Allstate

Workplace Division

AMERICAN HERITAGE LIFE INSURANCE COMPANY (AHL)

1776 AMERICAN HERITAGE LIFE DRIVE
JACKSONVILLE, FLORIDA 32224

☐ New Certificate
☐ Change/Increase Certificate # ______

ENROLLMENT FORM

Remarks

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.	SEX	SOCIAL SECURITY NUMBER	☐ Married ☐ Single
RESIDENT ADDRESS (Street or P.O. Box)	CITY	STATE	ZIP

BIRTHDATE (MM/DD/YEAR)	RESIDENT PHONE NUMBER	EMPLOYER	DATE HIRED (MM/DD/YEAR)

JOB TITLE	PLANT OR DIVISION	REHIRE DATE (MM/DD/YEAR)

BENEFICIARY'S NAME (Last, First, M.I.)	RELATIONSHIP

Are you adding any coverage or changing 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 ______

Do you currently have the following individual product with AHL? Accident ☐ Yes ☐ No

If you answered "Yes" to the product, please enter the Policy Number ______

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

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)

Accident ☐ Yes ☐ No	Base Units ______	Section 125 ☐ Yes ☐ No	☐ Employee Only ☐ Family	Total Mode Premium $ ______

Premium/Billing Mode ☐ Monthly ☐ Semi-monthly ☐ Bi-weekly ☐ Weekly ☐ Other ______	Case Number	Agent Number	Percentage Credit
	Employee ID		
Date of Issue ______	Situs State		

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 Signed ______ Employee's Signature ______