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. |
|---|---|---|---|---|---|
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## 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

# 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?

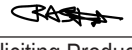
Spouse ☐ Yes ☐ No

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

The Capitol Group Assoc., Inc.

Soliciting Producer Name Printed