

APPLICATION FOR LIFE AND HEALTH INSURANCE TO: American Heritage Life Insurance Company 1776 American Heritage Life Drive, Jacksonville, Florida 32224

Employee/Payor (if other than Proposed Insured)			Employee's Date of Birth		Employee/Payor Social Security Number		Employee's I.D. Number		Date Hired			
PROPOSED INSURED	Proposed Insured (Last, First, M.I.)				<input type="checkbox"/> Emp. <input type="checkbox"/> Child	<input type="checkbox"/> Spouse <input type="checkbox"/> Other	Height	Weight	Social Security Number (if known)			
	Resident Address			City	State		Zip		Resident Phone Number			
	Employer				Occupation							
	Owner's Name and Address (if different than Proposed Insured's)			City	State	Zip	Social Security Number or Tax I.D. Number (Owner)			Owner's Email Address		
Primary Beneficiary - Full Name			Age	Relationship	Contingent Beneficiary - Full Name			Age	Relationship			

Please complete this section for persons to be insured (except information already provided above)

Relationship to Employee	CODE	Last Name	First Name	Date of Birth	Sex	Actively at Work*	Full Time Student	Used tobacco in any form in last 12 months?		
Employee	E					<input type="checkbox"/> Yes <input type="checkbox"/> No	N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Spouse	S					<input type="checkbox"/> Yes <input type="checkbox"/> No	N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Dependent						N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No	N/A		
Dependent						N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No	N/A		
Dependent						N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No	N/A		

*Actively at work means that he/she is actively at work now for wage or profit and has worked at least 20 hours each week performing all duties at his/her regular occupation at his/her regular place of employment for the last 3 months except for minor illness or injury of 1 week or less, or normal pregnancy.

List additional dependents on separate sheet. Relationship Codes: E-Employee, S-Spouse, C-Child (Son or Daughter), G-Grandchild, O-Other. Please provide details of "Other" in Remarks section.

INSURANCE PLANS	Universal Life _____ <input type="checkbox"/> SI <input type="checkbox"/> CGI		Face Amount	Riders	Rider	Rider	Rider	Rider	Rider	Rider	Rider	Mode Premium	
			Death Benefit Option <input type="checkbox"/> 1 <input type="checkbox"/> 2	Units/Amt									\$
	Term Life _____ <input type="checkbox"/> SI <input type="checkbox"/> CGI		Face Amount	Riders	Rider	Rider	Rider	Rider	Rider	Rider	Rider	Mode Premium	
				Units/Amt								\$	
	Disability _____ <input type="checkbox"/> SI <input type="checkbox"/> CGI Occupation Class <input type="checkbox"/> Preferred <input type="checkbox"/> Standard		Monthly Salary \$ _____	Elimination Period _____ Days Acc. _____ Days Sick.		Section 125 <input type="checkbox"/> Yes <input type="checkbox"/> No		Mode Premium					
			Monthly Benefit \$ _____	Benefit Period _____ Months				\$					
	Cancer _____ (Plan Type) <input type="checkbox"/> Individual <input type="checkbox"/> Family		Riders	Rider	Rider	Rider	Rider	Rider	Section 125 <input type="checkbox"/> Yes <input type="checkbox"/> No	Mode Premium			
			Units/Amts.						\$				
	Accident _____ (Plan Type and Units) <input type="checkbox"/> SI <input type="checkbox"/> CGI <input type="checkbox"/> Individual <input type="checkbox"/> Family		Monthly Salary \$ _____	Rider APDIR	Rider APBER	Rider APEXT	Rider APOPTR1	Rider APHCR1	Section 125 <input type="checkbox"/> Yes <input type="checkbox"/> No	Mode Premium			
			Rider Units						\$				
	SHOP _____ Units: _____ (Hospital Indemnity) <input type="checkbox"/> Individual <input type="checkbox"/> Ind. & Children <input type="checkbox"/> SI <input type="checkbox"/> CGI <input type="checkbox"/> Ind. & Spouse <input type="checkbox"/> Family		Rider IHR1	Rider SAR1	Rider IPBR1	Rider OPBR1	Rider OEAR1	Rider AHNR	Rider TR1	Rider ADIR1	Rider SDIR1	Section 125 <input type="checkbox"/> Yes <input type="checkbox"/> No	Mode Premium
									\$				
Heart/Stroke _____ <input type="checkbox"/> Individual <input type="checkbox"/> Family		Riders	Rider CIDR1	Rider ICR	Rider WBR	Rider	Rider	Section 125 <input type="checkbox"/> Yes <input type="checkbox"/> No	Mode Premium				
		Units: Units/Amt						\$					
Critical Illness _____ <input type="checkbox"/> Individual <input type="checkbox"/> Family <input type="checkbox"/> Single Parent Family		Riders	Rider CICR1	Rider WBR	Rider	Rider	Rider	Section 125 <input type="checkbox"/> Yes <input type="checkbox"/> No	Mode Premium				
		Basic Benefit Amount: Units/Amt						\$					

PAC <input type="checkbox"/> Checking <input type="checkbox"/> Savings		Transit Number _____ Routing Number _____ Draft Date _____	Account Name	Account Number	Total Mode Premium: \$ _____
Remarks		Premiums/Billing Mode <input type="checkbox"/> Monthly <input type="checkbox"/> Semi-Monthly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Weekly <input type="checkbox"/> Other		Producer Number	Percentage Credit
		Requested Issue Date _____		Servicing Agent	_____ %
		Date of First Deduction _____			_____ %
					_____ %
					_____ %

IF QUESTIONS 1-7 BELOW ARE ANSWERED "YES," PLEASE LIST THE REQUIRED HEALTH HISTORY IN QUESTION 8 BELOW.

All except Accident	1) Is any person to be insured now being treated, or in the last 10 years been treated or diagnosed by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance.	<input type="checkbox"/> Yes <input type="checkbox"/> No
All CGI	2) Has any person to be insured been disabled or hospitalized on an inpatient basis or had outpatient surgery in the last 6 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer (policies and riders) & SI Hospital Indemnity	3) a) Has any person to be insured in the last 10 years been diagnosed with or treated for any type of cancer, other than basal cell skin cancer? b) If the answer to 3a is yes, has any person to be insured in the last 10 years been diagnosed with or treated for leukemia, Hodgkin's Disease, lymphoma or cancer with any lymph node involvement or more than one metastasis? c) Has any person to be insured been diagnosed with or received treatment for any other type of cancer (other than those listed in 3b and/or basal cell skin cancer) during the last 5 years?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
Heart/Stroke, Intensive Care, SI Hospital Indemnity & Critical Illness	4) a) Has any person to be insured had in the last 10 years or is now being treated for: a stroke; a heart attack; a heart condition; heart trouble or any abnormality of the heart (including artery disease)? b) Has any person to be insured in the last year had a systolic blood pressure reading higher than 150 more than once or a diastolic blood pressure reading higher than 100 more than once?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
SI Life, Disability, Critical Illness & SI Sickness (DI) Riders to Accident	5) a) Has any person to be insured in the last 2 years, seen a physician (other than for colds, flu, normal pregnancy or a routine physical with no unfavorable results), had, been treated for, or been told by a member of the medical profession that he/she has: diabetes, emphysema, epilepsy, hepatitis, mental or nervous illness, ulcers, any disorder of the central nervous system (to include muscular dystrophy or multiple sclerosis); Parkinson's disease; lupus; rheumatoid arthritis; fibromyalgia; chronic fatigue syndrome; any disorder of the heart, kidneys, liver, lungs, or pancreas; paralysis; optic neuritis; cancer (except basal cell skin cancer), malignant tumor, leukemia, Hodgkin's Disease; or stroke? b) Has any person to be insured in the last 2 years had or been treated for asthma or any disorder of the back, neck or stomach? If yes, complete exclusion endorsement if applying for disability products. c) Has any person to be insured in the last year had a systolic blood pressure reading higher than 150 more than once or a diastolic blood pressure reading higher than 100 more than once? d) Has any person to be insured, in the last 2 years, been treated for or counseled for alcohol or drug abuse? e) Has any person to be insured had any medical or surgical procedures (including major organ transplant) advised or recommended by a doctor but not done at this time? f) Has any person to be insured received any advice, treatment, or consultation for Alzheimer's disease, dementia, senility, or organic brain syndrome?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
Critical Illness	6) Has any person to be insured or ANY 2 of their natural parents or natural siblings been diagnosed with the same disease before age 60, based on this list: heart disease, stroke, diabetes, cancer, kidney disease, or multiple sclerosis?	<input type="checkbox"/> Yes <input type="checkbox"/> No
SI Life	7) Has any person to be insured, in the last 3 years, had his/her driver's license suspended or revoked or been arrested for reckless or drunken driving and/or been involved in 3 or more motor vehicle accidents? If yes, provide additional details below.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Required Health History (For Critical Illness, list primary physician's name, address and telephone number)	8) Name _____ Nature of Illness/Injury or Medical Attention/Reason Last Consulted _____ Date and/or Duration _____ Name and Address of Physician or Hospital/Clinic _____ Use additional paper if needed	
All - Replacement	9) a) Proposed Insured. Is this insurance to replace or change any existing life (if applied for) or health (if applied for) coverage? If yes, indicate product being replaced or changed and complete replacement form provided by your producer if required by your state. _____ b) Producer. To your knowledge, is change or replacement involved?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
All - Existing	10) Proposed Insured. If you are applying for the type of coverage listed above, is there any other (not listed in question 9) life, cancer, heart/stroke, disability, hospital, critical illness or accident insurance in force or applied for on any person to be insured? If yes, list company name, policy number, year issued, type of coverage, and amount of benefit. _____ _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
All Health	11) I have received an Outline of Coverage for each health coverage?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer, Heart/Stroke, Critical Illness & Hosp. Ind.	12) Do you currently have an individual or group policy or contract that arranges or provides medical, hospital or surgical coverage not designed to supplement other private or governmental plans? If you have answered "No", you may not apply for Specified Disease (Cancer, Critical Illness and Heart/Stroke) or Hospital Indemnity Coverage.	<input type="checkbox"/> Yes <input type="checkbox"/> No

REPRESENTATION. I have read or had read to me the completed application and understand that any misstatement or misrepresentation in the application may result in loss of coverage. I represent that statements and answers given on this application are true, complete, and correctly recorded. • **UNDERSTANDING.** I understand that the "effective date" of the policy for health insurance coverages will be the policy date recorded on the policy, not the date the application is signed. I also understand that, if premiums for the policy(ies) is (are) to be paid by payroll deduction, these deductions may start before the "effective date" of the policy(ies) and that this does not change the effective date of coverage. If the policy(ies) is (are) not issued, American Heritage Life will refund any deductions it receives. I also understand that no producer (agent) has authority to waive any answer or otherwise modify this application, or to bind this company in any way by making any promise or representation that is not set out in writing in this application. • **AUTHORIZATION FOR SI LIFE AND CRITICAL ILLNESS.** I authorize any physician, medical practitioner, hospital, clinic or other medical facility, insurance company, or the Medical Information Bureau that has records or knowledge of me or my health to give to American Heritage Life, its subsidiaries or its reinsurers any information. I acknowledge receipt of the Important Notice About Privacy and MIB Notice form. A copy of this authorization is as valid as the original. This authorization applies to any dependent on whom insurance is requested. This authorization is valid for a period of 24 months from the date signed. I understand that I may revoke this authorization at any time by notifying American Heritage Life in writing of my desire to do so.

Signed at: City/State: _____ Date Signed: _____

Signature of Proposed Insured _____ Signature of Owner, if other than Insured _____

Producer's Statement. (Must Complete) I certify that to the best of my knowledge and belief the information in this application is complete, accurate and correctly recorded.

Signature of Producer _____ Print Producer's Name _____

AMERICAN HERITAGE LIFE INSURANCE COMPANY (AHL)

1776 American Heritage Life Drive, Jacksonville, FL 32224

ELECTRONIC DELIVERY (Please check YES or NO)

By checking the "Yes" box below, I agree to electronic delivery of my insurance policy(ies), describing my coverages and any accompanying notices ("my Policy"), and all future correspondence regarding my Policy, to include claim correspondence, explanations of benefit, periodic notices (such as privacy notices) and policy administration correspondence. If electronically delivered, I will be provided instructions on how to receive my Policy and correspondence regarding my Policy via the following address: www.allstateatwork.com/mybenefits.

I understand that to access these documents electronically, I will need a personal computer with internet access and appropriate browser software, and Adobe® Acrobat® Reader® software.

My consent is valid while I am covered under my Policy. At any time, I may withdraw my consent for any reason and receive future correspondence in paper, to include a paper copy of my Policy free of charge, by calling toll-free: 1-800-521-3535; or by writing to: Customer Care Center, American Heritage Life Insurance Company, 1776 American Heritage Life Drive, Jacksonville, Florida, 32224.

YES, I agree to receive my Policy and all correspondence regarding my Policy electronically via the internet.

NO, I prefer to receive paper copies of my Policy and all correspondence regarding my Policy.

Printed Name of Owner: _____ Social Security Number of Owner: _____

Signature of Proposed Insured: _____ Signature of Owner, if other than Insured: _____

Signature of Producer: _____ Print Producer's Name: _____

Account Number: _____ Date Signed: _____



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Workplace Division

Important Notice About Privacy:

In processing your application, an investigative report may be made. Information is obtained through interviews with third parties, such as family members, business associates, financial sources, friends, neighbors, or others with whom you are acquainted. This inquiry includes information as to your character, general information and personal characteristics. You have the right to make a written request within a reasonable period of time for a complete and accurate disclosure of additional information concerning the nature and scope of the investigation. No information obtained from the Medical Information Bureau pertaining to Acquired Immune Deficiency Syndrome (AIDS) will affect the issuance or the underwriting of this policy except, upon written consent, to be medically tested for AIDS and the results of such testing proved positive.

IN/MIBCA-1 (03/09)**Allstate**®

Workplace Division

MIB Notice:

Information regarding your insurability is treated as confidential. We or our reinsurers may, however, make a brief report to the Medical Information Bureau (Bureau), a non-profit membership organization of life insurance companies, which operates an information exchange for its members. If you apply to another Bureau member company for life or health insurance coverage or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information in its file. Upon receipt of a request from you, the Bureau arranges disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, contact the Bureau and seek a correction in accordance with the procedure set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734, PH. #866-692-6901 (TTY 866-346-3642 for hearing impaired). American Heritage Life or its reinsurers may release information in its file to other insurance companies that you apply to for life or health insurance, or submit a claim to for benefits. However, no specific information pertaining to Acquired Immune Deficiency Syndrome (AIDS) will be disclosed to anyone outside the company or its employees, insurance affiliates, agents or reinsurers, except, to a physician designated by the applicant, in writing or, in the absence of such designation, to the State Department of Health.

IN/MIBCA-1 (03/09)



Workplace Division

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 (SHIP).



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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 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).

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Workplace Division

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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 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.
- ✓ For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program (SHIIP).