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

Group Enrollment Form

Account No.	Employee ID	Requested Effective Date	First Deduction Date	Account	Location	Situs State

Deduction Mode *(choose one)*: ☐ Monthly ☐ Semi-Monthly ☐ Weekly ☐ Bi-Weekly ☐ Other _____

Remarks	*AHL home office use only*

General Information

Employee (Payor/Owner/Certificate holder) Name *(Last, First, M.I.)*	Birth Date	Social Security No.	☐ Male ☐ Female
Residence Street Address		Phone No.	
City, State, Zip	Email Address		
Employer/Association/Union	Hire Date	Occupation*	

**Occupation with the employer in the General Information section.*

Complete for all other persons you (the employee) are requesting to be insured

Last Name	First Name	Relationship	Gender	Birth Date	Social Security No.

Tobacco Use

If applying for Life or Critical Illness, has the employee used tobacco in the last 12 months? Employee ☐ Yes ☐ No

If applying for Life or Critical Illness, has the employee's spouse used tobacco in the last 12 months? Spouse ☐ Yes ☐ No

Qualifying Life Event

Are you applying for coverage or changing existing coverage due to a qualifying event? ☐ Yes ☐ No

Check the qualifying event: ☐ Marriage/Divorce ☐ Birth/Adoption ☐ Spouse New Job/Job Loss ☐ Termination ☐ Work Status Change ☐ Eligible/Ineligible Child ☐ Spouse/Dependent Child Death ☐ Employee Death

Qualifying event date _____ Current certificate number(s) _____

Termination of Current Coverage

Do you currently have any individual coverages with American Heritage Life Insurance Company that you wish to terminate in conjunction with this enrollment for group coverage? ☐ Yes ☐ No

If yes, enter the following information: Effective date of termination _____ Policy Number _____

Select the type of coverage: ☐ Accident ☐ Critical Illness ☐ Disability ☐ Hospital Indemnity

Employee Name _____ Account No. _____

Group Enrollment Form

Selection of Coverage *Answer yes or no and complete for each coverage selected.*

Accident (GVAP1 On and Off the Job Accident) Do you want this coverage? ☐ Yes ☐ No Section 125 ☐

Who do you want to cover?
- ☐ Employee Only
- ☐ Employee + Spouse
- ☐ Employee + Child(ren)
- ☐ Family

Choose One:
- ☐ Plan 1
- ☐ Plan 2

Your coverage will consist of:	Plan 1	Plan 2
Base Coverage	2	3
Benefit Enhancement Rider	1	2

Total Deduction

Accident (GVAP2 Off the Job Accident) Do you want this coverage? ☐ Yes ☐ No Section 125 ☐

Who do you want to cover?
- ☐ Employee Only
- ☐ Employee + Spouse
- ☐ Employee + Child(ren)
- ☐ Family

Choose One:
- ☐ Plan 1
- ☐ Plan 2

Your coverage will consist of:	Plan 1	Plan 2
Base Coverage	2	3
Benefit Enhancement Option	2	3
Outpatient Physician's Rider	1	1

Total Deduction

Critical Illness (GVCIP2) Do you want this coverage? ☐ Yes ☐ No Section 125 ☐

Who do you want to cover?
- ☐ Employee Only
- ☐ Employee + Spouse
- ☐ Employee + Child(ren)
- ☐ Family

Choose basic benefit amount:
- ☐ $10,000
- ☐ $20,000

Your coverage will consist of:
- ☒ Cancer Critical Illness Option
- ☒ Second Event Initial Critical Illness Option
- ☒ Wellness Option Units 2
- ☒ Second Event Cancer Critical Illness Option

Total Deduction

Disability (GVDIP Short-Term) My Lifeline Do you want this coverage? ☐ Yes ☐ No Section 125 ☐

Provide: Monthly Earnings* $ _____ Monthly Benefit $ _____

**Taxable (gross) monthly earnings from your occupation with the employer listed on the first page of this form.*

Choose elimination and benefit periods:

- ☐ Elimination Period: 7 Days Accident 7 Days Sickness Benefit Period: 3 Months
- ☐ Elimination Period: 14 Days Accident 14 Days Sickness Benefit Period: 3 Months
- ☐ Elimination Period: 14 Days Accident 14 Days Sickness Benefit Period: 6 Months

Total Deduction

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, provide the following: Company Name Year Issued

Monthly Benefit $ Elimination Period Benefit Period

Employee Name _____ Account No. _____

Group Enrollment Form

Hospital Indemnity (GVSP1) Do you want this coverage? ☐ Yes ☐ No Section 125 ☐

Who do you want to cover?

- ☐ Employee Only
- ☐ Employee + Spouse
- ☐ Employee + Child(ren)
- ☐ Family

Choose One:

- ☐ Plan 1
- ☐ Plan 2

Your coverage will consist of:	Plan 1	Plan 2
Hospital Related	1	3
Surgery/Inpatient Physician	1	1
Outpatient Related	1	1

Total Deduction

Life Do you want this coverage? ☐ Yes ☐ No ☒ *Guaranteed Issue*

Life product being offered: ☒ Term Life

Requested Face Amount $ _____ Employee Annual Base Salary $ _____

Total Deduction

Riders being applied for:	Units/Amt.

If the proposed insured is your spouse, provide the following for that proposed insured. ☐ Spouse

Proposed Insured Name *(Last, First, M.I.)*		Social Security No.	☐ Male ☐ Female
Residence Street Address		Birth Date	
City, State, Zip	Phone No.	Email Address	
Employer of Proposed Insured	Annual Salary	Occupation	

If you are requesting rider coverage for your spouse or child(ren) and his/her contact information is different from yours, provide his/her name, address, and phone number below.

Replacement and Existing Insurance *(Must answer)*

1a. **Replacement. Proposed Insured.** Is this insurance to replace, discontinue, or change any existing life or annuity coverage? ☐ Yes ☐ No

If yes, indicate product being replaced or changed and complete replacement form provided by your producer, if required by your state.

1b. **Producer.** To your knowledge, is change or replacement of life or annuity coverage involved? ☐ Yes ☐ No

2a. **Existing Insurance. Proposed Insured.** Is there any other (not listed in Question 1a.) life insurance or annuity coverage in force or applied for on the proposed insured? If yes, list company name, policy number, year issued, type of coverage, and amount of benefit and complete replacement form provided by your producer, if required by your state. ☐ Yes ☐ No

2b. **Producer.** To your knowledge, does the proposed insured have existing life or annuity coverage in force? ☐ Yes ☐ No

Group Enrollment Form

Illustration Regulation Certification for Term Life

OWNER. The owner must select one of the following statements.

☐ I certify that I have received an illustration conforming to the coverage applied for. I will complete the applicable illustration certification form provided, if required in my state.

☐ I certify that I did not receive an illustration conforming to the coverage applied for. I understand that an illustration conforming to the coverage issued will be provided upon delivery of the certificate.

PRODUCER. The producer must select one of the following statements.

☐ I certify that an illustration conforming to the coverage applied for was provided. I will complete the applicable illustration certification form provided, if required.

☐ I certify that no illustration conforming to the coverage applied for was provided, but that an illustration conforming to the coverage issued will be provided upon delivery of the certificate.

Beneficiary Designation

Your beneficiary designations will apply to all coverages and riders applied for, including designations for a spouse or covered dependent. For additional beneficiary designation options, complete form ABJ040.

Primary Beneficiary Name *(Last, First, M.I.)*		Social Security No.
Residence Address	Birth Date	Relationship
City, State, Zip	Phone No.	
Contingent Beneficiary Name *(Last, First, M.I.)*		Social Security No.
Residence Address	Birth Date	Relationship
City, State, Zip	Phone No.	

Eligibility Questions

Answer each question for the coverages for which you are applying.

Employee answer for the following: Disability, Life

Employee Actively At Work. Is the employee actively at work now, for wage or profit, and has he/she worked at least 20 hours each week performing all duties of his/her regular occupation at his/her regular place of employment for at least the last 3 months except for minor illness or injury of 1 week or less, or normal pregnancy? Employee ☐ Yes ☐ No

Spouse answer for the following: Life

Spouse Actively At Work. Is the employee's spouse actively at work now, for wage or profit, and has he/she worked at least 20 hours each week performing all duties of his/her regular occupation at his/her regular place of employment for at least the last 3 months except for minor illness or injury of 1 week or less, or normal pregnancy? Spouse ☐ Yes ☐ No

REPRESENTATION. The undersigned producer and I certify that I have read or had read to me this completed form and understand that any misstatement or misrepresentation in this form may result in loss of coverage. I represent that statements and answers given on this form are true, complete, and correctly recorded.

ACCEPTANCE/AUTHORIZATION. I hereby request all coverage(s) selected for which I am or may become eligible under the group coverages issued by American Heritage Life Insurance Company. 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 is signed. WAIVER/DECLINATION: I understand that if I refuse any coverage for which I am eligible, satisfactory proof of insurability may be required, at my own expense, should I desire to apply for it at a later date. Any such form may be declined on the basis of such proof.

Employee Signature _____ Date Signed _____

Producer's Statement. I certify that to the best of my knowledge and belief the information on this form is complete, accurate and correctly recorded.

Soliciting Producer Signature _____ Soliciting Producer Name Printed _____

Employee Name _____ Account No. _____

Group Enrollment Form

Home office or producer to complete before issue:

Producer Name	Producer Number	Percentage Credit	Producer Name	Producer Number	Percentage Credit
Servicing Producer			Soliciting Producer		

AMERICAN HERITAGE LIFE INSURANCE COMPANY
HOME OFFICE:
1776 AMERICAN HERITAGE LIFE DRIVE
JACKSONVILLE, FLORIDA 32224-6688
(904) 992-1776

A Stock Company

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses that result from accidental injury. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when it pays:

- Hospital or medical expenses up to the maximum stated in the policy

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- Hospitalization
- Physician services
- Outpatient prescription drugs if you are enrolled in Medicare Part D
- Other approved items and services

Before You Buy This Insurance

✓ Check the coverage in **all** health insurance policies you already have.
✓ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
✓ For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program (SHIIP).

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IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance pays a fixed dollar amount, regardless of your expenses, for each day you meet the policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when:

- any expenses or services covered by the policy are also covered by Medicare

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- outpatient prescription drugs if you are enrolled in Medicare Part D
- other approved items and services

Before You Buy This Insurance

- ✓ Check the coverage in **all** health insurance policies you already have.
- ✓ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- ✓ For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program (SHIIP).

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