



AMERICAN HERITAGE LIFE INSURANCE COMPANY (AHL)

1776 AMERICAN HERITAGE LIFE DRIVE
JACKSONVILLE, FLORIDA 32224

ENROLLMENT FORM

New Certificate Change/Increase Certificate # _____

Remarks: CUSTOM FORM	This box for AHL Home Office use only
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GENERAL INFORMATION

Member's Name (Last, First, M.I.)		<input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number	
Residence Address		City	State	Zip
Date of Birth	Phone Number	Email		
Association/Union Union Agener	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
		Member			
		Spouse			
		Child			

Are you applying for coverage or changing existing coverage due to a qualifying event?
Cancer/Specified Disease Yes No
 If "Yes," check the qualifying event:
 Marriage Spouse/Dependent Child Death Newly Eligible
 Divorce Eligible/Ineligible Child Termination
 Birth/Adoption Spouse New Job/Job Loss Member Death
 Date of Qualifying Event _____ Current Certificate Number(s) _____
 Do you currently have the following Individual coverage with American Heritage Life Insurance Company (AHL)?
 Cancer Yes No
 If you answered "Yes" to the coverage, please enter the Policy Number _____
 Do you wish to terminate this coverage? Yes No If "Yes," please enter effective date of termination _____

Premium/Billing Mode <input checked="" type="checkbox"/> Monthly <input type="checkbox"/> Semi-monthly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Weekly <input type="checkbox"/> Other	Account Number	Member ID	Situs State
Date of First Deduction _____ Coverage Effective Date <u>1-1-2019</u>	36133		GA

ENROLLMENT FORM

SELECTION OF COVERAGE

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

Cancer/Specified Disease (GVCP3) <input checked="" 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 type="checkbox"/> Yes <input type="checkbox"/> No		Total Mode Premium 38.86 EE \$ 66.00 + DEP		Home Office Use Only	
Benefits	Hospital	Radiation / Chemotherapy	Surgery Related	Misc.	<input checked="" type="checkbox"/> Cancer Initial Diagnosis Option			<input checked="" type="checkbox"/> Wellness Option		
Units	1	8	1	1	10			4		

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.

Date Signed _____ Employee's Signature _____

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.

Signature of Soliciting Producer _____ Print Soliciting Producer Name _____

To be completed by home office or producer, prior to issue:

Producer Name	Producer Number	National Producer Number (NPN)	Percentage Credit
Servicing Producer:			%
Soliciting Producer: Bret M. Boeger	0Y240		100 %
			%
			%
			%

(Union Agener)
(EF L70PA)
(2016)



Benefits

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 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 (SHIP).

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