

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.)		<input type="checkbox"/> Emp. <input type="checkbox"/> Spouse <input type="checkbox"/> M	Age	Birthdate	Height	Weight	Social Security Number
		<input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/> F					
Home Address			City	State	Zip	Home Phone Number	
Employer (if not same as case)				Occupation			Date Hired
Payor or Owner (if other than Proposed Insured)		<input type="checkbox"/> Payor <input type="checkbox"/> Owner	Social Security Number or Tax I.D. Number (Owner or Payor)				
Owner's 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

PLANS CANCELS SURVIVAL INSURANCE	Universal Life _____ <input type="checkbox"/> Simplified Issue <input type="checkbox"/> Select CGI	Face Amount _____	Life Riders	Rider	Rider	Rider	Rider	Rider	Rider	Rider	Rider	Mode Premium
		Death Benefit Option <input type="checkbox"/> 1 <input type="checkbox"/> 2	Units/Amt									\$
	Term Life _____ <input type="checkbox"/> Simplified Issue <input type="checkbox"/> Select CGI	Face Amount _____	Life Riders	Rider	Rider	Rider	Rider	Rider	Rider	Rider	Rider	Mode Premium
			Units/Amt									\$
	Disability _____ <input type="checkbox"/> Simplified Issue <input type="checkbox"/> Select CGI Occupation Class <input type="checkbox"/> Preferred <input type="checkbox"/> Standard	Monthly Salary \$ _____	Elimination Period _____ Days Acc. _____ Days Sick.	On The Job Rider <input type="checkbox"/> Yes <input type="checkbox"/> No	Accident Rider <input type="checkbox"/> Yes <input type="checkbox"/> No Units _____ <input type="checkbox"/> Individual <input type="checkbox"/> Family	Section 125 <input type="checkbox"/> Yes <input type="checkbox"/> No	Mode Premium					
		Monthly Benefit \$ _____	Benefit Period _____ Months				\$					
	Cancer _____ (Units or Benefit Package) <input type="checkbox"/> Individual <input type="checkbox"/> Family	Cancer Riders	Rider	Rider	Rider	Rider	Rider	Section 125 <input type="checkbox"/> Yes <input type="checkbox"/> No	Mode Premium			
		Units/Amts.						\$				
	Accident _____ (Units or Benefit Package) <input type="checkbox"/> Simplified Issue <input type="checkbox"/> Select CGI <input type="checkbox"/> Individual <input type="checkbox"/> Family	Monthly Salary \$ _____	Rider	Rider	Rider	Rider	Rider	Section 125 <input type="checkbox"/> Yes <input type="checkbox"/> No	Mode Premium			
		Rider Units						\$				
Hospital Indemnity _____ Units: _____ <input type="checkbox"/> Simplified Issue <input type="checkbox"/> Individual <input type="checkbox"/> Ind. & Children <input type="checkbox"/> Select CGI <input type="checkbox"/> Ind. & Spouse <input type="checkbox"/> Family	Rider IHR1	Rider SAR1	Rider IPBR1	Rider OPBR1	Rider OEAR1	Rider AHNR	Rider TR1	Rider ADIR1	Rider SDIR1	Section 125 <input type="checkbox"/> Yes <input type="checkbox"/> No	Mode Premium	
										\$		
Heart/Stroke _____ <input type="checkbox"/> Individual <input type="checkbox"/> Family	HSP2 Riders	Rider	Rider	Rider	Rider	Rider	Section 125 <input type="checkbox"/> Yes <input type="checkbox"/> No	Mode Premium				
Units or Benefit Level:	Units/Amt						\$					
Critical Illness _____ <input type="checkbox"/> Individual <input type="checkbox"/> Family <input type="checkbox"/> Single Parent Family	CI Riders	Rider	Rider	Rider	Rider	Rider	Section 125 <input type="checkbox"/> Yes <input type="checkbox"/> No	Mode Premium				
Basic Benefit Amount:	Units/Amt						\$					
Cash With Application _____ PAC Policies Transit Number _____ <input type="checkbox"/> Checking Account Number _____ <input type="checkbox"/> Savings Draft Date _____	Case Name _____		Case Number _____		Total Mode Premium: \$ _____							
	Premiums/Billing Mode <input type="checkbox"/> Monthly <input type="checkbox"/> Semi-Monthly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Weekly <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
IF ANY QUESTIONS 2-10 BELOW ARE ANSWERED "YES," PLEASE LIST THE REQUIRED HEALTH HISTORY IN QUESTION 11 BELOW.		
All Coverages	2. 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
All Life & Critical Illness	3. Has any person to be insured smoked cigarettes in the last 12 months? If so, who? _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
All Select CGI (Life, Hosp. Ind., Disability & Accident)	4. Has any person to be insured been disabled or hospitalized in the last 6 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Simplified Issue Life \$150,000 Or Below	5. a) In the last 3 years, has any person to be insured: had 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 for or excessively used 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> 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 for, cancer or any malignancy which includes: carcinoma; sarcoma; Hodgkin's Disease; leukemia; lymphoma; or any malignant tumor?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart/Stroke, ICU, SI Hosp. Ind. & Critical Illness	7. 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? 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
Simplified Issue Disability, Critical Illness & SI Sickness Riders to Accident Policy (Use Supplement for Disability Over \$3,000)	8. a) Has any person to be insured, in the last 2 years, 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 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 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
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 arrested for reckless or drunken driving and/or been involved in 3 or more motor vehicle accidents? If yes, provide additional details below.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Critical Illness	10. 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?	<input type="checkbox"/> Yes <input type="checkbox"/> 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 _____ <p align="center">Use additional paper if needed</p>	
All Coverages	12. Replacement. Is this insurance to replace or change any existing life or health coverage? If yes, complete replacement form provided by your producer if required by your state.	<input type="checkbox"/> Yes <input type="checkbox"/> 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. _____ _____	<input type="checkbox"/> Yes <input type="checkbox"/> 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. **FRAUD WARNING:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. • **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 or until I have cancelled the policy or I am no longer covered under the policy. 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. Yes No To your knowledge, does the proposed insured have existing coverage in force? Yes No To your knowledge, is change or replacement involved? 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 _____

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.

IN/MIB (01/03)**Allstate**[®]

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. #617-426-3660. 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/MIB (01/03)