AMERICAN HERITAGE LIFE INSURANCE COMPANY (AHL)
1776 AMERICAN HERITAGE LIFE DRIVE
JACKSONVILLE, FL 32224

Application for Life and Health Insurance Form

Account No.	Account Name	Requested Effective Date	First Deduction Date	Employee ID	*Remarks*

Billing Mode *(choose one)*: ☐ Monthly (12) ☐ Semi-Monthly (24) ☐ Bi-Weekly (26) ☐ Weekly (52) ☐ Other ________

Billing Method: ☐ Payroll Deduction ☐ Bank/Credit Union Draft *(Authorization required - complete form ABJ062)*

AHL home office use only	**Total Mode Premium**

General Information

Employee/Payor Name *(Last, First, M.I.)*	Birth Date	Social Security No.	☐ Male ☐ Female
Residence Street Address	Phone No.		
City, State, Zip	Email Address		
Employer	Hire Date	Occupation*	

**Occupation with the employer listed in the General Information section.*

Complete for all other persons you (the employee) are requesting to be insured

Last Name	First Name	Relationship	Gender	Birth Date	Social Security No.

Tobacco Use

If applying for Life, has the employee used tobacco in the last 12 months? **Employee** ☐ Yes ☐ No

If applying for Life, has the employee's spouse used tobacco in the last 12 months? **Spouse** ☐ Yes ☐ No

Selection of Coverage

Answer yes or no and complete for each coverage selected.

GI -- Guaranteed Issue
CGI -- Contingent Guaranteed Issue
SI -- Simplified Issue

Accident

Do you want this coverage? ☐ Yes ☐ No Section 125 ☐ **Select one:** ☐ Pre-tax ☐ Post-tax

Who do you want to cover?

☐ Individual
☐ Individual + Spouse
☐ Individual + Child(ren)
☐ Family

Mode Premium

Request Plan:

Plan Type ________________ Units______

☐ GI ☐ CGI ☐ SI

Monthly Earnings $ ____________

Request Riders:

	Units
☐ APDIR	
☐ APEXT	
☐ APHCR	
☐ BER	
☐ OPTR	

Employee Name ____________________ Account No. __________

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Disability (DI)

Do you want this coverage? ☐ Yes ☐ No Section 125 ☐ **Select one:** ☐ Pre-tax ☐ Post-tax

Request Plan: Plan Type ____________ ☐ GI ☐ CGI ☐ SI

Provide: Monthly Earnings* $ ____________

Monthly Benefit $ ____________

Taxable (gross) monthly earnings from your occupation with the employer listed on the first page of this form.

Occupation Class: ☐ Preferred ☐ Standard

Choose elimination and benefit periods:

Elimination Period: ______ Days Accident ______ Days Sickness Benefit Period: ______ Months

Mode Premium

Request riders:			Units
☐ Accidental D&D Rider	☐ Individual	☐ Family	
☐ On the Job Accident Total Disability Rider			

Hospital Indemnity (SHOP)[1]

Do you want this coverage? ☐ Yes ☐ No Section 125 ☐ **Select one:** ☐ Pre-tax ☐ Post-tax

Who do you want to cover?

☐ Individual
☐ Individual + Spouse
☐ Individual + Child(ren)
☐ Family

Mode Premium

Request Plan:

Plan Type ____________ Units ______

☐ CGI ☐ SI

Request Riders:	Units	Request Riders:	Units
☐ IHR1		☐ AHNR	
☐ SAR1		☐ TR1	
☐ IPBR1		☐ ADIR1	
☐ OPBR1		☐ SDIR1	
☐ OEAR1			

[1] *Supplemental Health Options Policy*

Life

Do you want this coverage? ☐ Yes ☐ No

Request Plan: Plan Type ____________ ☐ GI ☐ CGI ☐ SI

Choose one (UL only): Death Benefit Option ☐ 1 ☐ 2

Requested Face Amount $ ____________

Mode Premium

Request Riders:	Units	Request Riders:	Units
☐ ADB		☐ LTC	
☐ CI		☐ PW	
☐ CTR		☐ STR/ST	
☐ TIR/LT		☐ LBR/TI	
☐ FPOR		☐ OIR	

If the proposed insured is your spouse or child, provide the following information for that proposed insured. ☐ Spouse ☐ Child

Proposed Insured Name *(Last, First, M.I.)*	Social Security No.	☐ Male ☐ Female
Residence Street Address		Birth Date
City, State, Zip	Phone No.	Email Address
Employer of Proposed Insured	Annual Salary	Occupation

Answer if applying for spouse as proposed insured (CGI or SI Life). Is the employee's spouse actively at work now, for wage or profit, and has he/she worked at least 20 hours each week performing all duties of his/her regular occupation at his/her regular place of employment for at least the last 3 months except for minor illness or injury of 1 week or less, or normal pregnancy? ☐ Yes ☐ No

Answer if applying for child as proposed insured. Is the child proposed for coverage a full-time student? ☐ Yes ☐ No

If the answer is no and the child is 19 or older, is he/she actively at work now, for wage or profit, and has he/she worked at least 20 hours each week performing all duties of his/her regular occupation at his/her regular place of employment for at least the last 3 months (except for minor illness or injury of 1 week or less, or normal pregnancy)? ☐ Yes ☐ No

If applying for Life coverage for a dependent child (age 19 or older) as the proposed insured, has that dependent child used tobacco in the last 12 months? ☐ Yes ☐ No

Employee Name ______________________ Account No. ___________

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If you are requesting rider coverage for your spouse or child(ren) and his/her contact information is different from yours, provide his/her name, address, and phone number below.

Provide if owner is different than the employee or the proposed insured.

Owner Name ***(Last, First, M.I.)***		Social Security/Tax I.D. No.
Residence Street Address		Birth Date
City, State, Zip	Phone No.	Email Address

Beneficiary Designation

Your beneficiary designations will apply to all coverages and riders applied for, including designations for a spouse or covered dependent. For additional beneficiary designation options, complete form ABJ040.

Primary Beneficiary Name *(Last, First, M.I.)*		Social Security No.
Residence Address	Birth Date	Relationship
City, State, Zip	Phone No.	
Contingent Beneficiary Name *(Last, First, M.I.)*		Social Security No.
Residence Address	Birth Date	Relationship
City, State, Zip	Phone No.	

Eligibility Question

Answer for the following coverages: All products

Employee Actively At Work. Is the employee actively at work now, for wage or profit, and has he/she worked at least 20 hours each week performing all duties of his/her regular occupation at his/her regular place of employment for at least the last 3 months except for minor illness or injury of 1 week or less, or normal pregnancy? ☐ Yes ☐ No

Underwriting Questions

If requesting Guaranteed Issue, proceed to the Replacement and Existing Insurance section. For all other enrollments, answer each question for the coverages for which you are applying. If any of the questions below are answered yes, list the required health history at the end of the section.

Answer for the following: CGI & SI Accident w/Sickness DI Rider, CGI & SI Disability, CGI & SI Hospital Indemnity, CGI & SI Life

1. **AIDS History.** In the last 5 years, has a member of the medical profession diagnosed or treated the person(s) to be insured for Acquired Immune Deficiency Syndrome (AIDS), or has any person to be insured tested positive for antigens or antibodies to an AIDS virus?

   Employee ☐ Yes ☐ No
   Spouse ☐ Yes ☐ No
   Child(ren) ☐ Yes ☐ No

Answer for the following: SI Life, All CGI

2. **Recently Disabled/Hospitalized.** In the last 6 months, has the person(s) to be insured been disabled or hospitalized for anything other than lacerations or broken bones due to an accident, or normal pregnancy?

   Employee ☐ Yes ☐ No
   Spouse ☐ Yes ☐ No
   Child(ren) ☐ Yes ☐ No

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Answer for the following: SI Life

3. Chronic Disease History. In the last 2 years, has a member of the medical profession diagnosed or treated the person(s) to be insured for any of the following?

- Anemia (other than iron deficiency)
- Anxiety, depression or other mental or nervous illness (that resulted in hospitalizations, disability from work, or suicide attempts)
- Asthma (only if taking steroidal medication and/or have been hospitalized)
- Cancer, except basal cell carcinoma
- Diabetes
- Epilepsy and/or seizure disorder
- Heart attack, cardiomyopathy, congestive heart failure, heart murmur (and taking medication(s)), angioplasty, coronary artery bypass surgery, coronary artery disease, stent, pacemaker, heart valve replacement or any other heart disorder
- Hemophilia
- Hepatitis
- Kidney Disease/Disorder (including dialysis and/or chronic renal failure)
- Liver Disease/Disorder
- Lou Gehrig's Disease (ALS)
- Lung Disease/Disorder (other than asthma)
- Lupus
- Multiple Sclerosis
- Muscular Dystrophy
- Parkinson's Disease, scleroderma, polymyositis, or fibromyalgia
- Stroke including aneurysm, transient ischemic attack (TIA), or arteriovenous malformation
- Transplant of any organ
- Counseling for, or excessive use of, alcohol or any type of drugs

Employee ☐ Yes ☐ No
Spouse ☐ Yes ☐ No
Child(ren) ☐ Yes ☐ No

Answer for the following: SI Accident w/Sickness DI Rider, SI Disability, SI Hospital Indemnity, SI Life

4. Blood Pressure History. In the last year, has the person(s) to be insured had a systolic blood pressure reading higher than 150 more than once or a diastolic blood pressure reading higher than 100 more than once that was confirmed by a member of the medical profession?

Employee ☐ Yes ☐ No
Spouse ☐ Yes ☐ No
Child(ren) ☐ Yes ☐ No

Answer for the following: SI Life

5. Driving History. In the last 3 years, has the person(s) to be insured had his/her driver's license suspended or revoked due to driving violations, been convicted of reckless driving or driving under the influence, been involved in 3 or more motor vehicle accidents, or received 3 or more moving violations? If yes, provide details including license number and state of issue.

Employee ☐ Yes ☐ No
Spouse ☐ Yes ☐ No
Child(ren) ☐ Yes ☐ No

Answer for the following: SI Hospital Indemnity

6a. Cancer Diagnosis/Treatment History. Has a member of the medical profession ever diagnosed or treated the person(s) to be insured for any type of cancer (except basal cell carcinoma)?

Employee ☐ Yes ☐ No
Spouse ☐ Yes ☐ No
Child(ren) ☐ Yes ☐ No

6b. Cancer Leukemia/Lymphoma. If the answer to the Cancer Diagnosis/Treatment History question is yes, has a member of the medical profession diagnosed or treated that person(s) for Leukemia, Hodgkin's Disease, Lymphoma, or cancer with any lymph node involvement or metastasis?

Employee ☐ Yes ☐ No
Spouse ☐ Yes ☐ No
Child(ren) ☐ Yes ☐ No

6c. Cancer Other. If the answer to the Cancer Diagnosis/Treatment History question is yes, in the last 5 years has a member of the medical profession diagnosed or treated that person(s) for any other type of cancer (other than those listed in the Cancer Leukemia/Lymphoma question and/or basal cell carcinoma)?

Employee ☐ Yes ☐ No
Spouse ☐ Yes ☐ No
Child(ren) ☐ Yes ☐ No

Employee Name ______________________ Account No. ___________

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Answer for the following: SI Accident w/Sickness DI Rider, SI Disability

7. Major Medical Condition History. In the last 2 years, has a member of the medical profession diagnosed or treated the person(s) to be insured for any of the following?

Employee ☐ Yes ☐ No

- Cancer (except basal cell carcinoma)
- Central Nervous System Disease or disorder (to include Multiple Sclerosis or Muscular Dystrophy)
- Chronic Fatigue Syndrome
- Counseling for alcohol or drug abuse
- Diabetes
- Emphysema
- Fibromyalgia
- Heart Disease/Disorder
- Kidney Disease/Disorder (including dialysis and/or chronic renal failure)
- Liver Disease/Disorder
- Lung Disease/Disorder
- Lupus
- Optic Neuritis
- Pancreas Disease
- Parkinson's Disease
- Paralysis
- Rheumatoid Arthritis
- Stroke including aneurysm, transient ischemic attack (TIA), or arteriovenous malformation

Answer for the following: SI Accident w/Sickness DI Rider, SI Disability

8. Back/Asthma History. In the last 2 years, has the person(s) to be insured had any disease of, been impaired by, or received treatment from a member of the medical profession for, the following (other than minor illness)? If yes, complete exclusion endorsement if applying for sickness disability rider.

Employee ☐ Yes ☐ No

- Any disorder of the back or neck
- Asthma

Answer for the following: SI Hospital Indemnity

9. Heart/Stroke History. In the last 5 years, has a member of the medical profession diagnosed or treated the person(s) to be insured for any of the following?

Employee ☐ Yes ☐ No
Spouse ☐ Yes ☐ No
Child(ren) ☐ Yes ☐ No

- Any artery disease
- Any abnormality of the heart
- Heart attack
- Heart condition
- Heart trouble
- Stroke or transient ischemic attack (TIA)

Answer for the following: SI Accident w/Sickness Disability Rider, SI Disability, SI Hospital Indemnity, SI Life

10. Advised Medical Procedure History. In the last 5 years, has a member of the medical profession advised or recommended that the person(s) to be insured have any medical or surgical procedures (including organ transplant), which have not yet been performed?

Employee ☐ Yes ☐ No
Spouse ☐ Yes ☐ No
Child(ren) ☐ Yes ☐ No

Provide height and weight.

11. Employee for the following: SI Life, SI Accident w/Sickness Disability Rider, SI Disability, SI Hospital Indemnity — **Height:** _______ ft. _______ in **Weight:** _______ lbs.

Spouse for the following: SI Life (when proposed insured) — **Height:** _______ ft. _______ in **Weight:** _______ lbs.

Child for the following: SI Life (when proposed insured) — **Height:** _______ ft. _______ in **Weight:** _______ lbs.

Answer for the following: SI Life (over $150,000)

12. Physician Information. Provide the names and addresses of all physicians (or other members of the medical profession) for each person to be insured. The required health history section may be used if additional space is needed.

Answer for the following: All products

13. Required Health History. Provide health history for any yes answers to the underwriting questions. Include physician's (or other members of the medical profession) name, address and telephone number:

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Replacement and Existing Insurance

Replacement ***(Answer for proposed insured for all products).*** Will the insurance being applied for replace, discontinue, or change any existing life, annuity or health coverage that you currently have? If yes, indicate product being replaced or changed and complete replacement form provided if required by your state. ☐ Yes ☐ No

Existing Insurance ***(Answer for all insureds for all products).*** Is there any other insurance you didn't list that exists (or that you have applied for on another application with American Heritage Life Insurance Company or another company) for the person(s) to be insured? This would be insurance that corresponds to the coverage for which you are applying. If yes, list company name, policy number, year issued, type of coverage, and amount of benefit and complete replacement form provided by your producer, if required by your state. ☐ Yes ☐ No

REPRESENTATION. The undersigned producer and I certify that I have read or had read to me this completed form and understand that any misstatement or misrepresentation in this form may result in loss of coverage. I represent that statements and answers given on this form are true, complete, and correctly recorded. **UNDERSTANDING.** I understand that: if premiums for the coverage(s) is (are) to be paid by payroll deductions, these deductions may start before the "effective date" of coverage(s) and that this does not change the effective date of coverage; and the "effective date" for health insurance coverages will be the date recorded on the policy/certificate/benefit statement, not the date the application is signed. If the coverage(s) is (are) not issued, American Heritage Life Insurance Company 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 American Heritage Life Insurance Company in any way by making any promise or representation that is not set out in writing in this application. **I understand that if I refuse any coverage for which I am eligible, satisfactory proof of insurability may be required, at my own expense, should I desire to apply for it at a later date. Any such form may be declined on the basis of such proof. PREMIUM DEDUCTION AUTHORIZATION (EMPLOYEE). I AUTHORIZE** my employer to deduct from my salary or wages, if applicable, the necessary premium for the coverages requested. **AUTHORIZATION TO OBTAIN AND DISCLOSE CERTAIN DATA (FOR SI LIFE)**. I authorize any physician, medical practitioner, hospital, clinic or other medical facility, Pharmacy Benefit Managers, insurance company, or MIB, Inc., that has records or knowledge of my health including my prescription medication history to give to American Heritage Life Insurance Company, its subsidiaries or its reinsurers any information relating to the underwriting of insurance for which I am applying. I also authorize American Heritage Life Insurance Company, or its reinsurers, to make a brief report of my health information to MIB, Inc. I understand that there is a possibility of redisclosure of any information disclosed pursuant to this authorization and that information, once disclosed, may no longer be protected by federal rules governing privacy and confidentiality. I acknowledge receipt of the Important Notice About Privacy and MIB Notice form. I or my authorized representative may request a copy of this authorization. A copy of this authorization is as valid as the original. This authorization applies to any minor dependent for whom insurance is requested. This authorization is valid for 24 months from the date signed. I understand that I may revoke this authorization at any time by notifying American Heritage Life Insurance Company in writing of my desire to do so.

Hospital Indemnity: I ACKNOWLEDGE THAT THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN ADDITIONAL PAYMENT WITH MY TAXES.

Employee Signature *(If employee is not the owner, owner must sign)*	City/State	Date Signed
Proposed Insured Signature	City/State	Date Signed
Owner Signature *(If not employee)*	City/State	Date Signed

Soliciting producer must complete and sign

Replacement -- All Products. To your knowledge, is change or replacement of life, annuity, or health coverage involved? ☐ Yes ☐ No

Existing Insurance -- All Products. To your knowledge, does any person to be insured have existing coverage in force? ☐ Yes ☐ No

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.

Soliciting Producer Signature	Soliciting Producer Name Printed

Employee Name ______________________ Account No. ___________

Application for Life and Health Insurance Form

Home office or producer to complete before issue:

Producer Name	Producer Number	Percentage Credit	Producer Name	Producer Number	Percentage Credit
Servicing Producer			Soliciting Producer		

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. The purpose of this information is to determine your eligibility for insurance. This inquiry includes information as to your character, general information and personal characteristics. In certain limited circumstances, we are allowed by law to disclose necessary items of personal information to third parties without your specific authorization. You may request to be interviewed in connection with the preparation of the investigative report and 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. You or your representative are entitled to receive a copy of this investigative consumer report upon your request.

IN/MIBVA-3 **(2012)**

MIB Notice:

Information regarding your insurability is treated as confidential. We or our reinsurers may, however, make a brief report to MIB, Inc. (MIB), a not-for-profit membership organization of life insurance companies, which operates an information exchange for its members. If you apply to another MIB member company for life or health insurance coverage or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file. Upon receipt of a request from you, MIB arranges disclosure of any information it may have in your file. If you question the accuracy of information in MIB's file, contact MIB and seek a correction in accordance with the procedure set forth in the Federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734, PH. #866-692-6901. 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.

IN/MIBVA-3 **(2012)**

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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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).