home Office Use Only
SET ID/PLAN ID **ACTIV/AD&D** _____ **LIFE** _____
and/or **EMPLR/AD&D** _____ **LIFE** _____
and/or (other) ____________________

Child Basic Life
☐ Yes ☐ No

Life Benefit
☐ Fixed Amount $__________

Home Office Use Only
SET ID **ACTIV** or **EMPLR** or (other)
PLAN ID **OPTA** / **OPTB** / **OPTC** / **OPTD** / **OPTE**

Employee Voluntary Life with/without AD&D ☐ Yes ☐ No	**Salary** $__________	**Fixed Amount** $__________	**Total Mode Premium** $__________
Spouse Voluntary Life ☐ Yes ☐ No	**Life Benefit** ☐ Fixed Amount $__________ (Cannot exceed 50% of Employee Amount)		**Total Mode Premium** $__________
Child Voluntary Life ☐ Yes ☐ No	**Choose amount** ☐ $2,500 ☐ $5,000 ☐ $7,500 ☐ $10,000		**Total Mode Premium** $__________

SAMPLE

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: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Date Signed ____________________ Employee's Signature ____________________