



AMERICAN HERITAGE LIFE INSURANCE COMPANY (AHL)

1776 AMERICAN HERITAGE LIFE DRIVE
JACKSONVILLE, FLORIDA 32224

ENROLLMENT FORM

New Certificate Change/Increase Certificate # _____

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

Employee's/Payor's/Owner's (Certificateholder) 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		
Employer/Association/Union COMMUNITY LIVING EXPERIENCES		Date Hired	Occupation Administration/Care Giving	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
		Employee			
		Spouse			n/a
		Child			n/a
		Child			n/a
		Child			n/a

Are you applying for coverage or changing existing coverage due to a qualifying event?
Accident 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 Employee Death
 Date of Qualifying Event _____ Current Certificate Number(s) _____
 Do you currently have any of the following Individual coverages with American Heritage Life Insurance Company (AHL)?
 Accident Yes No Cancer Yes No Critical Illness Yes No Disability Yes No
 Hospital Indemnity Yes No
 If you answered "Yes" to any of the coverages, 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 type="checkbox"/> Monthly <input type="checkbox"/> Semi-monthly <input checked="" type="checkbox"/> Bi-weekly <input type="checkbox"/> Weekly <input type="checkbox"/> Other	Account Number	Employee ID	Situs State
Date of First Deduction _____ Coverage Effective Date _____	82208		OH

ENROLLMENT FORM SELECTION OF COVERAGE

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

Accident (GVAP6) On and Off the Job Accident <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Off the Job Accident <input type="checkbox"/> Yes <input type="checkbox"/> No	Base Units <div style="text-align: center; font-size: 24pt;">3</div>	<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 checked="" type="checkbox"/> No	Total Mode Premium \$ _____	Home Office Use Only
<input type="checkbox"/> Accident Treatment & Urgent Care Rider Units <u>4</u>		<input type="checkbox"/> Dislocation/Fracture Rider Units <u>4</u>			
<input type="checkbox"/> Emergency Room Services Rider Units <u>3</u>		<input type="checkbox"/> Benefit Enhancement Rider Units <u>4</u>			
<input type="checkbox"/> Outpatient Physician's Rider Units <u>2</u>		<input type="checkbox"/> Accidental Death, Dismemberment and Functional Loss Rider Units <u>2</u>			

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.

FRAUD NOTICE: Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent act, which is a crime and subjects such person to criminal and civil penalties.

Date Signed _____ Employee's Signature **X** _____

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 Philip N. McKelvey _____

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: McGohan Brabender	6XXA0		100 %
			%
			%
			%



AMERICAN HERITAGE LIFE INSURANCE COMPANY

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

A Stock Company

<p>IMPORTANT NOTICE TO PERSONS ON MEDICARE THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS</p>
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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

<p>Before You Buy This Insurance</p>

- ✓ 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).



Benefits

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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

<p>Before You Buy This Insurance</p>

- ✓ 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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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.
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