

AMERICAN HERITAGE LIFE INSURANCE COMPANY (AHL)

1776 AMERICAN HERITAGE LIFE DRIVE
JACKSONVILLE, FLORIDA 32224



Allstate

ENROLLMENT FORM

Workplace Division

GENERAL INFORMATION SECTION

Please print with black ink (Please complete entire section for all coverages)

EMPLOYEE'S NAME Last (Sr, Jr, etc.)		First	M.I.	<input type="checkbox"/> M <input type="checkbox"/> F	SOCIAL SECURITY NUMBER	<input type="checkbox"/> Married <input type="checkbox"/> Single
HOME ADDRESS (Street or P.O. Box)				CITY	STATE	ZIP
BIRTHDATE (MM/DD/YEAR)	HOME PHONE NUMBER	EMPLOYER University of North Alabama			DATE HIRED (MM/DD/YEAR)	
OCCUPATION	PLANT OR DIVISION	BENEFICIARY'S NAME (Last, First, M.I.)		RELATIONSHIP		
Are you adding any coverage or changing any of your existing coverage due to marriage, birth, adoption, employment status change, etc.? <input type="checkbox"/> Yes <input type="checkbox"/> No						
If "yes", indicate type of change: _____						
Date of change _____ Current Certificate Number _____						

DEPENDENT COVERAGE SECTION

(Please complete if dependent coverage elected. Use additional paper if needed.)

Dependent's Name (Last, First, M.I.)	Relationship	Sex	Date of Birth (MM/DD/YEAR)	Social Security Number

Cancer/Specified Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Plan <u>1</u>	Section 125 <input type="checkbox"/> Yes <input type="checkbox"/> No	Total Monthly Premium				
			Low Option	High Option			
		Employee Only <input type="checkbox"/> \$ 12.56 <input type="checkbox"/> \$ 28.20		Family <input type="checkbox"/> \$ 21.56 <input type="checkbox"/> \$ 48.36			
Benefits	Hospital	Radiation / Chemotherapy	Surgery Related	Misc.	Initial Diagnosis Option <input checked="" type="checkbox"/>	Intensive Care Option <input checked="" type="checkbox"/>	Cancer Screening Option <input checked="" type="checkbox"/>
Units							
<input type="checkbox"/> Low Option	1	2	1	1	2	2	2
<input type="checkbox"/> High Option	3	4	3	1	5	4	4
Do you currently have an individual Cancer product with AHL? <input type="checkbox"/> Yes <input type="checkbox"/> No							
If "Yes", please enter the Policy Number _____							
Do you wish to terminate this coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", please enter the effective date of termination _____							

Premium/Billing Mode	Case Number	Producer/ Agent Number	Percentage Credit
	<input checked="" type="checkbox"/> Monthly	Employee ID	6ERA0 100%
	Issue Date _____ Cash With Application _____	Situs State AL	

ACCEPTANCE: I hereby request all coverage 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 earnings any contributions required of me for the payment of premiums for such coverage. • **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 _____ Employee's
Signed _____ Signature _____