☐ 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	Accident Rider ☐ Yes ☐ No Units _____ ☐ Individual ☐ Family	Section 125 ☐ Yes ☐ No
	Monthly Benefit $ _____	Benefit Period _____ Months			$

Cancer _____ (Plan Type) ☐ Individual ☐ Family	Riders	Rider	Rider	Rider	Rider	Rider		Section 125 ☐ Yes ☐ No	Mode Premium
	Units/Amts.								$
Accident _____ (Plan Type and Units) ☐ SI ☐ CGI ☐ Individual ☐ Family	Monthly Salary $_____	Rider APDIR	Rider APBER	Rider APEXT	Rider APOPTR1	Rider APHCR1		Section 125 ☐ Yes ☐ No	Mode Premium
	Rider Units								$

SHOP _____ Units: _____ **(Hospital Indemnity)** ☐ Individual ☐ Ind. & Children ☐ Ind. & Spouse ☐ Family ☐ SI ☐ CGI	Rider IHR1	Rider SAR1	Rider IPBR1	Rider OPBR1	Rider OEAR1	Rider AHNR	Rider TR1	Rider ADIR1	Rider	Section 125 ☐ Yes ☐ No	Mode Premium $
Critical Illness _____ ☐ Individual ☐ Family ☐ Single Parent Family Basic Benefit Amount:										Section 125 ☐ Yes ☐ No	Mode Premium $

PAC ☐ Checking ☐ Savings	Account Name	Account Number	Total Mode Premium: $
Transit Number _____ Routing Number _____ Draft Date _____			

Remarks	Premiums/Billing Mode ☐ Monthly ☐ Semi-Monthly ☐ Bi-weekly ☐ Weekly ☐ Other	Producer Number / Servicing Agent	Percentage Credit
	Requested Issue Date _____		%
	Date of First Deduction _____		%
			%
			%
			%

SI - Simplified Issue CGI - Contingent Guarantee Issue Insurance Plans - See your brochure/illustration for additional explanation of policies/riders

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), 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
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?	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No
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?	☐ Yes ☐ No ☐ Yes ☐ 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?	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ 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?	☐ Yes ☐ 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.	☐ Yes ☐ 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?	☐ Yes ☐ No ☐ Yes ☐ 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, 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. _____ _____	☐ Yes ☐ No
All Health	11) I have received an Outline of Coverage for each health coverage?	☐ Yes ☐ No
All Critical Illness	12) Do you currently have major medical coverage? If you answered "No", you may not apply for Critical Illness Coverage. **Critical Illness coverage should not be purchased as a replacement for any major medical policy.**	☐ 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 AND CRITICAL ILLNESS.** 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.

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 _____

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.

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

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

Date Signed: _____