Allstate. Benefits

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

GENERAL INFORMATION

Employee's Name (Last, First, M.I.)	☐ M ☐ F	Social Security Number	
Residence Address	City	State	Zip
Date of Birth / Phone Number	Email		
Employer/Association/Union: **The University of North Alabama** / 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
		Employee			
		Spouse			

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 ☐ Employee 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	Account Number	Employee ID	Situs State
☒ Semi-monthly Date of First Deduction _____ Coverage Effective Date _____	06436		AL

(The University of North Alabama)
(EF L70PA)
(2016)

ENROLLMENT FORM

SELECTION OF COVERAGE

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

Cancer/Specified Disease (GVCP3) ☐ Yes ☐ No	**Monthly Premiums**		Section 125	**Home Office Use Only**
	Low Plan	**High Plan**	☐ Yes ☐ No	
Employee Only	☐ $14.13	☐ $31.51		
Family	☐ $24.20	☐ $53.92		

Benefits	Hospital	Radiation / Chemotherapy	Surgery Related	Misc.	☒ Cancer Initial Diagnosis Option	☒ Intensive Care Option	☒ Wellness Option
Units							
Low Plan	1	2	1	1	2	2	2
High Plan	3	4	3	1	5	4	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.

FRAUD NOTICE: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

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: Mike Hunter	**6ERA0**		**100** %
Soliciting Producer:			%
			%
			%
			%

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(2016)