

PLEASE PRINT WITH BLACK INK

APPLICATION FOR LIFE AND HEALTH INSURANCE TO:

American Heritage Life Insurance Company

1776 American Heritage Life Drive, Jacksonville, Florida 32224

Proposed Insured (Print) (Last, First, M.I.)		☐ Emp. ☐ Child	☐ Spouse ☐ Other	☐ M ☐ F	Age	Birthdate	Height	Weight	Social Security Number	
Home Address		City			State		Zip		Home Phone Number	
Employer (if not same as case)				Occupation				Date Hired		
Payor (if other than Proposed Insured)				Social Security Number or Tax I.D. Number (Owner or Payor)				Employee ID		
Owner's Name and Address (if different than Proposed Insured's)						City		State		Zip
Primary Beneficiary - Full Name Age Relationship					Contingent Beneficiary - Full Name Age Relationship					
Secondary Addressee for Life Insurance - Full Name/Address										

DEPENDENTS PROPOSED FOR COVERAGE

Last Name	First Name	M.I.	Relationship	Date of Birth	Age	Sex

PLANS	Universal Life _____ ☐ Simplified Issue ☐ Select CGI		Face Amount	Life Riders	Rider	Rider	Rider	Rider	Rider	Rider	Rider	Mode Premium	
			Death Benefit Option ☐ 1 ☐ 2	Units/Amt								\$	
	Term Life _____ ☐ Simplified Issue ☐ Select CGI		Face Amount	Life Riders	Rider	Rider	Rider	Rider	Rider	Rider	Rider	Mode Premium	
				Units/Amt								\$	
	Disability _____ ☐ Simplified Issue ☐ Select CGI Occupation Class ☐ Preferred ☐ Standard		Monthly Salary \$ _____	Elimination Period _____ Days Acc. _____ Days Sick.		On The Job Rider ☐ Yes ☐ No		Accident Rider ☐ Yes ☐ No Units _____ ☐ Individual ☐ Family		Section 125 ☐ Yes ☐ No	Mode Premium		
			Monthly Benefit \$ _____	Benefit Period _____ Months							\$		
	Cancer _____ (Units or Benefit Package) ☐ Individual ☐ Family		Cancer Riders	Rider	Rider	Rider	Rider	Rider	Rider	Section 125 ☐ Yes ☐ No	Mode Premium		
			Units/Amts.							\$			
	Accident _____ (Units or Benefit Package) ☐ Simplified Issue ☐ Select CGI ☐ Individual ☐ Family		Monthly Salary \$ _____	Rider APDIR	Rider APBER	Rider APEXT	Rider APOPTR1	Rider APHCR1	Section 125 ☐ Yes ☐ No	Mode Premium			
			Rider Units						\$				
INSURANCE	Hosp. Ind. (SHOP) _____ Units: ☐ Simplified Issue ☐ Individual ☐ Ind. & Children ☐ Select CGI ☐ Ind. & Spouse ☐ Family		Rider IHR1	Rider SAR1	Rider IPBR1	Rider OPBR1	Rider QEAR1	Rider AHNR	Rider TR1	Rider ADIR1	Rider SDIR1	Section 125 ☐ Yes ☐ No	Mode Premium
												\$	
	Heart/Stroke _____ ☐ Individual ☐ Family Units or Benefit Level:		HSP2 Riders	Rider CIDR1	Rider ICR	Rider WBR3	Rider	Rider	Section 125 ☐ Yes ☐ No	Mode Premium			
			Units/Amt						\$				
	Critical Illness _____ ☐ Individual ☐ Family ☐ Single Parent Family Basic Benefit Amount:		CI Riders	Rider	Rider	Rider	Rider	Rider	Section 125 ☐ Yes ☐ No	Mode Premium			
			Units/Amt						\$				
	Cash With Application _____ PAC Policies Transit Number _____ ☐ Checking Account Number _____ ☐ Savings Draft Date _____		Case Name		Case Number		Total Mode Premium: \$						
			Premiums/Billing Mode ☐ Monthly ☐ Semi-Monthly ☐ Bi-weekly ☐ Weekly ☐ Other		Requested Issue Date _____ Date of First Deduction _____								
	Remarks		Producer Number		Percentage Credit								
	Home Office Use												

NON-MEDICAL QUESTIONNAIRE		
All Coverages	1. Is the proposed insured actively at work now and has he/she 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?	☐ Yes ☐ No
IF QUESTION 1 ABOVE IS ANSWERED "NO" OR QUESTION 2-10 BELOW ARE ANSWERED "YES," PLEASE LIST THE REQUIRED HEALTH HISTORY IN QUESTION 11 BELOW.		
All Coverages	2. Has any person to be insured been tested positive for exposure to the HIV infection or been diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) caused by the HIV infection or other sickness or condition derived from such infection?	☐ Yes ☐ No
All Life & Critical Illness	3. Has any person to be insured smoked cigarettes in the last 12 months? If so, who? _____	☐ Yes ☐ No
All Select CGI & Heart/Stroke	4. Has any person to be insured been disabled or hospitalized in the last 6 months?	☐ Yes ☐ No
Simplified Issue Life \$150,000 Or Below	5. a) In the last 3 years, has any person to be insured: been treated by a licensed medical provider for a chronic disease (including but not limited to heart disorder, stroke, cancer, diabetes, etc.); been hospitalized; seen a physician (other than for colds, flu or normal pregnancy or a routine physical with no unfavorable results); or been counseled by a member of the medical profession or in an accredited alcohol or drug rehabilitation program for alcohol or any type of drugs? b) Is any person to be insured currently under the care of a physician? c) Has any person to be insured ever been rated or declined for life insurance?	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No
Cancer (policies and riders), SI Hosp. Ind. & Critical Illness	6. Is any person to be insured currently undergoing any diagnostic test for, now being treated for, or ever been treated by a licensed medical provider for, cancer or any malignancy which includes: carcinoma; sarcoma; Hodgkin's Disease; leukemia; lymphoma; or any malignant tumor?	☐ Yes ☐ No
Intensive Care Rider, SI Hosp. Ind. & Critical Illness	7. a) Is any person to be insured now being treated for, or ever been treated by a licensed medical provider for: a stroke; a heart attack; a heart condition; heart trouble; any abnormality of the heart (including artery disease); or diabetes? b) Has any person to be insured ever been diagnosed with hypertension or high blood pressure? c) If the answer to 7b is yes, in the last year has that person had a systolic blood pressure reading higher than 150 more than once or a diastolic blood pressure reading higher than 100 more than once?	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No
Simplified Issue Disability, Critical Illness & SI Sickness Riders to Accident Policy	8. a) Has any person to be insured, in the last 2 years, been treated for, or been told by a licensed medical provider that he/she has: diabetes, emphysema, asthma, 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, pancreas, or back (including neck); paralysis; optic neuritis; cancer (except basal cell skin cancer), malignant tumor, leukemia, Hodgkin's Disease; or stroke? b) Has any person to be insured ever been diagnosed with hypertension or high blood pressure? c) If the answer to 8b is yes, in the last year has that person 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 by a licensed medical provider 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 by a member of the medical profession for Alzheimer's disease, dementia, senility, or organic brain syndrome?	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No
SI Life & All SI Accident policies and riders	9. Has any person to be insured, in the last 3 years, had his/her driver's license suspended or revoked or been convicted of reckless or drunken driving and/or been involved in 3 or more motor vehicle accidents? If yes, provide additional details below.	☐ Yes ☐ No
Critical Illness	10. To the best of your knowledge and belief, has any person to be insured or ANY 2 of their natural parents or natural siblings been diagnosed by a licensed medical provider with the same disease before age 60, based on this list: heart disease, stroke, diabetes, cancer, kidney disease, or multiple sclerosis?	☐ Yes ☐ No
Required Health History (For Critical Illness, list primary physician's name, address and telephone number)	11. 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 Coverages	12. Replacement. Is this insurance to replace or change any existing life or health coverage? If yes, indicate product being replaced or changed and complete replacement form provided by your producer if required by your state.	☐ Yes ☐ No
All Coverages	13. Existing Insurance. Is there any other life, cancer, heart/stroke, disability, hospital, critical illness or accident insurance in force or applied for on proposed insured? If yes, list company name, policy number, year issued, type of coverage, and amount of benefit.	☐ Yes ☐ No

REPRESENTATION. I have read or had read to me the completed application and understand that the statements contained in this application are representations, not warranties and 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 Specifications page, 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.** I authorize any physician, medical practitioner, hospital, clinic or other medical facility, insurance company, the Medical Information Bureau or other organization, institution or person, 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.

FRAUD WARNING: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

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

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

Producer's Statement. 1. To your knowledge, is change or replacement involved? ☐ Yes ☐ No
2. 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 _____ Florida Agent License No. _____

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 Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS) will affect the issuance or the underwriting of this policy except, upon written consent, to be medically tested for HIV or AIDS and the results of such testing proved positive.

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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 P.O. Box 105, Essex Station, Boston, MA 02112, 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 Human Immunodeficiency Virus (HIV) or 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.

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