☐ New Policy ☐ Change/Increase Policy # _____

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.)	☐ Emp. ☐ Spouse ☐ Child ☐ 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					☐ Yes ☐ No	N/A	☐ Yes ☐ No
Spouse	S					☐ Yes ☐ No	N/A	☐ Yes ☐ No
Dependent						N/A	☐ Yes ☐ No	N/A
Dependent						N/A	☐ Yes ☐ No	N/A
Dependent						N/A	☐ Yes ☐ 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 _____ ☐ SI ☐ CGI	Face Amount	Riders	Rider	Rider	Rider	Rider	Rider	Rider	Rider	Mode Premium
	Death Benefit Option ☐ 1 ☐ 2	Units/Amt								$
Term Life _____ ☐ SI ☐ CGI	Face Amount _____	Riders	Rider	Rider	Rider	Rider	Rider	Rider	Rider	Mode Premium
		Units/Amt								$

Disability _____ ☐ SI ☐ CGI **Occupation Class** ☐ Preferred ☐ Standard	Monthly Salary $ _____	Elimination Period _____ Days Acc. _____ Days Sick.	On The Job Rider ☐ Yes ☐ No	Section 125 ☐ Yes ☐ No	Mode Premium $
	Monthly Benefit $ _____	Benefit Period _____ Months	Mental Disorder Rider ☐ Yes ☐ No		

Accident _____ (Plan Type and Units) ☐ SI ☐ CGI ☐ Individual ☐ Family	Monthly Salary $ _____	Rider APBER	Rider APEXT	Rider	Rider	Rider	Section 125 ☐ Yes ☐ No	Mode Premium $
	Rider Units							

PAC ☐ Checking ☐ Savings
Transit Number _____
Routing Number _____
Draft Date _____

Account Name	Account Number	Total Mode Premium: $ 0.00

Remarks

Premiums/Billing Mode
☐ Monthly ☐ Semi-Monthly ☐ Bi-weekly ☐ Weekly ☐ Other

Requested Issue Date _____

Date of First Deduction _____

Producer Number	Percentage Credit
Servicing Agent	%
	%
	%
	%
	%

IF QUESTIONS 1-4 BELOW ARE ANSWERED "YES," PLEASE LIST THE REQUIRED HEALTH HISTORY IN QUESTION 5 BELOW.		
All except Accident	1) Is any person to be insured now being treated, or ever been treated or diagnosed by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC), or has ever tested positive for antigens or antibodies to an AIDS virus?	☐ Yes ☐ 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?	☐ Yes ☐ No
SI Life & Disability	3) 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?	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No
SI Life	4) 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.	☐ Yes ☐ No
Required Health History	5) 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	6) 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?	☐ Yes ☐ No ☐ Yes ☐ No
All - Existing	7) **Proposed Insured.** If you are applying for the type of coverage listed above, is there any other (not listed in question 6) life, disability, 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.	☐ Yes ☐ 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.** 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 relating to the underwriting of insurance for which I am applying. 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. I or my representative may request a copy of this authorization. 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: _____

Allstate®

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. You may request the specific reason or reasons for an adverse underwriting decision, the identity source of that information and/or the specific items of personal or privileged information that support those reasons. 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.

IN/MIBMA-1 (03/09)

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 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.

IN/MIBMA-1 (03/09)

Allstate
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 (SHIIP).