AMERICAN HERITAGE LIFE INSURANCE COMPANY (AHL)

1776 AMERICAN HERITAGE LIFE DRIVE
JACKSONVILLE, FLORIDA 32224

ENROLLMENT AND EVIDENCE OF INSURABILITY FORM

☐ New Certificate ☐ Change/Increase Certificate # _____

Remarks:	This box for AHL Home Office use only

GENERAL INFORMATION

Employee's/Payor's/Owner's (Certificateholder) Name (Last, First, M.I.)	☐ M ☐ F	Social Security Number	
Residence Address	City	State	Zip
Date of Birth / Phone Number	Email		
Employer/Association/Union / Date Hired	Occupation	Plant Or Division	
Primary Beneficiary's Full Name and Address / City / State / Zip	Relationship		
Phone Number / Date of Birth	Social Security Number		
Contingent Beneficiary's Full Name and Address / City / State / Zip	Relationship		
Phone Number / Date of Birth	Social Security Number		

COMPLETE THIS SECTION FOR PERSONS TO BE INSURED

Last Name	First Name	Relationship	Sex	Date of Birth	Social Security Number	Tobacco Use* (Life or Critical Illness)
		Employee				** ☐ Yes ☐ No
		Spouse				** ☐ Yes ☐ No
						^ ☐ Yes ☐ No
						^ ☐ Yes ☐ No
						^ ☐ Yes ☐ No

***Has any adult (19 and older) person to be insured used tobacco in the last 12 months? (**If applying for Life or Critical Illness. ^For dependents ages 19 and older, if applying for Life.)**

Are you applying for coverage or changing existing coverage due to a qualifying event?

Accident	☐ Yes ☐ No	**Disability (STD)**	☐ Yes ☐ No
Cancer/Specified Disease	☐ Yes ☐ No	**Hospital Indemnity**	☐ Yes ☐ No
Critical Illness	☐ Yes ☐ No	**Term Life**	☐ Yes ☐ No
Dental	☐ Yes ☐ No	**Universal Life**	☐ Yes ☐ No

If "Yes", check the qualifying event:

☐ Marriage	☐ Spouse/Dependent Child Death	☐ Newly Eligible
☐ Divorce	☐ Eligible/Ineligible Child	☐ Termination
☐ Birth/Adoption	☐ Spouse New Job/Job Loss	☐ Employee Death

Date of Qualifying Event _____ Current Certificate Number(s) _____

Do you currently have any of the following Individual coverages with American Heritage Life Insurance Company (AHL)?
Accident ☐ Yes ☐ No Cancer ☐ Yes ☐ No Critical Illness ☐ Yes ☐ No Disability ☐ Yes ☐ No
Hospital Indemnity ☐ Yes ☐ No

If you answered "Yes" to any of the coverages, please enter the Policy Number _____

Do you wish to terminate this coverage? ☐ Yes ☐ No If "Yes", please enter effective date of termination _____

ENROLLMENT AND EVIDENCE OF INSURABILITY FORM

Premium/Billing Mode ☐ Monthly ☐ Semi-monthly ☐ Bi-weekly ☐ Weekly ☐ Other Date of First Deduction _____ Coverage Effective Date _____	Account Number	Employee ID	Situs State

SELECTION OF COVERAGE

(Answer Yes or No and complete for each coverage selected)

Accident (GVAP6) On and Off the Job Accident ☐ Yes ☐ No Off the Job Accident ☐ Yes ☐ No	Base Units ____	☐ Employee Only ☐ Employee+Spouse ☐ Employee+Child(ren) ☐ Family	Section 125 ☐ Yes ☐ No	Total Mode Premium $_____	**Home Office Use Only**

☐ Accident Treatment & Urgent Care Rider **Units** ____	☐ Dislocation/Fracture Rider **Units** ____
☐ Emergency Room Services Rider **Units** ____	☐ Benefit Enhancement Rider **Units** ____
☐ Outpatient Physician's Rider **Units** ____	☐ Accidental Death, Dismemberment and Functional Loss Rider **Units** ____

Accident (GVAP2) (Off the Job Accident) ☐ Yes ☐ No	Base Units ____	☐ Employee Only ☐ Employee+Spouse ☐ Employee+Child(ren) ☐ Family	Section 125 ☐ Yes ☐ No	Total Mode Premium $_____	**Home Office Use Only**

☐ Benefit Enhancement Option **Units** ____	☐ Family Fracture Option	☐ Outpatient Physician's Rider **Units** ____

Layoff Rider: ☐ Premium Refund Upon Layoff Rider **(Not available on Section 125 plans)**

Accident (GVAP1) (On and Off the Job Accident) ☐ Yes ☐ No	Base Units ____	☐ Employee Only ☐ Employee+Spouse ☐ Employee+Child(ren) ☐ Family	Section 125 ☐ Yes ☐ No	Total Mode Premium $_____	**Home Office Use Only**

☐ Benefit Enhancement Rider **Units** ____	☐ Family Fracture Option

Optional Disability Riders for Employee ☐ Off the Job Accident ☐ Off the Job Accident and Sickness ☐ On and Off the Job Accident ☐ On and Off the Job Accident and Sickness	Employee Monthly Salary $_____	Rider Units _____
Optional Disability Riders for Spouse ☐ On and Off the Job Accident for Insured Spouse* ☐ On and Off the Job Accident and Sickness for Insured Spouse* ***Available only when Employee + Spouse or Family coverage is selected and the insured spouse has worked 20 hours per week for 3 or more consecutive months.**	Spouse Monthly Salary $_____	Rider Units _____

Layoff Rider: ☐ Premium Refund Upon Layoff Rider **(Not available on Section 125 plans)**

Cancer/Specified Disease (GVCP3) ☐ Yes ☐ No	☐ Employee Only ☐ Employee+Spouse ☐ Employee+Child(ren) ☐ Family	Section 125 ☐ Yes ☐ No	Total Mode Premium $_____	**Home Office Use Only**

Benefits	Hospital	Radiation / Chemotherapy	Surgery Related	Misc.	☐ Cancer Initial Diagnosis Option	☐ Cancer Progressive Benefit Option	☐ Intensive Care Option	☐ Wellness Option
Units				1				

Layoff Rider: ☐ Premium Refund Upon Layoff Rider **(Not available on Section 125 plans)**

ENROLLMENT AND EVIDENCE OF INSURABILITY FORM

SELECTION OF COVERAGE

(Answer Yes or No and complete for each coverage selected)

Cancer/Specified Disease (GVCP2) ☐ Yes ☐ No	Plan ____	☐ Employee Only ☐ Family	Section 125 ☐ Yes ☐ No	Total Mode Premium $_____	**Home Office Use Only**

Benefits	Hospital	Radiation / Chemotherapy	Surgery Related	Misc.	☐ Cancer Initial Diagnosis Option	☐ Intensive Care Option	☐ Cancer Screening Option
Units				1			

Critical Illness (GVCIP2) ☐ Yes ☐ No	☐ Employee Only ☐ Employee+Spouse ☐ Employee+Child(ren) ☐ Family	Section 125 ☐ Yes ☐ No	Total Mode Premium $_____	**Home Office Use Only**

Basic Benefit Amount $_____	☐ No Pre-Existing Option	☐ 2nd Event Cancer Critical Illness Option	☐ 2nd Evaluation Benefit Rider	☐ Supplemental Critical Illness Option I (HIV)

☐ Supplemental Critical Illness Option II	☐ Increasing Critical Illness Benefit Units _____	☐ Wellness Option Units _____	☐ Cancer Critical Illness Option	☐ 2nd Event Initial Critical Illness Option	☐ Chronic Illness Critical Illness Rider ☐ 90 days ☐ 365 days

Layoff Rider: ☐ Premium Refund Upon Layoff Rider **(Not available on Section 125 plans)**

Critical Illness (GVCIP1) (My Lifeline) ☐ Yes ☐ No	☐ Employee Only ☐ Employee+Spouse ☐ Employee+Child(ren) ☐ Family	Section 125 ☐ Yes ☐ No	Total Mode Premium $_____	**Home Office Use Only**

Basic Benefit Amount $_____ If covered, Basic Benefit Amount for spouse or other dependents is 50% of the employee's.	☐ Critical Illness Cancer Option	☐ Recurrence Option	☐ Wellness Option Units _____	☐ 2nd Evaluation Benefit Rider

Disability (Short-Term) (GVDIP) (My Lifeline) ☐ Yes ☐ No	Monthly Salary $_____	Monthly Benefit $_____	Section 125 ☐ Yes ☐ No	Total Mode Premium $_____	**Home Office Use Only**

Elimination Period Days Acc. _____ Days Sick. _____	Benefit Period Months _____

Rider	Family Medical Leave & Doula Services Rider	Increasing Benefit Period Rider	Premium Refund Upon Layoff Rider*	On-the-Job Accident Disability Rider	Survivor & Accident Rider	Rider	Rider
Rider/Units/ Benefit Amount	☐ _____	☐ _____	☐ _____	☐ _____	☐ _____	☐ _____	☐ _____

***Not available on Section 125.**

A. Is this insurance to replace any existing disability coverage? ☐ Yes ☐ No

If yes, provide the Company Name _____

B. Is there any other disability insurance in force or applied for that will continue after the effective date of this coverage? ☐ Yes ☐ No
If yes, complete the following:

Company Name _____ Year Issued _____

Monthly Benefit $_____ Elimination Period _____ Benefit Period _____

ENROLLMENT AND EVIDENCE OF INSURABILITY FORM

SELECTION OF COVERAGE

(Answer Yes or No and complete for each coverage selected)

Hospital Indemnity (GVSP1) ☐ Yes ☐ No	☐ Employee Only ☐ Employee+Spouse ☐ Employee+Child(ren) ☐ Family	Section 125 ☐ Yes ☐ No	Total Mode Premium $_____	**Home Office Use Only**

Benefits	Hospital Related	Surgery / Inpatient Physician	Outpatient Related	☐ Diagnostic / Wellness Option	☐ Prescription Drug Option	☐ Disability Rider	☐ Life Rider
Units						1	

Layoff Rider: ☐ Premium Refund Upon Layoff Rider **(Not available on Section 125 plans)**

Heritage Choice Dental ☐ Yes ☐ No	☐ Plan 1 ☐ Plan 4 ☐ Plan 2 ☐ Plan 5 ☐ Plan 3	☐ Employee Only ☐ Employee+Spouse ☐ Employee+One Child ☐ Family	Section 125 ☐ Yes ☐ No	Total Mode Premium $_____

Were you covered under your Employer's prior Dental Plan? ☐ Yes ☐ No If "Yes", please enter the date coverage effective _____	**Home Office Use Only**

ENROLLMENT AND EVIDENCE OF INSURABILITY FORM

SELECTION OF COVERAGE

(Answer Yes or No and complete for each coverage selected)

Abbreviations: CGI - Contingent Guaranteed Issue GI - Guaranteed Issue SI - Simplified Issue

Life ☐ Universal Life (UL) ☐ Term Life ☐ Yes ☐ No ☐ CGI ☐ GI (Employee only) ☐ SI	Face Amount $_____	Total Mode Premium $_____	**Home Office Use Only**

Death Benefit Option ☐ 1 ☐ 2 (UL ONLY)	Employee's Annual Salary $_____

Life Riders	Rider	Rider	Rider	Rider	Rider	Rider	Rider	Rider
Units/Amt								

If this coverage is for your spouse, your child or grandchild, complete this section.

Name (Last, First, M.I.)	☐ Spouse ☐ Child* ☐ Grandchild*	☐ M ☐ F	Social Security Number	Date of Birth

Residence Address	City	State	Zip

Occupation	Employer	Annual Salary $_____	Phone Number

Owner's (Certificateholder's) Name and Residence Address (if other than Employee)	City	State	Zip

Primary Beneficiary's Full Name and Address	City	State	Zip	Relationship

Phone Number	Date of Birth	Social Security Number

Contingent Beneficiary's Full Name and Address	City	State	Zip	Relationship

Phone Number	Date of Birth	Social Security Number

*Is the Child or Grandchild proposed for coverage a full time student? ☐ Yes ☐ No
If the answer is no and the Child or Grandchild is 19 or over, is he or she actively at work now, for wage or profit, and has he/she worked at least 20 hours each week performing all duties of his/her regular occupation at his/her regular place of employment for at least the last 3 months except for minor illness or injury of 1 week or less, or normal pregnancy? ☐ Yes ☐ No

Replacement and Existing Insurance Section (Must Answer)

1a. Replacement. Proposed Insured. Is this insurance to replace or change any existing life coverage? If yes, indicate product being replaced or changed and complete replacement form provided by your producer, if required by your state.	☐ Yes ☐ No
1b. Producer. To your knowledge, is change or replacement involved?	☐ Yes ☐ No
2a. Existing Insurance. Proposed Insured. Is there any other (not listed in Question 1a.) life insurance in force or applied for on the proposed insured? If yes, list company name, policy number, year issued, type of coverage, and amount of benefit.	☐ Yes ☐ No
2b. Producer. To your knowledge, does the proposed insured have existing coverage in force?	☐ Yes ☐ No

Illustration Regulation Certification

3a. Illustration Certification. Owner. The owner certifies that no illustration conforming to the coverage applied for was provided, but that an illustration conforming to the coverage issued will be provided upon delivery of the certificate. If no, complete the applicable illustration certification form provided, if required in your state.	☐ Yes ☐ No
3b. Producer. The Producer certifies that no illustration conforming to the coverage applied for was provided, but that an illustration conforming to the coverage issued will be provided upon delivery of the certificate. If no, complete the applicable illustration certification form provided, if required in your state.	☐ Yes ☐ No

ENROLLMENT AND EVIDENCE OF INSURABILITY FORM

EVIDENCE OF INSURABILITY

(Please complete each question applicable to coverages selected.)
Abbreviations: EE - Employee SP - Spouse CH - Child(ren) Y - Yes N - No

Eligibility Question			EE	SP	CH
Accident w/ Sickness DI Rider, Cancer, Critical Illness, Dental, Disability, Hospital Indemnity, GI, CGI & SI Life	**1.**	Is the employee and the employee's spouse if applying for life and/or accident with sickness disability rider actively at work now, for wage or profit, and has he/she worked at least 20 hours each week performing all duties of his/her regular occupation at his/her regular place of employment for at least the last 3 months except for minor illness or injury of 1 week or less, or normal pregnancy?	☐Y ☐N	☐Y ☐N	N/A
If any of the questions below are answered "yes", please list the required health history on page 8.					
Underwriting Questions			**EE**	**SP**	**CH**
Accident w/ Sickness DI Rider, Cancer, Critical Illness, Disability, Hospital Indemnity, CGI & SI Life	**2.**	Has any person to be insured, in the last 5 years, been diagnosed with or treated by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS), or AIDS Related Complex (ARC), or tested positive for antigens or antibodies to an AIDS virus?	☐Y ☐N	☐Y ☐N	☐Y ☐N
CGI Life	**3.**	Has any person to be insured, in the last 6 months, been disabled or hospitalized for anything other than normal pregnancy, lacerations or broken bones due to an accident?	☐Y ☐N	☐Y ☐N	☐Y ☐N
SI Life	**4.**	Has any person to be insured, in the last 2 years, been diagnosed or treated by a member of the medical profession for any of the following? • Anemia (other than iron deficiency) • Anxiety, depression or other mental or nervous illness (that would include hospitalizations, disability from work, or suicide attempts) • Asthma (other than taking non-steroidal medication as needed with no hospitalizations), or any other lung disorder • Cancer, except basal cell carcinoma • Diabetes • Epilepsy with a seizure • Heart attack, cardiomyopathy, congestive heart failure, heart murmur (and taking medication(s)), angioplasty, coronary artery bypass surgery, coronary artery disease, stent, pacemaker, heart valve replacement or any other heart disorder • Hemophilia • Hepatitis • Kidney Disease involving dialysis or chronic renal failure • Liver Disease • Lou Gehrig's Disease (ALS) • Lupus • Multiple Sclerosis • Muscular Dystrophy • Parkinson's Disease, scleroderma, polymyositis, or fibromyalgia • Stroke including aneurysm, transient ischemic attack (TIA), or arteriovenous malformation • Transplant of any organ • Counseling for, or excessive use of, alcohol or any type of drugs	☐Y ☐N	☐Y ☐N	☐Y ☐N
Accident w/ Sickness DI Rider, Cancer w/ Intensive Care Option, Critical Illness, Disability, Hospital Indemnity & SI Life	**5.**	Has any person to be insured, in the last year, been diagnosed by a member of the medical profession with a systolic blood pressure reading higher than 150 more than once or a diastolic blood pressure reading higher than 100 more than once?	☐Y ☐N	☐Y ☐N	☐Y ☐N
SI Life	**6.**	Has any person to be insured, in the last 3 years: had his/her driver's license suspended or revoked; been convicted of reckless or drunken driving; or been involved in 3 or more motor vehicle accidents?	☐Y ☐N	☐Y ☐N	☐Y ☐N
Cancer, Cancer Initial Diagnosis Option, Cancer Progressive Benefit Option, Critical Illness Cancer Option & Hospital Indemnity	**7a.**	Has any person to be insured ever been diagnosed with or treated by a member of the medical profession for any type of cancer, other than basal cell carcinoma?	☐Y ☐N	☐Y ☐N	☐Y ☐N
	7b.	If the answer to 7a. is yes, has that person(s) been diagnosed with or treated by a member of the medical profession for Leukemia, Hodgkin's Disease, Lymphoma, or Cancer with any lymph node involvement or more than one metastasis?	☐Y ☐N	☐Y ☐N	☐Y ☐N
	7c.	If the answer to 7a. is yes, has that person(s), in the last 5 years, been diagnosed with or treated by a member of the medical profession for any other type of cancer (other than those listed in 7b. and/or basal cell carcinoma)?	☐Y ☐N	☐Y ☐N	☐Y ☐N

ENROLLMENT AND EVIDENCE OF INSURABILITY FORM

EVIDENCE OF INSURABILITY

(Please complete each question applicable to coverages selected.)

Abbreviations: EE - Employee SP - Spouse CH - Child(ren) Y - Yes N - No

If any of the questions below are answered "yes", please list the required health history on page 8.

	Underwriting Questions (Continued)	EE	SP	CH
Accident w/ Sickness DI Rider, Critical Illness & Disability	**8.** Has any person to be insured, in the last 2 years, had or been diagnosed with or treated by a member of the medical profession for any of the following? • Central Nervous System Disease or disorder (to include Multiple Sclerosis or Muscular Dystrophy) • Chronic Fatigue Syndrome • Diabetes • Emphysema • Fibromyalgia • Heart Disease • Liver Disease • Lung Disease • Lupus • Optic Neuritis • Parkinson's Disease • Paralysis • Rheumatoid Arthritis	☐Y ☐N	☐Y ☐N	☐Y☐N
Accident w/ Sickness DI Rider & Disability	**9.** Has any person to be insured, in the last 2 years, had or been diagnosed with or treated by a member of the medical profession for any of the following? • Counseling for alcohol or drug abuse • Pancreas Disease	☐Y ☐N	☐Y ☐N	☐Y☐N
Accident w/ Sickness DI Rider & Disability	**10.** Has any person to be insured, in the last 2 years, had any disease, impairment of, or treatment by a member of the medical profession (other than minor illness) for the following? • Any disorder of the back or neck • Asthma	☐Y ☐N	☐Y ☐N	☐Y☐N
Cancer w/ Intensive Care Option & Hospital Indemnity	**11.** Has any person to be insured, in the last 5 years, been diagnosed with or treated by a member of the medical profession for a stroke or transient ischemic attack (TIA), a heart attack, a heart condition, heart trouble, any abnormality of the heart, or any artery disease?	☐Y ☐N	☐Y ☐N	☐Y☐N
Accident w/ Sickness DI Rider, Critical Illness, Disability, Hospital Indemnity & SI Life	**12.** Has any person to be insured, in the last 5 years, had any medical or surgical procedures (including organ transplant) advised or recommended by a member of the medical profession, but not done at this time?	☐Y ☐N	☐Y ☐N	☐Y☐N
Chronic Illness Critical Illness Rider & Critical Illness Supplemental Benefits Option	**13.** Has any person to be insured, in the last 5 years, been diagnosed with or received any advice, treatment or consultation by a member of the medical profession for any of the following? • Alzheimer's Disease, dementia, senility or organic brain syndrome • Macular degeneration, glaucoma, optic neuritis, or cataracts • An average hearing threshold sensitivity for air conduction of 40 decibels or greater	☐Y ☐N	☐Y ☐N	☐Y☐N
Chronic Illness Critical Illness Rider	**14.** Has any person to be insured, in the last 2 years, had or been diagnosed with or treated by a member of the medical profession for any of the following? • Addison's Disease • Benign Brain Tumor • Huntington's Disease • Osteomyelitis • Osteoporosis • Lou Gehrig's Disease (ALS)	☐Y ☐N	☐Y ☐N	☐Y☐N
Cancer	**15.** Has any person to be insured ever been diagnosed with or treated by a member of the medical profession for any of the following? • Addison's Disease • Brucellosis • Cerebrospinal meningitis • Cystic Fibrosis • Encephalitis • Hansen's Disease • Hepatitis (Chronic B or Chronic C with liver failure or hepatoma) • Legionnaires' Disease • Lou Gehrig's Disease (ALS) • Lyme Disease • Muscular Dystrophy • Multiple Sclerosis • Myasthenia Gravis • Osteomyelitis • Primary Biliary Cirrhosis • Primary Sclerosing Cholangitis • Reye's Syndrome • Rocky Mountain Spotted Fever • Sickle Cell Anemia • Systemic Lupus Erythematosus • Tetanus • Tuberculosis • Thalassemia • Tularemia • Typhoid Fever	☐Y ☐N	☐Y ☐N	☐Y☐N
Disability & Hospital Indemnity	**16.** Is any person to be insured currently pregnant or undergoing fertility treatment?	☐Y ☐N	☐Y ☐N	☐Y☐N

ENROLLMENT AND EVIDENCE OF INSURABILITY FORM

EVIDENCE OF INSURABILITY

(Please complete each question applicable to coverages selected.)

Abbreviations: EE - Employee SP - Spouse CH - Child(ren) Y - Yes N - No

If any of the questions below are answered "yes", please list the required health history on page 8.	
Underwriting Questions (Continued)	
Height and Weight	**17.** Provide Height and Weight Employee (Accident w/Sickness DI Rider, Cancer w/Intensive Care Option, Critical Illness, Disability, Hospital Indemnity, and SI Life): Height:____ ft. ____ in. Weight: ____ lbs. Spouse (Accident Sickness Rider and Critical Illness): Height:____ ft. ____ in. Weight: ____ lbs.
Critical Illness (over $50,000) & SI Life (over $150,000)	**18.** Provide the names and addresses of all physicians (or other members of the medical profession) for each person to be insured; the required health history section may be used if additional space is needed.
Required Health History	**19.** Provide health history for any "Yes" answers to the Underwriting questions. Include physician's (or other members of the medical profession) name, address and telephone number:

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: if premiums for the coverage(s) is (are) to be paid by payroll deductions, these deductions may start before the "effective date" of coverage(s) and that this does not change the effective date of coverage; and the “effective date” for health insurance coverages will be the date recorded on the policy/certificate/benefit statement, not the date the application is signed. If the coverage(s) 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 AHL in any way by making any promise or representation that is not set out in writing in this application. I understand that if I refuse any coverage for which I am eligible, satisfactory proof of insurability may be required, at my own expense, should I desire to apply for it at a later date. Any such application may be declined on the basis of such proof. **PREMIUM DEDUCTION AUTHORIZATION. I AUTHORIZE** my employer to deduct from my salary or wages, if applicable, the necessary premium for the coverages requested. **AUTHORIZATION TO OBTAIN AND DISCLOSE CERTAIN DATA (FOR SI LIFE AND CRITICAL ILLNESS)**. I authorize any physician, medical practitioner, hospital, clinic or other medical facility, Pharmacy Benefit Managers, insurance company, MIB, Inc. or other organization, institution or person, that has records or knowledge of me or my health including my prescription medication history to give to AHL, its subsidiaries or its reinsurers any information. I also authorize AHL, or its reinsurers, to make a brief report of my health information to MIB, Inc. I understand that there is a possibility of redisclosure of any information disclosed pursuant to this authorization and that information, once disclosed, may no longer be protected by federal rules governing privacy and confidentiality. 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 24 months from the date signed. I understand that I may revoke this authorization at any time by notifying AHL 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 _____

Signature of Employee/Payor, if not Insured or Owner _____

Producer’s Statement. I certify that to the best of my knowledge and belief the information on this form is complete, accurate and correctly recorded.

Signature of Soliciting Producer _____ Print Soliciting Producer Name _____

To be completed by home office or producer, prior to issue:

Producer Name	Producer Number	National Producer Number (NPN)	Percentage Credit
Servicing Producer:			%
Soliciting Producer:			%
			%
			%
			%

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. You may request to be interviewed in connection with the report and may also receive a copy of the report upon request. This inquiry includes information as to your character, general information and personal characteristics. In certain limited circumstances, we are allowed by law to disclose necessary items of personal information to third parties without your specific authorization. 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.

IN/MIB-3 **(2012)**

MIB Notice:

Information regarding your insurability is treated as confidential. We or our reinsurers may, however, make a brief report to MIB, Inc. (MIB), a not-for profit membership organization of life insurance companies, which operates an information exchange for its members. If you apply to another MIB member company for life or health insurance coverage or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file. Upon receipt of a request from you, MIB arranges disclosure of any information it may have in your file. If you question the accuracy of information in the MIB file, contact MIB and seek a correction in accordance with the procedure set forth in the Federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734, PH. #866-692-6901. 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/MIB-3 **(2012)**

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).

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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 only when you are treated for one of the specific diseases or health conditions listed in the policy. 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
- hospice
- 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).

AWD3431-1

AMERICAN HERITAGE LIFE INSURANCE COMPANY
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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 pays a fixed dollar amount, regardless of your expenses, for each day you meet the policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when:

- any expenses or services covered by the policy are also covered by Medicare

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
- hospice
- 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).

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