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

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 **ODU Research Foundation**	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	Tobacco Use* (Critical Illness)
		Employee				** ☐ Yes ☐ No
		Spouse				** ☐ Yes ☐ 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?
Critical Illness ☐ 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)?
Critical Illness ☐ 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
☐ Monthly ☐ Semi-monthly ☐ Bi-weekly ☐ Weekly ☐ Other			
Date of First Deduction _____ Coverage Effective Date _____	**V1510**		**VA**

ENROLLMENT FORM
SELECTION OF COVERAGE

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

Critical Illness (GVCIP1) (My Lifeline) ☐ Yes ☐ No	☐ Employee Only ☐ Employee+Spouse ☐ Employee+Child(ren) ☐ Family	Section 125 ☐ Yes ☒ No	Total Mode Premium $ _____	**Home Office Use Only**
Basic Benefit Amount $10,000 If covered, Basic Benefit Amount for spouse or other dependents is 50% of the employee's.				
☒ Wellness Option Units 4		☒ Critical Illness Cancer Option		

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 American Heritage Life Insurance Company. **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.

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: **Mercer Health**	**7GPT0**		**100** %
Soliciting Producer:			%
			%
			%
			%