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

	☐ ☐			
	hone Numb [illegible]			
Employer/Association/ nion **ODU Research Foundation**	Date Hire.	Occupation	lant Or Di ision	
rimary eneficiary s ull Name an. A . ress			Relationship	
hone Number	Date of irth	Social Security Number		
Contingent eneficiary s ull Name an. A . ress			Relationship	
hone Number	Date of irth	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 applyin for Critical Illness)**

Are you applying for co erage or changing existing co erage. ue to a ualifying e ent

Critical Illness ☐ Yes ☐ No

If. Yes, check the ualifying e ent:

☐ arriage	☐ Spouse/Depen. ent Chil Death	☐ Newly Eligible
☐ Di orce	☐ Eligible/Ineligible Chil.	☐ Termination
☐ irth/A option	☐ Spouse New ob/ ob Loss	☐ Employee Death

Date of , ualifying E ent ____________ Current Certificate Number s ____________

Do you currently ha e the following In i i ual co erage with American Heritage Life Insurance Company AHL

Critical Illness ☐ Yes ☐ No

If you answere. , Yes, to the co erage please enter the olicy Number____________

Do you wish to terminate this co erage ☐ Yes ☐ No If. Yes, please enter effecti e. ate of termination____________

Premium Billin Mode ☐ onthly ☐ Semi-monthly ☐ i-weekly ☐ eekly ☐ Other Date of irst De. uction ____________ Co erage Effecti e Date ____________	Account Number **V1 1**	Employee ID	Situs State **VA**

ENROLLMENT FORM
SELECTION OF COVERAGE

Answer Yes or No an complete for each co erage selecte

Critical Illness (GVCIP1)			m	Total o e	Home Office Use Only

Basic Benefit Amount 1 ,

If co ere asic enefit Amount for spouse or other epen ents is , of the employee s

ellness Option nits ______