☒ Producer Assisted ☐ Self Enrollment ☐ New Policy ☐ Change/Increase Policy #_____

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

## EMPLOYEE INFORMATION

| 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 INFORMATION

| Proposed Insured (Last, First, M.I.) | ☐ M ☐ F | ☐ Employee ☐ Spouse ☐ Child ☐ Other | Social Security Number |
|---|---|---|---|
| | | | |

| Residence Address | City | State | Zip | Phone Number |
|---|---|---|---|---|
| | | | | |

| Employer | Occupation |
|---|---|
| | |

| Owner's Name and Address (if different than Proposed Insured's) | City | State | Zip | Owner's Phone Number |
|---|---|---|---|---|
| | | | | |

| Owner's Date of Birth (if different than Proposed Insured's) | Owner's Social Security Number or Tax I.D. Number (if different than Proposed Insured's) | Owner's Email Address |
|---|---|---|
| | | |

| Primary Beneficiary's Full Name and Address | City | State | Zip | Relationship | Phone Number | Date of Birth | Social Security Number |
|---|---|---|---|---|---|---|---|
| | | | | | | | |

| Contingent Beneficiary's Full Name and Address | City | State | Zip | Relationship | Phone Number | Date of Birth | Social Security Number |
|---|---|---|---|---|---|---|---|
| | | | | | | | |

## COMPLETE THIS SECTION FOR PERSONS TO BE INSURED

| Relationship to Employee | Last Name | First Name | Date of Birth | Sex | Relationship | Actively at Work*^ | Full Time Student^ | Tobacco Use [1]^ |
|---|---|---|---|---|---|---|---|---|
| Employee | | | | | Employee | ☐ Yes ☐ No | N/A | **☐ Yes ☐ No |
| Spouse | | | | | Spouse | ☐ Yes ☐ No | N/A | **☐ Yes ☐ No |
| Dependent | | | | | | ☐ Yes ☐ No | ☐ Yes ☐ No | ^☐ Yes ☐ No |
| Dependent | | | | | | ☐ Yes ☐ No | ☐ Yes ☐ No | ^☐ Yes ☐ No |
| Dependent | | | | | | ☐ Yes ☐ No | ☐ Yes ☐ No | ^☐ Yes ☐ No |

*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.

[1]Has anyone to be insured used tobacco in the last 12 months? (****If applying for Life. ^For dependents ages 19 and older, if applying for Life.**)

## INSURANCE PLANS

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

| **Accident** _____ ☐ GI ☐ CGI ☐ SI (Plan Type and Units) | ☐ AP2 ☐ AP3 | ☐ Individual ☐ Family | Monthly Salary $_____ | Section 125 ☐ Yes ☐ No | Mode Premium $_____ |
|---|---|---|---|---|---|

| Riders | Rider APDIR | Rider APBER | Rider APEXT | Rider APOPTR1 | Rider APHCR1 | Rider | Rider | Rider |
|---|---|---|---|---|---|---|---|---|
| Units/Amt | | | | | | | | |

| **Cancer** _____ (Plan Type) | ☐ CP10A ☐ CP10B ☐ CBP | ☐ Individual ☐ Family | Section 125 ☐ Yes ☐ No | Mode Premium $_____ |
|---|---|---|---|---|

| Riders | Rider CER/CABR | Rider ICR | Rider CLR | Rider CPR | Rider CFR | Rider WBR | Rider | Rider |
|---|---|---|---|---|---|---|---|---|
| Units/Amt | | | | | | | | |

| **Disability (DI)** _____ ☐ GI ☐ CGI ☐ SI | Monthly Salary $_____ | Elimination Period _____ Days Acc. _____ Days Sick. | Section 125 ☐ Yes ☐ No | Mode Premium $_____ |
|---|---|---|---|---|
| **Occupation Class** ☐ Preferred ☐ Standard | Monthly Benefit $_____ | Benefit Period _____ Months | On The Job Rider ☐ Yes ☐ No | Accident Rider ☐ Yes ☐ No Units _____ ☐ Individual ☐ Family |

| **Heart/Stroke** _____ Units _____ ☐ GI ☐ CGI ☐ SI (Plan Type) | ☐ Individual ☐ Family | Section 125 ☐ Yes ☐ No | Mode Premium $_____ |
|---|---|---|---|

| Riders | Rider CIDR1 | Rider ICR | Rider WBR | Rider | Rider | Rider | Rider | Rider |
|---|---|---|---|---|---|---|---|---|
| Units/Amt | | | | | | | | |

| Hospital Indemnity (SHOP)[1] _____ Units _____ (Plan Type) ☐ CGI ☐ SI | ☐ Individual ☐ Individual & Children ☐ Individual & Spouse ☐ Family | Section 125 ☐ Yes ☐ No | Mode Premium $ _____ |
|---|---|---|---|

| Riders | Rider IHR1 | Rider SAR1 | Rider IPBR1 | Rider OPBR1 | Rider OEAR1 | Rider AHNR | Rider TR1 | Rider ADIR1 | Rider SDIR1 |
|---|---|---|---|---|---|---|---|---|---|
| Units/Amt | | | | | | | | | |

[1] Supplemental Health Options Policy

| Life ☐ Universal (UL20) ☐ Universal (UL21) ☐ GI (Employee Only) ☐ Term ☐ CGI ☐ SI | Death Benefit Option ☐ 1 ☐ 2 Universal Life ONLY | Face Amount $ _____ | Mode Premium $ _____ |
|---|---|---|---|

| Riders | Rider ADB | Rider PW | Rider STR | Rider CTR | Rider LBR | Rider FPOR | Rider LTC | Rider OIR | Rider TIR | Rider |
|---|---|---|---|---|---|---|---|---|---|---|
| Units/Amt | | | | | | | | | | |

| Billing Method ☐ Payroll Deduction ☐ Bank/Credit Union Draft (Authorization Required)* *Complete form ABJ062 | Name on Bank/Credit Union Account _____ Bank/Credit Union Account Number _____ Routing Number _____ Draft Date _____ | Billing Mode: ☐ Monthly ☐ Semi-Monthly ☐ Bi-weekly ☐ Weekly ☐ Other _____ | Coverage Effective Date _____ Date of First Deduction _____ | Total Mode Premium: $ _____ |
|---|---|---|---|---|

| Remarks | Account (Case) Name | Account (Case) Number |
|---|---|---|
| | | |

**IF REQUESTING GUARANTEED ISSUE, PLEASE PROCEED TO QUESTION 15 BELOW. FOR ALL OTHER ENROLLMENTS, IF ANY UNDERWRITING QUESTIONS BELOW ARE ANSWERED "YES", PLEASE LIST THE REQUIRED HEALTH HISTORY IN QUESTION 14 ON PAGE 3.**

Abbreviations: EE - Employee SP - Spouse CH - Child(ren) Y - Yes N - No

| | UNDERWRITING QUESTIONS | EE | SP | CH |
|---|---|---|---|---|
| **CGI & SI Accident w/ Sickness DI Rider, Cancer, CGI & SI Disability, Heart/Stroke, Hospital Indemnity & CGI & SI Life** | 1. Has any person to be insured, in the last 10 years, been diagnosed with or treated by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC), or tested positive for antigens or antibodies to an AIDS virus? | ☐Y ☐N | ☐Y ☐N | ☐Y ☐N |
| **All CGI** | 2. Has any person to be insured, in the last 6 months, been disabled or hospitalized for anything other than normal pregnancy, lacerations or broken bones due to an accident? | ☐Y ☐N | ☐Y ☐N | ☐Y ☐N |
| **Cancer & SI Hospital Indemnity** | 3a. Has any person to be insured ever been diagnosed with or treated by a member of the medical profession for any type of cancer, other than basal cell carcinoma? | ☐Y ☐N | ☐Y ☐N | ☐Y ☐N |
| | 3b. If the answer to 3a. is yes, has that person(s) been diagnosed with or treated by a member of the medical profession for Leukemia, Hodgkin's Disease, Lymphoma, or Cancer with any lymph node involvement or more than one metastasis? | ☐Y ☐N | ☐Y ☐N | ☐Y ☐N |
| | 3c. If the answer to 3a. is yes, has that person(s), in the last 5 years, been diagnosed with or treated by a member of the medical profession for any other type of cancer (other than those listed in 3b. and/or basal cell carcinoma)? | ☐Y ☐N | ☐Y ☐N | ☐Y ☐N |
| **Heart/Stroke, Cancer w/ Intensive Care & SI Hospital Indemnity** | 4. Has any person to be insured, in the last 5 years, been diagnosed with or treated by a member of the medical profession for a stroke or transient ischemic attack (TIA), a heart attack, a heart condition, heart trouble, any abnormality of the heart, or any artery disease? | ☐Y ☐N | ☐Y ☐N | ☐Y ☐N |
| **SI Life** | 5. Has any person to be insured, in the last 2 years, been diagnosed or treated by a member of the medical profession for any of the following? • Anemia (other than iron deficiency) • Anxiety, depression or other mental or nervous illness (that would include hospitalizations, disability from work, or suicide attempts) • Asthma (other than taking non-steroidal medication as needed with no hospitalizations), or any other lung disorder • Cancer, except basal cell carcinoma • Diabetes • Epilepsy with a seizure • 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 involving dialysis or chronic renal failure • Liver Disease • Lou Gehrig's Disease (ALS) • 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 | ☐Y ☐N | ☐Y ☐N | ☐Y ☐N |

**IF REQUESTING GUARANTEED ISSUE, PLEASE PROCEED TO QUESTION 15 BELOW. FOR ALL OTHER ENROLLMENTS, IF ANY UNDERWRITING QUESTIONS BELOW ARE ANSWERED "YES", PLEASE LIST THE REQUIRED HEALTH HISTORY IN QUESTION 14 ON PAGE 3.**

Abbreviations: EE - Employee SP - Spouse CH - Child(ren) Y - Yes N - No

| | UNDERWRITING QUESTIONS (Continued) | EE | SP | CH |
|---|---|---|---|---|
| **SI Accident w/ Sickness DI Rider, SI Disability, SI Hospital Indemnity & SI Life** | 6. Has any person to be insured, in the last 5 years, had any medical or surgical procedures (including organ transplant) advised or recommended by a member of the medical profession, but not done at this time? | ☐Y ☐N | ☐Y ☐N | ☐Y ☐N |
| **SI Life** | 7. Has any person to be insured, in the last 3 years: had his/her driver's license suspended or revoked; been convicted of reckless or drunken driving; or been involved in 3 or more motor vehicle accidents? | ☐Y ☐N | ☐Y ☐N | ☐Y ☐N |
| **SI Accident w/ Sickness DI Rider, Cancer w/ Intensive Care, SI Disability, SI Heart/Stroke, Hospital Indemnity & SI Life** | 8. Has any person to be insured, in the last year, been diagnosed by a member of the medical profession with a systolic blood pressure reading higher than 150 more than once or a diastolic blood pressure reading higher than 100 more than once? | ☐Y ☐N | ☐Y ☐N | ☐Y ☐N |
| **SI Accident w/ Sickness DI Rider & SI Disability** | 9. Has any person to be insured, in the last 2 years, had any disease, impairment of, or treatment by a member of the medical profession (other than minor illness) for the following?<br>• Any disorder of the back or neck • Asthma | ☐Y ☐N | ☐Y ☐N | ☐Y ☐N |
| **SI Accident w/ Sickness DI Rider & SI Disability** | 10. Has any person to be insured, in the last 2 years, had or been diagnosed with or treated by a member of the medical profession for any of the following?<br>• Central Nervous System Disease or disorder (to include Multiple Sclerosis or Muscular Dystrophy)<br>• Chronic Fatigue Syndrome<br>• Diabetes<br>• Emphysema<br>• Fibromyalgia<br>• Heart Disease<br>• Liver Disease<br>• Lung Disease<br>• Lupus<br>• Optic Neuritis<br>• Parkinson's Disease<br>• Paralysis<br>• Rheumatoid Arthritis | ☐Y ☐N | ☐Y ☐N | ☐Y ☐N |
| **SI Accident w/ Sickness DI Rider & SI Disability** | 11. Has any person to be insured, in the last 2 years, had or been diagnosed with or treated by a member of the medical profession for any of the following?<br>• Counseling for alcohol or drug abuse • Pancreas Disease | ☐Y ☐N | ☐Y ☐N | ☐Y ☐N |
| **SI Accident w/ Sickness DI Rider, Cancer w/ Intensive Care, SI Disability, SI Heart/Stroke, SI Hospital Indemnity & SI Life** | 12. Provide Height and Weight of Proposed Insured:<br>Height: Weight: | | | |
| **SI Life (over $150,000)** | 13. 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.<br>_____ | | | |
| **Required Health History** | 14. 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:<br>_____ | | | |
| **All-Replacement** | 15. Is this insurance to replace, discontinue or change any existing life or annuity (if applied for) or health (if applied for) coverage? If yes, indicate product being replaced or changed and complete replacement form provided if required by your state.<br>_____ | ☐Y ☐N | ☐Y ☐N | ☐Y ☐N |
| **All-Existing Insurance** | 16. If you are applying for the type of coverage listed, is there any other (not listed in question 15) insurance of that type in force or applied for (other than this application) on any person to be insured: Coverage Type: life, annuity, cancer, heart/stroke, disability, hospital or accident? 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.<br>_____ | ☐Y ☐N | ☐Y ☐N | ☐Y ☐N |

## ELECTRONIC ACCEPTANCE (Please check YES or NO)

By checking the "Yes" box, I elect electronic delivery of my policy(ies), including all documents accompanying my policy(ies). If electronically delivered, I understand that I will receive instructions at the email address I have provided on how to receive my policy and accompanying documents at: www.allstatebenefits.com/mybenefits.

☐ Yes ☐ No

By checking the "Yes" box, I elect electronic delivery of all contractual, regulatory and administrative correspondence (correspondence) regarding my policy(ies), to include claim correspondence, explanations of benefits, periodic notices (such as privacy notices) and other correspondence. If electronically delivered, I understand that I will receive instructions at the last email address I have provided on how to receive correspondence at: www.allstatebenefits.com/mybenefits.

☐ Yes ☐ No

I understand and agree that to receive electronic delivery, I must have a computer with internet access, a web browser that is Microsoft Internet Explorer version 5.0 or greater, an e-mail account, and the ability to download PDF files using Adobe Acrobat Reader version 5.0 or higher and a printer or other device to download and print or save any documents I wish to retain.

I understand and I agree that my consent is valid while I remain covered. 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(ies), 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.

**REPRESENTATION.** The undersigned producer and I certify that 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: 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. **PREMIUM DEDUCTION AUTHORIZATION. 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 the Medical Information Bureau (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 dependent on 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.

**FRAUD NOTICE: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.**

**Health Coverage Disclosure: Please be aware that these health products contain pre-existing conditions, waiting periods, elimination periods, and/or reduction in benefits at certain ages. Please read your health coverages thoroughly.**

Signed at: City/State _____ Date Signed _____

Signature of Proposed Insured _____

Signature of Owner, if other than Insured _____

Signature of Employee/Payor, if not Insured or Owner _____

**SOLICITING PRODUCER MUST COMPLETE AND SIGN WHEN APPLICATION IS PRODUCER ASSISTED**

| | | |
|---|---|---|
| **All-Replacement** | 1. To your knowledge, is change or replacement of life, annuity or health coverage involved? | ☐ Yes ☐ No |
| **All-Existing Insurance** | 2. 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.

Signature of Soliciting Producer _____ Print Soliciting Producer Name _____

To be completed by home office or producer, prior to issue:

| **Producer Name** | **Producer Number** | **National Producer Number (NPN)** | **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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## 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 (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.
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- ✓ For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program (SHIIP).

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