AMERICAN HERITAGE LIFE INSURANCE COMPANY
1776 AMERICAN HERITAGE LIFE DRIVE, JACKSONVILE, FLORIDA 32224

Health Insurance Enrollment Form **Print in Black Ink**

1. ENROLLEE INFORMATION (PLEASE PRINT)

a. Names of Persons proposed for coverage

Primary Insured ____
(Last) (First) (M.I.)

Date of Birth ______________________ Age ________________ Sex ____________

For Family Coverage – Name of Spouse ________________________________ Date of Birth ________

Name(s) of Children ________________________________ Date of Birth ________

________________________________ Date of Birth ________

________________________________ Date of Birth ________

b. Address ____City ____________________
(Number and Street)

State ________ Zip ______________ Phone (___)__________ SSN (Primary Insured) ____________________

2. ACTIVELY AT WORK

Is this coverage being offered through payroll deduction? Yes ________ No ________ If yes, is primary enrollee actively at work now and has he/she worked at least 30 hours per week for the last 6 months (except for minor illness of 1 week or less or normal pregnancy?) Yes __________ No _____ Employer's Name ____________________

3. SELECTION OF COVERAGE

	Form/Plan	No. of Units	Modal Premium
Cancer ____________________	________	__________	$__________
Other ____________________	________	__________	$__________
____________________	________	__________	$

Individual ___ Family ____

Total Modal Premium $ __________

4. PAYMENT MODE Payroll Allotment: Monthly ______ Semi-Monthly _____ Bi-Weekly _____Weekly _____ Other _______

Direct Bill: Annual _____ Semi-Annual _____ Quarterly ____ Pre-Authorized Check (Mo.) _____

5. NON-MEDICAL QUESTIONNAIRE

Has any person to be covered ever had, been treated for, or been told by a member of the medical profession they have: **a.** cancer or any malignancy which includes carcinoma, sarcoma, Hodgkin's Disease, Leukemia, lymphoma or malignant tumor, Yes ____ No ___ **b.** (only if ICU coverage is requested) a stroke, a heart attack, a heart condition, heart trouble, any abnormality of the heart (including artery disease), or uncontrolled hypertension Yes ____ No ____ **c.** Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) or ever tested positive for antigens or antibodies to an AIDS virus? Yes ______ No ____

If 'yes" to either **a**. **b** or **c**, list: Person(s) ____________________ Condition(s) ____________________________

6. REPLACEMENT

Will this coverage replace or change any existing cancer insurance coverage? Yes ______ No ____

If yes, give company name and policy # ____

REPRESENTATION. I have read or had read to me the completed enrollment form. I realize that any material misstatements or misrepresentations on this form may result in loss of coverage. I represent that statements and answers given are true, complete and correctly recorded. I understand that the Cancer coverage I am applying for contains a pre-existing condition limitation, which means no coverage is provided for a pre-existing condition as defined in the policy during the pre-existing condition limitation period. I understand that no insurance will be in effect until my certificate is issued and the first premium is paid.

Signature of
Proposed Insured ____________________________ Signed At ______________________ Date ______________

AGENT'S STATEMENT. (When required) To your knowledge, is replacement or change involved? Yes _______ No ______ I have asked the applicant every question which is answered, and accurately recorded the answers.

Agent Name (Please Print) ____________________________ Signature ____________________________________

Case Name ____________________	Case # ____________________	Agent # ______________	Prem. Split ___________ %
Payor ID or SSN ________________	Date of 1st Deduction __________	Agent # ______________	Prem. Split ___________ %
Frequency or Deduction __________	Proposed Issue Date ___________	Agent # ______________	Prem. Split ___________ %

B-850 (9/97)