AMERICAN HERITAGE LIFE INSURANCE COMPANY (AHL)

1776 AMERICAN HERITAGE LIFE DRIVE
JACKSONVILLE, FLORIDA 32224

Allstate
Workplace Division

ENROLLMENT FORM

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.	☐ M ☐ F	SOCIAL SECURITY NUMBER	☐ Married ☐ Single
HOME ADDRESS (Street or P.O. Box)		CITY / STATE / ZIP	
BIRTHDATE (MM/DD/YEAR)	HOME PHONE NUMBER	EMPLOYER **Southeastern University**	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.? ☐ Yes ☐ 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 ☐ Yes ☐ No

Plan 1

Section 125 ☐ Yes ☐ No

Total Semi-Monthly Premium:

	Low Option	High Option
☐ Employee Only	$ 7.05	$ 16.12
☐ Family	$ 12.05	$ 27.87

Benefits	Hospital	Radiation / Chemotherapy	Surgery Related	Misc.	Initial Diagnosis Option ☑	Intensive Care Option ☑	Cancer Screening Option ☑
Units:							
Low	**1**	**2**	**1**	**1**	**1**	**2**	**4**
High	**3**	**4**	**3**	**1**	**5**	**7**	**4**

Do you currently have an individual Cancer product with AHL? ☐ Yes ☐ No

If "Yes", please enter the Policy Number _____

Do you wish to terminate this coverage? ☐ Yes ☐ No If "Yes", please enter the effective date of termination _____

Premium/Billing Mode	Case Number	Producer/ Agent Number	Percentage Credit
☑ Semi-Monthly	Employee ID		
Issue Date _____	Situs State **FL**		
Cash With Application _____			

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.

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 _____