



**AMERICAN HERITAGE LIFE INSURANCE COMPANY (AHL)**  
**1776 AMERICAN HERITAGE LIFE DRIVE**  
**JACKSONVILLE, FLORIDA 32224**

**ENROLLMENT FORM**

New Certificate    Change/Increase Certificate # \_\_\_\_\_

Remarks: Employee is Actively at Work	This box for AHL Home Office use only
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**GENERAL INFORMATION**

Employee's Name (Last, First, M.I.)		<input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number	
Residence Address		City		State
Date of Birth		Phone Number		Email
Employer/Association/Union Hillsborough County Clerk of Circuit Court		Date Hired		Occupation Clerk of Circuit Court
Primary Beneficiary's Full Name and Address			City	State   Zip
Phone Number		Date of Birth		Social Security Number
Contingent Beneficiary's Full Name and Address			City	State   Zip
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	Tobacco Use* (Critical Illness)
		Employee				** <input type="checkbox"/> Yes <input type="checkbox"/> No
		Spouse				** <input type="checkbox"/> Yes <input type="checkbox"/> No

\*Has any adult (19 and older) person to be insured used tobacco in the last 12 months? (\*\*if applying for Critical Illness.)

Are you applying for coverage or changing existing coverage due to a qualifying event?

<b>Accident</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Critical Illness</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Cancer/Specified Disease</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Hospital Indemnity</b> <input type="checkbox"/> Yes <input type="checkbox"/> No

If "Yes", check the qualifying event:

<input type="checkbox"/> Marriage	<input type="checkbox"/> Spouse/Dependent Child Death	<input type="checkbox"/> Newly Eligible
<input type="checkbox"/> Divorce	<input type="checkbox"/> Eligible/Ineligible Child	<input type="checkbox"/> Termination
<input type="checkbox"/> Birth/Adoption	<input type="checkbox"/> Spouse New Job/Job Loss	<input type="checkbox"/> 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    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 \_\_\_\_\_

<b>Premium/Billing Mode</b> <input checked="" type="checkbox"/> Bi-Weekly	Account Number 31468	Employee ID	Situs State FL
Date of First Deduction _____ Coverage Effective Date <u>1/1/2018</u>			

## ENROLLMENT FORM

### SELECTION OF COVERAGE

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

<b>Accident (GVAP1)</b> (On and Off the Job Accident) <input type="checkbox"/> Yes <input type="checkbox"/> No	Base Units <u>2</u>	<input type="checkbox"/> Employee Only <input type="checkbox"/> Employee+Spouse <input type="checkbox"/> Employee+Child(ren) <input type="checkbox"/> Family	Section 125 <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Total Premium \$ _____	<b>Home Office Use Only</b>
<input checked="" type="checkbox"/> Benefit Enhancement Rider Units <u>2</u>					

<b>Cancer/Specified Disease (GVCP2)</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	Plan <u>1</u>	<input type="checkbox"/> Employee Only <input type="checkbox"/> Family	Section 125 <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Total Premium \$ _____	<b>Home Office Use Only</b>		
<b>Benefits</b>	Hospital	Radiation / Chemotherapy	Surgery Related	Misc.	<input checked="" type="checkbox"/> Cancer Initial Diagnosis Option	<input checked="" type="checkbox"/> Cancer Screening	<input checked="" type="checkbox"/> Intensive Care Unit
<b>Units</b>	2	4	1	1	5	4	2

<b>Critical Illness (GVCIP2)</b> <input 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 checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Total Premium \$ _____	<b>Home Office Use Only</b>
<b>Basic Benefit Amount</b> <input checked="" type="checkbox"/> \$15,000				
<input checked="" type="checkbox"/> Supplemental Critical Illness Option II	<input checked="" type="checkbox"/> Wellness Option Units <u>4</u>	<input checked="" type="checkbox"/> 2 <sup>nd</sup> Event Initial Critical Illness Option		

<b>Hospital Indemnity (GVSP1)</b> <input 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 checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Total Premium \$ _____	<b>Home Office Use Only</b>
<b>Benefits</b>	Hospital Related	Surgery / Inpatient Physician	Outpatient Related	
<b>Units</b>	2	1	1	

**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 injure, defraud or deceive any insurer, files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Date Signed \_\_\_\_\_ **Employee’s Signature** \_\_\_\_\_

**Agent’s (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 Florida Agent (Producer) \_\_\_\_\_

Print Soliciting Agent (Producer) Name BeneCom Corporation/ Bradley J Shattuck

Florida Agent License Number Agency #R004515 Lic#A239806

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

Agent (Producer) Name	Agent (Producer) Number	National Agent (Producer) Number (NPN)	Percentage Credit
<b>Servicing Agent (Producer):</b> Benecom	4T1G0		0 %
<b>Soliciting Agent (Producer):</b> Benecom	4T1G0		90 %
Writing Agent: Amber Hoadley	801N0		10 %
			%



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**ELECTRONIC DELIVERY ELECTION (Please check YES or NO)**

By checking the "Yes" box, I elect electronic delivery of my certificate(s) of insurance (certificate(s)) and/or my policy(ies), including all documents accompanying my certificate(s) and/or my policies. I also elect electronic delivery of all contractual, regulatory and administrative correspondence (correspondence) regarding my certificate(s) and/or my policy(ies), to include claim correspondence, explanations of benefits, periodic notices (such as privacy notices) and other correspondence. If electronically delivered, I understand that I will be mailed instructions at the last provided residence address and/or email address on how to receive my certificate(s), policy(ies) and correspondence at: [www.allstatebenefits.com/mybenefits](http://www.allstatebenefits.com/mybenefits).

Yes  No

I understand and agree that to receive electronic delivery, I must have a computer with internet access, a web browser that is Microsoft Internet Explorer version 9.0 or greater, an e-mail account, and the ability to download PDF files using Adobe Acrobat Reader version 5.0 or higher and a printer or other device to download and print or save any documents I wish to retain.

I understand and I agree that my consent is valid while I remain covered. At any time, I may withdraw my consent for any reason and receive future correspondence in paper to include a paper copy of my certificate(s) and/or my policy(ies), free of charge, by calling toll-free: 1-800-521-3535; or by writing to: Customer Care Center, American Heritage Life Insurance Company, 1776 American Heritage Life Drive, Jacksonville, Florida, 32224.

I understand and agree that this election is effective for all certificate(s) and/or policy(ies) applied for and/or enrolled in on the date signed as noted below.

Proposed Insured Name: \_\_\_\_\_ Date Signed: \_\_\_\_\_

Owner Printed Name (if other than Insured): \_\_\_\_\_ Account Number (if applicable): \_\_\_\_\_

Owner Social Security Number: \_\_\_\_\_ Account Name (if applicable): \_\_\_\_\_

Owner Signature: \_\_\_\_\_