



**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
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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	Zip
Date of Birth	Phone Number	Email		
Employer/Association/Union <b>Ave Maria University</b>		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				** <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?  
**Accident**  Yes  No      **Critical Illness**  Yes  No      **Indemnity Medical**  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 any of the following Individual coverages with American Heritage Life Insurance Company (AHL)?  
 Accident  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"/> Weekly	Account Number	Employee ID	Situs State
Date of First Deduction _____ Coverage Effective Date _____	<b>30148</b>		<b>FL</b>

**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 type="checkbox"/> Yes <input type="checkbox"/> No	Total Weekly Premium \$ _____	<b>Home Office Use Only</b>
	<input checked="" type="checkbox"/> Benefit Enhancement Rider Units <u>  2  </u>		<input checked="" type="checkbox"/> Outpatient Physician's Rider Units <u>  2  </u>		

<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 type="checkbox"/> Yes <input type="checkbox"/> No	Total Weekly Premium \$ _____	<b>Home Office Use Only</b>
	<b>Basic Benefit Amount \$10,000</b>			
<input checked="" type="checkbox"/> Supplemental Critical Illness Option II	<input checked="" type="checkbox"/> Wellness Option Units <u>  2  </u>	<input checked="" type="checkbox"/> Cancer Critical Illness Option		

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Group No.	Account	Location	Dep Code	Smoker	Issue State	Effective Date
			E S C F	EE Y or N SP Y or N		

<b>Indemnity Medical II (GIM2) (New Generation)</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 type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Plan 1 <input type="checkbox"/> Plan 2	Total Weekly Premium \$ _____	<b>Home Office Use Only</b>
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**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 \_\_\_\_\_

Florida Agent License Number \_\_\_\_\_

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
Servicing Agent (Producer): <b>Healthsmart Benefit Solutions</b>			<b>50</b> %
Soliciting Agent (Producer): <b>Brown &amp; Brown of Florida</b>	<b>8LKY0</b>		<b>50</b> %
			%
			%
			%



## AMERICAN HERITAGE LIFE INSURANCE COMPANY

HOME OFFICE:  
1776 AMERICAN HERITAGE LIFE DRIVE  
JACKSONVILLE, FLORIDA 32224-6688  
(904) 992-1776

A Stock Company

<p><b>IMPORTANT NOTICE TO PERSONS ON MEDICARE THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS</b></p>
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### **This is not Medicare Supplement Insurance**

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses that result from accidental injury. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

#### **This insurance duplicates Medicare benefits when it pays:**

- Hospital or medical expenses up to the maximum stated in the policy

**Medicare generally pays for most or all of these expenses.**

**Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:**

- Hospitalization
- Physician services
- Outpatient prescription drugs if you are enrolled in Medicare Part D
- Other approved items and services

<p><b>Before You Buy This Insurance</b></p>
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- ✓ Check the coverage in **all** health insurance policies you already have.
- ✓ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- ✓ For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program (SHIIP).



Benefits

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### IMPORTANT NOTICE TO PERSONS ON MEDICARE THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

#### **This is not Medicare Supplement Insurance**

This insurance pays a fixed dollar amount, regardless of your expenses, for each day you meet the policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

#### **This insurance duplicates Medicare benefits when:**

- any expenses or services covered by the policy are also covered by Medicare

#### **Medicare generally pays for most or all of these expenses.**

**Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:**

- hospitalization
- physician services
- hospice
- outpatient prescription drugs if you are enrolled in Medicare Part D
- other approved items and services

#### **Before You Buy This Insurance**

- ✓ Check the coverage in **all** health insurance policies you already have.
- ✓ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- ✓ For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program (SHIIP).