PLEASE PRINT WITH BLACK INK

# APPLICATION FOR LIFE AND HEALTH INSURANCE TO:

**AMERICAN HERITAGE LIFE INSURANCE COMPANY**
1776 AMERICAN HERITAGE LIFE DRIVE
JACKSONVILLE, FLORIDA 32224-6687

| Proposed Insured (Last, First, M.I.) | ☐ Self ☐ Spouse ☐ Child ☐ Other | ☐ M ☐ F | Age | Birthdate | Height | Weight | Social Security Number |
|---|---|---|---|---|---|---|---|
| | | | | | | | |

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

| Employer | Occupation | Date Hired |
|---|---|---|
| | | |

| Payor (if other than Proposed Insured) | Social Security Number or Tax I.D. Number (Owner or Payor) |
|---|---|
| | |

| 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 |
|---|---|
| | |

## DEPENDENTS PROPOSED FOR COVERAGE

| Last Name | First Name | M.I. | Relationship | Date of Birth | Age | Sex |
|---|---|---|---|---|---|---|
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## INSURANCE PLANS

| Universal Life | Face Amount | Riders | Rider | Rider | Rider | Rider | Rider | Rider | Rider | Mode Premium |
|---|---|---|---|---|---|---|---|---|---|---|
| | Death Benefit Option ☐ 1 ☐ 2 | Units/Amt | | | | | | | | $ |

| Term Life | Face Amount | Riders | Rider | Rider | Rider | Rider | Rider | Rider | Rider | Mode Premium |
|---|---|---|---|---|---|---|---|---|---|---|
| | | Units/Amt | | | | | | | | $ |

| Cancer ☐ Individual ☐ Family | Riders | Rider | Rider | Rider | Rider | Rider | Mode Premium |
|---|---|---|---|---|---|---|---|
| Benefit / Plan: | Units/Amts. | | | | | | $ |

| Accident ☐ Individual ☐ Family | Monthly Salary $ | Rider APDIR | Rider APBER | Rider APEXT | Rider APOPTR1 | Rider APHCR1 | Mode Premium |
|---|---|---|---|---|---|---|---|
| Benefit / Plan: | Units | | | | | | $ |

| SHOP ☐ Individual ☐ Individual & Children ☐ Individual & Spouse ☐ Family | Base Plan | Rider IHR1 | Rider SAR1 | Rider IPBR1 | Rider OEAR1 | Rider OPBR1 | Rider AHNR | Rider TR1 | Rider ADIR1 | Rider SDIR1 | Mode Premium |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Benefit / Plan: | Units | Units | Units | Units | Units | Units | Units | Units | Units | Units | $ |

| Heart/Stroke ☐ Individual ☐ Family | Riders | Rider CIDR1 | Rider ICR | Rider WBR3 | Rider | Rider | Mode Premium |
|---|---|---|---|---|---|---|---|
| Units or Benefit Level: | Units/Amt | | | | | | $ |

Cash With Application ☐ Yes ☐ No

Premiums/Billing Mode ☐ Annual ☐ PAC

Total Mode Premium $

PAC Policies
☐ Checking
☐ Savings

Transit Number ____________________
Account Number ____________________
Draft Date ____________________

Home Office Use

Producer Number
____________________
____________________
____________________

Remarks

## NON-MEDICAL QUESTIONNAIRE

| Coverage | Question | Answer |
|---|---|---|
| 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? **(If no, please explain in question 11 below or on supplement on next page.)** | ☐ Yes ☐ No |

**IF ANY QUESTIONS 2-8 BELOW ARE ANSWERED "YES," PLEASE LIST THE REQUIRED HEALTH HISTORY IN QUESTION 11 BELOW.**
**The applicant does not have to disclose an HIV (AIDS virus) test which was administered: (1) to a criminal offender or crime victim as a result of a crime that was reported to the police; (2) to a patient who received the services of emergency medical services personnel at a hospital or medical care facility; (3) to emergency medical personnel who were tested as a result of performing emergency medical services. Refer to the Authorization below for a definition of "Emergency Medical Personnel."**

| Coverage | Question | Answer |
|---|---|---|
| All Coverages | 2. a) 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 Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?<br>b) Has any person to be insured ever had any new insurance or reinstatement limited, postponed, or declined; or claimed or been refused disability income benefits? | ☐ Yes ☐ No<br>☐ Yes ☐ No |
| All Life | 3. Has any person to be insured used tobacco in any form in the last 12 months?<br>If so, who and what type? ______ | ☐ Yes ☐ No |
| All Life | 4. a) In the last 3 years, has any person to be insured been seen by a physician (other than for colds, flu, normal pregnancy or a routine physical examination with no unfavorable results), been hospitalized, been disabled or treated for a disorder?<br>b) In the last 3 years, has any person to be insured had diagnostic or therapeutic procedure done?<br>c) In the last 3 years, has any person to be insured been counseled by a member of the medical profession for alcohol or any type of drugs? | ☐ Yes ☐ No<br>☐ Yes ☐ No<br>☐ Yes ☐ No |
| Cancer (Policies & Riders) & Life | 5. a) Is any person to be insured now being treated for, or ever been treated for, cancer or any malignancy which includes: carcinoma; sarcoma; Hodgkin's Disease; leukemia; lymphoma; or any malignant tumor?<br>b) Has any person to be insured had any medical or surgical procedures advised or recommended by a doctor but not done at this time? | ☐ Yes ☐ No<br>☐ Yes ☐ No |
| Heart/Stroke, ICU & Life | 6. a) Is any person to be insured now being treated for, or ever been treated for: a stroke; a heart attack; a heart condition; heart trouble; any abnormality of the heart (including artery disease); or diabetes?<br>b) Has any person to be insured in the past 5 years been diagnosed with hypertension or high blood pressure?<br>c) If the answer to 6b above 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<br>☐ Yes ☐ No<br>☐ Yes ☐ No |
| Hosp. Ind. (SHOP) & Sickness Riders to Accident Policy | 7. a) In the last 3 years, has any person to be insured had, been treated for, or been told by a member of the medical profession 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 (MD) or multiple sclerosis (MS); 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 a stroke?<br>b) Has any person to be insured in the past 5 years been diagnosed with hypertension or high blood pressure?<br>c) If the answer to 7b above 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?<br>d) Has any person to be insured, in the last 2 years, been treated for or counseled by a member of the medical profession for alcohol or drug abuse?<br>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?<br>f) Has any person to be insured received any advice, treatment, or consultation for Alzheimer's disease, dementia, senility, or organic brain syndrome?<br>g) Is any person to be insured pregnant at this time? | ☐ Yes ☐ No<br>☐ Yes ☐ No<br>☐ Yes ☐ No<br>☐ Yes ☐ No<br>☐ Yes ☐ No<br>☐ Yes ☐ No<br>☐ Yes ☐ No |
| Accident Policy | 8. In the last 3 years, has any person to be insured had his/her driver's license suspended or revoked or been convicted of reckless or drunken driving? If yes, provide additional details in #11 below. | ☐ Yes ☐ No |
| All Coverages | 9. **Replacement.** Is this insurance to replace or change any existing life or health coverage?<br>If yes, indicate product being replaced or changed and complete replacement form provided by your producer if required by your state.<br>______ | ☐ Yes ☐ No |
| All Coverages | 10. **Existing Insurance.** Is there any other life, cancer, heart/stroke, hospital, 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.<br>______<br>______ | ☐ Yes ☐ No |

| Required Health History (Please Supply Additional Information On Supplement On Next Page If Needed) | 11. Question# | Name | Disease or Injury-Dates | Duration | Result | Name & Address of Doctor |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |

**REPRESENTATION.** I have read or had read to me the completed application and understand that the statements contained in this applicaton are representations, not warranties and that any fraudulent or material 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 to the best of my knowledge and belief. • **UNDERSTANDING.** I understand that the "effective date" of the insurance coverage(s) will be the policy date recorded on the Policy Specifications page. **The effective date of the policy(ies) is not the date the application is signed.** If the policy(ies) is (are) not issued, American Heritage Life will refund any premiums it receives. I also understand that no producer 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.** This authorization excludes the release of information about HIV (AIDS Virus) tests which were administered (1) to a criminal offender or crime victim as a result of a crime that was reported to the police; (2) a patient who received the services of emergency medical services personnel at a hospital or medical care facility; (3) to emergency medical personnel who were tested as a result of performing emergency medical services. The term **"emergency medical personnel"** includes individuals employed to provide pre-hospital emergency services; licensed police officers, firefighters, paramedics; emergency medical technicians, licensed nurses, rescue squad personnel, or other individuals who serve as volunteers of an ambulance service who provide emergency medical services; crime lab personnel, correctional guards, including security guards at the Minnesota security hospital, who experience a significant exposure to an inmate who is transported to a facility for emergency medical care; and other persons who render emergency care or assistance at the scene of an emergency, or while an injured person is being transported to receive medical care and who would qualify for immunity under the good samaritan law. 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.**
1. To your knowledge, is change or replacement involved? ☐ Yes ☐ No
2. Did you receive money and give a Receipt for Cash with Application with this application? ☐ Yes ☐ No If yes, record amount here $______ .
3. 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 ______

## APPLICATION TO AMERICAN HERITAGE LIFE INSURANCE COMPANY
## NON-MEDICAL QUESTIONNAIRE - SUPPLEMENTAL EXPLANATIONS (CONT.)

Proposed Insured ______________________________

| Quest./# | Name | Disease or Injury - Dates | Duration | Result | Name & Address of Doctor |
|---|---|---|---|---|---|
| | | | | | |
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Other Explanations:

______________________________

______________________________

This supplements and is part of my application signed on the same date for the proposed insured above. The information above is true, complete and correctly recorded to the best of my knowledge and belief.

Date: ______________________

Signature of Proposed Insured ______________________ Signature of Owner if other than Insured______________________

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### RECEIPT FOR CASH WITH APPLICATION

1. All checks must be made payable to American Heritage Life Insurance Company. Do not make checks payable to the producer or leave the payee blank.
2. If your application is approved and accepted, your coverage will be effective on the date of final underwriting approval.
3. If your application is approved and accepted, the cash submitted with your application will be applied towards your first premium payment due for the coverage applied for.
4. If your application is approved and accepted, there is no coverage between the date of your application and the effective date of the policy.
5. This receipt is issued on the condition that any check or other method of payment is good and collectible. The deposit of your payment to our account does not guarantee acceptance for insurance.
6. If your application is denied, you will receive no coverage and your payment submitted with your application will be refunded to you.

I have read and explained this RECEIPT FOR CASH WITH APPLICATION to the applicant. I have received an amount of
$ ______________ from ______________________ which I will remit to the home office with the application for insurance.

Signature of Producer: ______________________ Date: ______________________

I have personally completed an application for an individually underwritten insurance policy. The producer has read and explained this RECEIPT FOR CASH WITH APPLICATION to me. I understand that I will not receive any insurance coverage unless my application is approved and accepted by American Heritage Life Insurance Company and a policy(ies) is (are) issued.

Signature of Applicant: ______________________Date:______________________

## PRODUCER INSTRUCTIONS

1. Complete the entire application to the extent appropriate for the coverage applied for.

2. Non-Medical Questionnaire - Always complete, even if a medical exam is required.

3. Medical History - If more space is needed to explain answers to the non-medical questions, use the reverse side of this page (top) and get additional signatures requested.

4. Multiple Plans Requested - You may use one application to apply for multiple products only if the primary insured and the owner are the same for all. Otherwise, use separate applications.

5. Signatures - Each proposed insured and the owner (if different) must sign.

6. MIB and Important Notice - Always give this to the applicant.

7. Receipt for Cash with Application - Give this only when the first full payment on the plan, mode of payment, and amount applied for is received. Read the terms of this receipt. Do not take money and give receipt without H.O. approval if life coverage exceeds $100,000. Also, don't give this receipt or take cash if Question 1 is answered "No" and/or any of the Questions 2, 4-8 are answered "Yes." Instead, mark as a trial application and take cash on delivery if issued.

8. Producer's Statement - Check the yes/no boxes appropriately and sign. Print your name legibly.

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### 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.

### 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, 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.

**IN/MIBMN-1 (03/07)**