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

All references to spouse include civil union and domestic partner relationships.

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 AHL 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 ☐ Cancer ☐ 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)

Section 125 ☐

Do you want this coverage? ☐ Yes ☐ No

Who do you want to cover?

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

Total Deduction ________

Choose coverage:	Units
Base Coverage	________
☐ Employee Off-the-Job Accident Disability Rider	________
☐ Employee On and Off-the-Job Accident Disability Rider	________
☐ Employee Off-the-Job Accident/Sickness Disability Rider	________
☐ Employee On and Off-the-Job Accident/Sickness Disability Rider	________
☐ Benefit Enhancement Rider	________

Provide for disability riders:

Employee Monthly Earnings $ ________

Accident (GVAP2 Off the Job Accident)

Section 125 ☐

Do you want this coverage? ☐ Yes ☐ No

Who do you want to cover?

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

Total Deduction ________

Choose coverage:	Units
Base Coverage	________
☐ Benefit Enhancement Option	________
☐ Outpatient Physician's Rider	________

Accident (GVAP6)

Section 125 ☐

Do you want this coverage? ☐ Yes ☐ No

Who do you want to cover?

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

Total Deduction ________

Choose coverage:	Units
Base Coverage	________
☐ Accident Treatment & Urgent Care Rider	________
☐ Emergency Room Services Rider	________
☐ Outpatient Physician's Rider	________
☐ Dislocation/Fracture Rider	________
☐ Benefit Enhancement Rider	________
☐ Accidental Death, Dismemberment & Functional Loss Rider	________

Cancer/Specified Disease (GVCP2)

Section 125 ☐

Do you want this coverage? ☐ Yes ☐ No

Who do you want to cover?

- ☐ Employee Only
- ☐ Family

Plan ________

Total Deduction ________

Choose coverage:	Units
Hospital	________
Radiation/Chemotherapy	________
Surgery Related	________
Miscellaneous	1
☐ Cancer Initial Diagnosis Option	________
☐ Intensive Care Option	________
☐ Cancer Screening Option	________

Employee Name ________ Account No. ________

Group Enrollment Form

Cancer/Specified Disease (GVCP3)

Section 125 ☐

Do you want this coverage? ☐ Yes ☐ No

Who do you want to cover?

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

Total Deduction

Choose coverage:

Coverage	Units
Hospital	
Radiation/Chemotherapy	
Surgery Related	
Miscellaneous	1
☐ Cancer Initial Diagnosis Option	
☐ Intensive Care Option	
☐ Wellness Option	
☐ Cancer Progressive Benefit Option	

Critical Illness (GVCIP1) My Lifeline

Section 125 ☐

Do you want this coverage? ☐ Yes ☐ No

Who do you want to cover?

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

Total Deduction

Choose coverage:

- ☐ Critical Illness Cancer Option
- ☐ Recurrence Option
- ☐ Wellness Option Units ______
- ☐ Second Evaluation Benefit Rider

Basic Benefit Amount*: $ ____________

**If covered, basic benefit amount for spouse and other dependents is 50% of employee benefit.*

Critical Illness (GVCIP2)

Section 125 ☐

Do you want this coverage? ☐ Yes ☐ No

Who do you want to cover?

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

Total Deduction

Choose coverage:

- ☐ Cancer Critical Illness Option
- ☐ Second Event Initial Critical Illness Option
- ☐ Wellness Option Units ______
- ☐ Second Event Cancer Critical Illness Option
- ☐ Supplemental Critical Illness Option I (HIV)
- ☐ Supplemental Critical Illness Option II
- ☐ Second Evaluation Benefit Rider

Basic Benefit Amount: $ ____________

Employee Name ________ Account No. ________

Group Enrollment Form

Critical Illness (GVCIP4) My Lifeline

Section 125 ☐

Do you want this coverage? ☐ Yes ☐ No

Who do you want to cover?

- ☐ Employee + Child(ren)
- ☐ Family

Total Deduction ________

Choose coverage:

Basic Benefit Amount: $ ____________

- ☐ Cancer Critical Illness Option
- ☐ Reoccurrence of Critical Illness Option
- ☐ Second Evaluation, Transportation & Lodging Rider
- ☐ Reoccurrence of Cancer Critical Illness Option
- ☐ Supplemental Critical Illness Rider with HIV
- ☐ Supplemental Critical Illness Rider without HIV
- ☐ Wellness Rider - Fixed Units ____
- ☐ Wellness Rider - Variable Units ____
- ☐ Skin Cancer Rider
- ☐ Cardiopulmonary Enhancement Rider
- ☐ Specified Chronic Illness Rider
- ☐ Specified Chronic Illness or Injury Rider
- ☐ Lifestyle Enhancement Rider

Disability (GVDIP Short-Term) My Lifeline

Section 125 ☐

Do you want this coverage? ☐ Yes ☐ No

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: ____ Days Accident ____ Days Sickness

Benefit Period: ____ Months

Total Deduction ________

Choose coverage:

Rider	Units
☐ On-the-Job Accident Disability Rider	____
☐ Family Medical Leave & Doula Services Rider	____
☐ Increasing Benefit Period Rider	____
☐ Survivor & Accident Rider	____

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 ________

Hospital Indemnity (GVSP1)

Section 125 ☐

Do you want this coverage? ☐ Yes ☐ No

Who do you want to cover?

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

Total Deduction ________

Choose coverage:

Coverage	Units
Hospital Related	____
Surgery/Inpatient Physician	____
Outpatient Related	____
☐ Diagnostic/Wellness Option	____
☐ Prescription Drug Option	____
☐ Disability Rider	____
☐ Life Rider	____

Employee Name _________ Account No. __________

Group Enrollment Form

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

Life product being offered: ☐ Universal Life (UL) ☐ Term Life ☐ Whole Life

Choose one (UL only): Death Benefit Option ☐ 1 ☐ 2

Requested Face Amount $ _________________

Employee Annual Base Salary $ ________________

Total Deduction

Riders being applied for:	Units/Amt.

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 or change any existing life 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 involved? ☐ Yes ☐ No

2a. Existing Insurance. Proposed Insured. Is there any other (not listed in Question 1a.) life insurance 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. ☐ Yes ☐ No

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

Illustration Regulation Certification for Universal Life and 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.

Group Enrollment Form

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

ACCEPTANCE/AUTHORIZATION. I hereby request all coverage(s) selected 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 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

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 provides limited benefits, if you meet the policy conditions, for hospital or medical expenses only when you are treated for one of the specific diseases or health conditions listed in the policy. 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
- 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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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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