



AMERICAN HERITAGE LIFE INSURANCE COMPANY (AHL)

1776 AMERICAN HERITAGE LIFE DRIVE
JACKSONVILLE, FLORIDA 32224

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

- New Certificate
 Change/Increase Certificate # _____

ENROLLMENT FORM

Remarks
 Group number 91827

GENERAL INFORMATION SECTION

(Please complete entire section for all coverages)

Please print with black ink

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 Jackson County			DATE HIRED (MM/DD/YEAR)		
JOB TITLE		PLANT OR DIVISION			REHIRE DATE (MM/DD/YEAR)		
EMPLOYEE'S EMAIL		BENEFICIARY'S NAME (Last, First, M.I.)			RELATIONSHIP		
Are you adding coverage or changing 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 _____							
Do you currently have the following individual product with AHL? Critical Illness <input type="checkbox"/> Yes <input type="checkbox"/> No If you answered "Yes" to the product, please enter the Policy Number _____ Do you wish to terminate this coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", please enter effective date of termination _____							

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

ENROLLMENT FORM

SELECTION OF COVERAGE SECTION

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

Critical Illness (GVCIP1) (New Generation) <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 checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Total Mode Premium \$ _____	Home Office Use Only SET ID _____
Basic Benefit Amount \$ _____ If requesting coverage for spouse or dependents, the basic benefit amount is 50% of the employee.				Recurrence Option <input checked="" type="checkbox"/>
Has any person to be insured (employee or spouse) used tobacco in any form in the last 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No				

ELECTRONIC ACCEPTANCE (Please check YES or NO)

By checking the "Yes" box below, I agree to electronic delivery of my certificate of insurance, describing my coverage under the group policy ("my Certificate"), and all future correspondence regarding my Certificate, to include claim correspondence, explanations of benefit, periodic notices (such as privacy notices) and certificate administration correspondence. If electronically delivered, I will be provided instructions on how to receive my Certificate and correspondence regarding my Certificate via the following address: www.allstateatwork.com/mybenefits.

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 future correspondence in paper to include 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 my Certificate and all correspondence regarding my Certificate electronically via the internet.
- NO, I prefer to receive paper copies of my Certificate and all correspondence regarding my Certificate.

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** _____