Workplace Division

GROUP INSURANCE ENROLLMENT FORM TO:
American Heritage Life Insurance Company
1776 American Heritage Life Drive
Jacksonville, Florida 32224

For Home Office use only

Group No.	Account
Dep Code E C S F	Location Code
EFFECTIVE DATE	

Please print with black ink.

EMPLOYEE'S NAME Last (Sr, Jr, etc) First M. I.	SEX	SOCIAL SECURITY NUMBER – –	☐ Married ☐ Single
HOME ADDRESS (Street or P.O. Box)	CITY	STATE	ZIP
BIRTHDAY (MM/DD/YR)	PHONE NUMBER	EMPLOYER **USDA**	DATE OF HIRE (MM/DD/YR)
JOB TITLE	PLANT OR DIVISION		

Heritage Choice Dental ☐ Yes ☐ No	☐ Plan 1 ☐ Plan 3	☐ Employee Only ☐ Employee + Spouse ☐ Employee + Child ☐ Family	Section 125 ☐ Yes ☐ No	Total Mode Premium $________________
Were you covered under your Employer's prior Dental Plan? ☐ Yes ☐ No If "Yes," please enter the date coverage effective:__________________				**Home Office Use Only** **P1NG1 P1NG2 P1NG3**

Premium/Billing Mode	Case Number	Agent Number	Percentage Credit
☐ Monthly ☐ Semi-Monthly ☐ Bi-weekly			%
☐ Weekly ☐ Other____________	Employee Number		%
Requested Issue Date___________			%
Date of First Deduction___________	Situs State		%
Cash With Application___________	District of Columbia		%

DEPENDENT COVERAGE SECTION *(Please complete if dependent coverage elected)*

Dependents Name (Last, First, M. I.)	SEX	Date of Birth (MM/DD/YR)	Social Security Number
Spouse			– –
Child			– –
Child			– –
Child			– –
Child			– –

ACCEPTANCE: I hereby request all coverage checked "yes" above for which I am or may become eligible under the group coverages issued by the American Heritage Life Insurance Company. 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 Signed____ Employee's Signature____

G-5017 (08/02) (USDA)

J.M. Marketing
P.O. Box 10685
Springfield, MO 65808