



Allstate

AMERICAN HERITAGE LIFE INSURANCE COMPANY (AHL)

1776 AMERICAN HERITAGE LIFE DRIVE
JACKSONVILLE, FLORIDA 32224

Workplace Division

ENROLLMENT FORM

Please print with black ink

EMPLOYEE'S NAME Last (Sr, Jr, etc)		First	M.I.	SEX	SOCIAL SECURITY NUMBER		<input type="checkbox"/> Married <input type="checkbox"/> Single
HOME ADDRESS (Street or P.O. Box)				CITY	STATE	ZIP	
BIRTHDAY (MM/DD/YEAR)		PHONE NUMBER		EMPLOYER Charleston Southern University		DATE OF HIRE (MM/DD/YEAR)	
JOB TITLE				PLANT OR DIVISION			
Are you changing any of your existing coverage due to a qualifying event such as marriage, birth, or adoption? <input type="checkbox"/> Yes <input type="checkbox"/> No							
If "yes", please complete the following: Qualifying Event _____							
Date of Qualifying Event _____ Current Certificate Number _____							

Dependent's Name (Last, First, M.I.)	Sex	Date of Birth (MM/DD/YEAR)	Social Security Number
	Spouse		
	Child		
	Child		
	Child		

Cancer/Specified Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Plan 1	Section 125 <input type="checkbox"/> Yes <input type="checkbox"/> No		Please Choose One:				
		Employee only	Total Weekly Premium	Total Monthly Premium				
				<input type="checkbox"/> \$ _____	<input type="checkbox"/> \$ _____			
				Family	<input type="checkbox"/> \$ _____	<input type="checkbox"/> \$ _____		
Benefits	Hospital	Radiation / Chemotherapy	Surgery Related	Misc.	Initial Diagnosis Option <input checked="" type="checkbox"/>	Intensive Care Option <input checked="" type="checkbox"/>	Cancer Screening Option <input checked="" type="checkbox"/>	
Units								
<input type="checkbox"/> Low Option	2	4	1	1	N/A	N/A	4	
<input type="checkbox"/> High Option	3	4	3	1	4	6	4	
Do you currently have an individual Cancer product with AHL? <input type="checkbox"/> Yes <input type="checkbox"/> No								
If "Yes", please enter the Policy Number _____								
Do you wish to terminate this coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", please enter the effective date of termination _____								

Premium/Billing Mode <input type="checkbox"/> Monthly <input type="checkbox"/> Weekly Requested Issue Date _____ Date of First Deduction _____ Cash With Application _____	Case Number 48606	Agent Number 3MMYO	Percentage Credit 100%
	Employee Number		
	Situs State South Carolina		

ACCEPTANCE: I hereby request all coverage 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 earnings any contributions required of me for the payment of premiums for such coverage. 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.

Date _____ Employee's
Signed _____ Signature _____