



AMERICAN HERITAGE LIFE INSURANCE COMPANY (AHL)

1776 AMERICAN HERITAGE LIFE DRIVE
JACKSONVILLE, FLORIDA 32224

ENROLLMENT FORM

New Certificate Change/Increase Certificate # _____

Remarks: CUSTOM FORM	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 McCoy Federal Credit Union	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. For Critical Illness, tobacco rating applies to all covered persons if either the employee or the employee's spouse answers "Yes" to Tobacco Use.)

Are you applying for coverage or changing existing coverage due to a qualifying event?

Accident <input type="checkbox"/> Yes <input type="checkbox"/> No	Critical Illness <input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer/Specified Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Hospital Indemnity <input type="checkbox"/> Yes <input type="checkbox"/> 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(s) _____

Do you currently have any of the following Individual coverages with American Heritage Life Insurance Company (AHL)?

Accident Yes No Cancer 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 _____

Premium/Billing Mode <input checked="" type="checkbox"/> Bi-weekly	Account Number	Employee ID	Situs State
Date of First Deduction _____ Coverage Effective Date _____	24265		FL

(McCoy Federal Credit Union)
(EOI L70PA)
(2016)

ENROLLMENT FORM

SELECTION OF COVERAGE

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

Accident (GVAP1) (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 checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Total Bi-weekly Premium \$ _____	Home Office Use Only
<input checked="" type="checkbox"/> Benefit Enhancement Rider Units <u> 2 </u>					

Cancer/Specified Disease (GVCP2) <input type="checkbox"/> Yes <input type="checkbox"/> No	Plan <u> 1 </u>	<input type="checkbox"/> Employee Only <input type="checkbox"/> Family	Section 125 <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Total Bi-weekly Premium \$ _____	Home Office Use Only
Benefits	Hospital	Radiation / Chemotherapy	Surgery Related	Misc.	<input checked="" type="checkbox"/> Cancer Screening Option
Units					
<input type="checkbox"/> Low Plan	1	2	1	1	4
<input type="checkbox"/> High Plan	2	4	1	1	4

Critical Illness (GVCIP2) <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 checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Total Bi-weekly Premium \$ _____	Home Office Use Only
Basic Benefit Amount \$10,000				
<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		

Hospital Indemnity (GVSP1) <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 checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Total Bi-weekly Premium \$ _____	Home Office Use Only
Benefits	Hospital Related	Surgery / Inpatient Physician	Outpatient Related	<input checked="" type="checkbox"/> Prescription Drug Option
Units				
<input type="checkbox"/> Low Plan	1	1	1	N/A
<input type="checkbox"/> Medium Plan	2	1	1	N/A
<input type="checkbox"/> High Plan	2	1	1	2

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): Renaissance Benefit Advisors	1P0F0		%
Soliciting Agent (Producer):			%
			%
			%
			%

(McCoy Federal Credit Union)
(EOI L70PA)
(2016)



AMERICAN HERITAGE LIFE INSURANCE COMPANY

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

A Stock Company

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

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

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).



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

This is not Medicare Supplement Insurance

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses only when you are treated for one of the specific diseases or health conditions listed in the policy. 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
- 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 (SHIP).

AWD3431-1



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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.
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