

# 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

		<input type="checkbox"/>		
		<input type="checkbox"/>		
	Home Number		Date of Birth	Social Security Number
Employer/Association/ Union <b>ODU Research Foundation</b>		Date Hire	Occupation	Plant or Division
Primary Beneficiary's Full Name and Address				Relationship
Home Number		Date of Birth	Social Security Number	
Contingent Beneficiary's Full Name and Address				Relationship
Home 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 applyin 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:

<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 \_\_\_\_\_

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 \_\_\_\_\_

<b>Premium Billing Mode</b> <input type="checkbox"/> Monthly <input type="checkbox"/> Semi-monthly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Weekly <input type="checkbox"/> Other Date of First Deduction _____ Coverage Effective Date _____	Account Number	Employee ID	Situs State
	<b>V1 1</b>		<b>VA</b>



**ENROLLMENT FORM**  
**SELECTION OF COVERAGE**

Answer Yes or No and complete for each coverage selected

<b>Critical Illness (GVCIP1)</b>		m	Total a e	<b>Home Office Use Only</b>
<p><b>Basic Benefit Amount 1 ,</b></p> <p>If coverage basic benefit Amount for spouse or other dependents is <input type="checkbox"/> of the employee's</p> <p>Illness Option units _____</p>				