☒ Producer Assisted ☐ New Policy ☐ Change/Increase Policy #_____

APPLICATION FOR LIFE AND HEALTH INSURANCE TO: American Heritage Life Insurance Company (AHL) 1776 American Heritage Life Drive, Jacksonville, Florida 32224

EMPLOYEE INFORMATION

Employee/Payor Name (if other than Proposed Insured)	Employee Date of Birth	Employee/Payor Social Security Number	Employee I.D. Number	Date Hired

PROPOSED INSURED INFORMATION

Proposed Insured Name (Last, First, M.I.)	☐ M ☐ F	☐ Employee ☐ Spouse ☐ Child ☐ Other	Social Security Number

Residence Address	City	State	Zip	Phone Number

Employer	Occupation
USPS	

Owner Name and Address (if different than Proposed Insured)	City	State	Zip	Owner Phone Number

Owner Date of Birth (if different than Proposed Insured)	Owner Social Security Number or Tax I.D. Number (if different than Proposed Insured)	Owner Email Address

Primary Beneficiary Name (Last, First, M.I.) and Address	City	State	Zip	Relationship	Phone Number	Date of Birth	Social Security Number
Contingent Beneficiary Name (Last, First, M.I.) and Address	City	State	Zip	Relationship	Phone Number	Date of Birth	Social Security Number

COMPLETE THIS SECTION FOR PERSONS TO BE INSURED

Relationship to Employee	Last Name	First Name	Date of Birth	Sex	Relationship	Actively at Work*	Full Time Student^	Has any adult (19 and older) person to be insured used tobacco in the last 12 months?
Employee					Employee	☐ Yes ☐ No	N/A	**☐ Yes ☐ No
Spouse					Spouse	☐ Yes ☐ No	N/A	**☐ Yes ☐ No
Dependent						^☐ Yes ☐ No	☐ Yes ☐ No	^☐ Yes ☐ No
Dependent						^☐ Yes ☐ No	☐ Yes ☐ No	^☐ Yes ☐ No
Dependent						^☐ Yes ☐ No	☐ Yes ☐ No	^☐ Yes ☐ No

*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? ^For dependents ages 19 and older, if applying for Life policy. **If applying for Life or Critical Illness.

INSURANCE PLANS

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

Accident _____ ☐ GI ☐ CGI ☐ SI (Plan Type and Units)	☐ AP2 ☐ AP6 ☐ AP3	☐ Individual ☐ Individual & Children ☐ Individual & Spouse ☐ Family	Monthly Salary $_____	Section 125 ☐ Yes ☐ No	Mode Premium $_____

Riders	Rider APDIR	Rider APEXT	Rider APHCR	Rider BER	Rider OPTR	Rider AP6DF	Rider AP6AUC	Rider AP6ERS	Rider AP6ADD
Units/Amt									

Cancer _____ (Plan Type)	☐ CP10A ☐ CP12 ☐ CP10B	☐ Individual ☐ Family	Section 125 ☐ Yes ☐ No	Mode Premium $_____

Policy Options	Hospital		Radiation/Chemotherapy		Surgery Related		Misc.
Units/Amt							
Riders	Rider CABR	Rider ICR	Rider CLR	Rider CPR	Rider CFR	Rider WBR-Fixed	Rider CP12WBR-Variable
Units/Amt							

Critical Illness _____ ☐ GI ☐ SI (Plan Type)	☐ CILP1	Basic Benefit Amount $_____	☐ Individual ☐ Single Parent Family ☐ Family	Section 125 ☐ Yes ☐ No	Mode Premium $_____

Riders	Rider CICR1	Rider WBR	Rider	Rider	Rider	Rider	Rider	Rider
Units/Amt								

Disability (DI) _____ ☐ GI ☐ CGI ☐ SI	Monthly Salary $_____	Elimination Period _____ Days Acc. _____ Days Sick.	Section 125 ☐ Yes ☐ No	Mode Premium $_____
Occupation Class ☐ Preferred ☐ Standard	Monthly Benefit $_____	Benefit Period _____ Months	On The Job Rider ☐ Yes ☐ No	Accident Rider ☐ Yes ☐ No Units _____ ☐ Individual ☐ Family

Heart/Stroke ☐ GI ☐ CGI ☐ SI (Plan Type)			☐ HSP2	Units	☐ Individual ☐ Family		Section 125 ☐ Yes ☐ No	Mode Premium $
Riders	Rider CIDR1	Rider ICR	Rider WBR	Rider	Rider	Rider	Rider	Rider
Units/Amt								

Hospital Indemnity (SHOP)* ☐ CGI ☐ SI (Plan Type)				☐ CHC	Units	☐ Individual ☐ Individual & Children ☐ Individual & Spouse ☐ Family			Section 125 ☐ Yes ☐ No	Mode Premium $
Riders	Rider IHR1	Rider SAR1	Rider IPBR1	Rider OPBR1	Rider OEAR1	Rider AHNR	Rider TR1	Rider ADIR1	Rider SDIR1	
Units/Amt										

*Must have minimum essential health coverage to elect Hospital Indemnity.

Life	☐ Universal (UL20) ☐ Universal (UL21)	☐ Term (20YT)	☐ GI ☐ CGI	☐ SI	Death Benefit Option (Universal Life ONLY) ☐ 1 ☐ 2	Face Amount $		Mode Premium $
Riders	Rider ADB	Rider PW	Rider STR	Rider CTR	Rider LBR	Rider FPOR	Rider LTC	Rider OIR	Rider TIR
Units/Amt									

Billing Method:	Name on Bank/Credit Union Account	Billing Mode:	Coverage Effective Date	Total Mode Premium:
X Payroll Deduction	Bank/Credit Union Account Number	☐ Monthly (12) ☐ Semi-Monthly (24)		
☐ Bank/Credit Union Draft (Authorization Required)*	Routing Number	X Bi-weekly (26) ☐ Weekly (52)	Date of First Deduction	$
*Complete form ABJ062	Draft Date	☐ Other		

Remarks	Account (Case) Name	Account (Case) Number
	USPS	

IF REQUESTING GUARANTEED ISSUE, PLEASE PROCEED TO QUESTION 15. FOR ALL OTHER ENROLLMENTS, IF ANY UNDERWRITING QUESTIONS BELOW ARE ANSWERED "YES", PLEASE LIST THE REQUIRED HEALTH HISTORY IN QUESTION 14.

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

	UNDERWRITING QUESTIONS	EE	SP	CH
CGI & SI Accident w/ Sickness DI Rider, Cancer, SI Critical Illness, CGI & SI Disability, CGI & SI Heart/Stroke, CGI & SI Hospital Indemnity & CGI & SI Life	1. 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
All CGI	2. 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
Cancer, SI Critical Illness Cancer Rider, SI Heart/Stroke Cancer Rider & SI Hospital Indemnity	3a. 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
	3b. If the answer to 3a. 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
	3c. If the answer to 3a. 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 3b. and/or basal cell carcinoma)?	☐Y ☐N	☐Y ☐N	☐Y ☐N
Cancer w/ Intensive Care, SI Heart/Stroke & SI Hospital Indemnity	4. 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
SI Life	5. 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

IF REQUESTING GUARANTEED ISSUE, PLEASE PROCEED TO QUESTION 15. FOR ALL OTHER ENROLLMENTS, IF ANY UNDERWRITING QUESTIONS BELOW ARE ANSWERED "YES", PLEASE LIST THE REQUIRED HEALTH HISTORY IN QUESTION 14.

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

	UNDERWRITING QUESTIONS	EE	SP	CH
SI Accident w/ Sickness DI Rider, SI Critical Illness, SI Disability, SI Hospital Indemnity & SI Life	6. 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
SI Life	7. 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
SI Accident w/ Sickness DI Rider, Cancer w/ Intensive Care, SI Critical Illness, SI Disability, SI Heart/Stroke, SI Hospital Indemnity & SI Life	8. 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 Accident w/ Sickness DI Rider & SI Disability	9. 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? If yes, complete exclusion endorsement if applying for sickness disability rider. • Any disorder of the back or neck • Asthma	☐Y ☐N	☐Y ☐N	N/A
SI Accident w/ Sickness DI Rider, SI Critical Illness & SI Disability	10. 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? • Cancer, except basal cell carcinoma • Kidney Disease/Disorder • Central Nervous System Disease or disorder (to include Multiple Sclerosis or Muscular Dystrophy) • Liver Disease • Lung Disease • Chronic Fatigue Syndrome • Lupus • Diabetes • Optic Neuritis • Emphysema • Parkinson's Disease • Fibromyalgia • Paralysis • Heart Disease • Rheumatoid Arthritis	☐Y ☐N	☐Y ☐N	☐Y ☐N
SI Accident w/ Sickness DI Rider & SI Disability	11. 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	N/A
Height and Weight	12. Provide Height and Weight Employee (SI Accident w/ Sickness DI Rider, Cancer w/ Intensive Care Option, SI Critical Illness, SI Disability, SI Heart/Stroke, SI Hospital Indemnity, and SI Life): Height: ____ ft. ____ in. Weight: ____ lbs. Spouse (SI Critical Illness and SI Life (when Policy Proposed Insured)): Height: ____ ft. ____ in. Weight: ____ lbs.			
SI Critical Illness (over $50,000) & SI Life (over $150,000)	13. 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	14. 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:			
All-Replacement (Answer for Proposed Insured)	15. 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 if required by your state.	☐Y ☐N	☐Y ☐N	☐Y ☐N
All-Existing Insurance (Answer for Proposed Insured)	16. If you are applying for the type of coverage in the following list, is there any other insurance of that type (not listed in your answer to the Replacement Question) in force or applied for other than this application on any person to be insured (Coverage Types: life, cancer, heart/stroke, disability, hospital, critical illness or accident)? If yes, list company name, policy number, year issued, type of coverage and amount of benefit and complete the replacement form provided.	☐Y ☐N	☐Y ☐N	☐Y ☐N
All Life (Answer for Proposed Insured)	17. **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 policy. If no, complete the applicable illustration certification form provided, if required in your state.	☐Y ☐N	N/A	N/A
Hospital Indemnity	18. Do you currently have other health coverage that is minimum essential coverage, per federal law? If you have answered "No," you may not apply for Hospital Indemnity coverage.	☐Y ☐N	☐Y ☐N	☐Y ☐N

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. **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 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 AHL in writing of my desire to do so.

Hospital Indemnity: I ACKNOWLEDGE THAT THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN ADDITIONAL PAYMENT WITH MY TAXES.

I hereby attest that I am purchasing this policy as a supplement or in addition to other major medical health insurance coverage, also known as "minimum essential coverage."

FRAUD NOTICE: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

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 _____

SOLICITING PRODUCER MUST COMPLETE AND SIGN WHEN APPLICATION IS PRODUCER ASSISTED

All-Replacement	1. To your knowledge, is change or replacement involved?	☐ Yes ☐ ~~No~~
All-Existing Insurance	2. To your knowledge, does any person to be insured have existing coverage in force?	☐ Yes ☐ No
GI, CGI & SI Life	3. 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 policy. If no, complete the applicable illustration certification form provided, if required in your state.	☐ Yes ☐ No

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: Louis Giannini	8XRCO	558510	50 %
Soliciting Producer: Pamela Hendon	670YO	872 1063	50 %
Pamela Hendon	8XLAO	872 1063	0 %
			%

POSTAL EASE
ALLOTMENT AUTHORIZATION
(877)477-3273

PRIVACY ACT: The collection of this information is authorized by 39 U.S>C. 401, 1003 and 5 U.S.C. 8339. This information will be used to transfer a portion of your salary , to those financial organizations for credit to your designated account. As routine use, this information may be disclosed to financial organizations, to an appropriate law enforcement agency for investigative or prosecutive purposes, to a congressional office at your request, to OMB for review or private relief legislation and, where pertinent, in a legal proceeding to which the Postal Service is a party. Completion of this form is voluntary; however, if you fail to provide this information. your requested action will not be accomplished.

Part I

1. Employee Name:

2. Postal Ease PIN Number

3. Employee Address:

4. Employee ID Number

_____
Home Address

__ __ __ __ __ __ __ __

_____
City State Zip

5. Social Security # _____

Part II

6. a. ESTABLISH allotment of $_____

6. b. CANCEL allotment of: $_____

6. c. CHANGE allotment from: $_____ to $_____

7. a. Financial Organization Routing Number: 1210-0024 8

7. b. Account Number: 17760000 __ __ __ - __ __ - __ __ __ __

8. Account Type: Savings (X) Checking ( )

9. Financial Organization: Wells Fargo
255 2nd Ave South
Minneapolis, MN 55401

Part III

I certify that I authorize the use of my PIN and ID number for this transaction. I have read and understand the information printed above. In signing this form I authorize my payment to be sent to the financial institution named above to be deposited to the designated account.

10. a. Employee Signature:

10. b. Date Signed:

11. Effective Date:

12. Confirmation Number: