

SERFF Tracking Number: ALST-125680422 State: Arkansas
Filing Company: American Heritage Life Insurance Company State Tracking Number: 39205
Company Tracking Number: AWD4500AR-2
TOI: H14G Group Health - Hospital Indemnity Sub-TOI: H14G.000 Health - Hospital Indemnity
Product Name: Indemnity, Minimedical EOI
Project Name/Number: /

Filing at a Glance

Company: American Heritage Life Insurance Company

Product Name: Indemnity, Minimedical EOI SERFF Tr Num: ALST-125680422 State: ArkansasLH
TOI: H14G Group Health - Hospital Indemnity SERFF Status: Closed State Tr Num: 39205
Sub-TOI: H14G.000 Health - Hospital Indemnity Co Tr Num: AWD4500AR-2 State Status: Approved-Closed
Filing Type: Form Co Status: Reviewer(s): Rosalind Minor
Authors: Angie Redden, Lynn Disposition Date: 06/10/2008
Bautista, Patti Hicks
Date Submitted: 06/05/2008 Disposition Status: Approved-Closed
Implementation Date Requested: On Approval Implementation Date:

State Filing Description:

General Information

Project Name: Status of Filing in Domicile: Pending
Project Number: Date Approved in Domicile:
Requested Filing Mode: Review & Approval Domicile Status Comments:
Explanation for Combination/Other: Market Type: Group
Submission Type: New Submission Group Market Size: Small and Large
Overall Rate Impact: Group Market Type: Employer, Association
Filing Status Changed: 06/10/2008 Deemer Date:
State Status Changed: 06/10/2008
Corresponding Filing Tracking Number:
Filing Description:
Form AWD4500AR-2 is being submitted for your approval. AWD4500AR-2 replaces form AWD4500AR-1, which was filed and approved by your department on 6/23/2005. This form will be used to apply for group products already approved by your department.

If you have any questions regarding this filing, please contact me at patti.hicks@allstate.com, or (904) 992-3424.

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Company and Contact

Filing Contact Information

Patti Hicks, Senior Filing Analyst patti.hicks@allstate.com
 1776 American Heritage Life Drive (904) 992-3424 [Phone]
 Jacksonville, FL 32224-6687 (904) 992-2975[FAX]

Filing Company Information

American Heritage Life Insurance Company CoCode: 60534 State of Domicile: Florida
 ATTN: Legal/Compliance Group Code: 8 Company Type: Life and Health
 1776 American Heritage Life Drive
 Jacksonville, FL 32224-9983 Group Name: Allstate State ID Number:
 (904) 992-1776 ext. [Phone] FEIN Number: 59-0781901

Filing Fees

Fee Required? Yes
 Fee Amount: \$50.00
 Retaliatory? No
 Fee Explanation: \$50.00 per filing
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
American Heritage Life Insurance Company	\$50.00	06/05/2008	20677508

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	06/10/2008	06/10/2008

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Disposition Date: 06/10/2008

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Cover letter	Approved-Closed	Yes
Form	Enrollment and Evidence of Insurability Form	Approved-Closed	Yes

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Form Schedule

Lead Form Number: AWD4500AR-2

Review Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	AWD4500AR-2	Application/ Enrollment and Evidence of Insurability Form	Revised	Replaced Form #: AWD4500AR-1 Previous Filing #:		AWD4500AR-2.pdf

AMERICAN HERITAGE LIFE INSURANCE COMPANY (AHL)
1776 AMERICAN HERITAGE LIFE DRIVE
JACKSONVILLE, FLORIDA 32224



Allstate

Workplace Division

**ENROLLMENT AND
EVIDENCE OF INSURABILITY FORM**
[Check appropriate box(es)]

- AHL minimedical®** (enrollment only)
- Heritage Choice Dental** (enrollment only)
- Indemnity Minimedical**
- Short-Term Disability**
- Long-Term Disability**
- Life/Accidental Death & Dismemberment]**

[For AHL Home Office use only

Group No.	Account	Location
Dep Code E S C F	Smoker EE Y or N SP Y or N	Issue State
EFFECTIVE DATE]		

[For AHL Home Office use only

Notes] _____

GENERAL INFORMATION SECTION
(Please complete entire section for all coverages)

Please print with black ink

EMPLOYEE'S NAME Last (Sr, Jr, etc)		First	M.I.	SEX	[SOCIAL SECURITY NUMBER]	<input type="checkbox"/> Married <input type="checkbox"/> Single
HOME ADDRESS (Street or P.O. Box)				CITY	STATE	ZIP
BIRTHDAY (MM/DD/YR)	PHONE NUMBER	EMPLOYER			DATE OF HIRE (MM/DD/YR)	
JOB TITLE		PLANT OR DIVISION		[CURRENT EARNINGS \$ _____ (also check appropriate box) <input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Bi-weekly (26) <input type="checkbox"/> Semi-monthly (24) <input type="checkbox"/> Annually]		
GROUP POLICY NAME (If different from the employer name)						
[BENEFICIARY'S NAME (Last, First, M.I.)			RELATIONSHIP			
Are you <u>adding</u> any coverage or <u>changing</u> any of your existing coverage due to marriage, birth, adoption, employment status change, etc.?						
AHL minimedical®		<input type="checkbox"/> Yes <input type="checkbox"/> No	Heritage Choice Dental		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Indemnity Minimedical		<input type="checkbox"/> Yes <input type="checkbox"/> No	Short-Term Disability		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Long-Term Disability		<input type="checkbox"/> Yes <input type="checkbox"/> No	Life/Accidental Death & Dismemberment		<input type="checkbox"/> Yes <input type="checkbox"/> No	
If "Yes", indicate type of change _____						
Date of change (MM/DD/YR) _____ Current Certificate Number _____]						

[DEPENDENT COVERAGE SECTION

(Please complete if dependent coverage elected. Use additional paper if needed.)

Abbreviations: Med-Medical Den-Dental Ind-Indemnity Minimedical

Choose Plan(s)				Dependent's Name (Last, First, M.I.)	Sex	Date of Birth (MM/DD/YR)
Med	Den	Ind	Life			
				Spouse		
				Child		
				Child		
				Child]		

ENROLLMENT AND EVIDENCE OF INSURABILITY FORM

SELECTION OF COVERAGE SECTION

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

[AHL minimedical®] <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Essential <input type="checkbox"/> Advantage <input type="checkbox"/> Advantage Extra	Hospital Indemnity <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Employee Only <input type="checkbox"/> Employee+ Spouse <input type="checkbox"/> Employee+ Child <input type="checkbox"/> Family	Section 125 <input type="checkbox"/> Yes <input type="checkbox"/> No	Home Office Use Only SET ID _____
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If you did not elect MEDICAL coverage, is this because of other health coverage? Yes No

[Notice of Preexisting Conditions Exclusion: This plan imposes a Preexisting Conditions Exclusion. This means that if you have a medical condition before coming to our plan, you might have to wait a certain period of time before the plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis, care or treatment was recommended or received within a 6-month period. Generally, this 6-month period ends the day before your coverage becomes effective. However, if you were in a waiting period for coverage, the 6-month period ends on the day before the waiting period begins. The preexisting condition exclusion does not apply to pregnancy or to a child who is enrolled in the plan within 30 days after birth, adoption, or placement for adoption. This exclusion may last up to 12 months (18 months if you are a late enrollee) from your first day of coverage, or, if you were in a waiting period, from the first day of your waiting period. However, you can reduce the length of this exclusion period by the number of days of your prior "creditable coverage". Most prior health coverage is considered creditable coverage and can be used to reduce the preexisting condition exclusion if you have not experienced a break in coverage of at least 63 days. To reduce the 12-month (or 18-month) exclusion period by your creditable coverage, you should give us a copy of any certificates of creditable coverage you have. If you do not have a certificate, but you do have prior health coverage, we will help you obtain one from your prior plan or issuer. There are also other ways that you can show you have creditable coverage. Please contact us if you need help demonstrating creditable coverage. All questions about the preexisting condition exclusion and creditable coverage should be directed to our Customer Service Department at 1-800-937-7039.]]

[Heritage Choice Dental] <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Plan 1 <input type="checkbox"/> Plan 4 <input type="checkbox"/> Plan 2 <input type="checkbox"/> Plan 5 <input type="checkbox"/> Plan 3	<input type="checkbox"/> Employee Only <input type="checkbox"/> Employee + Spouse	<input type="checkbox"/> Employee + Child <input type="checkbox"/> Family	Section 125 <input type="checkbox"/> Yes <input type="checkbox"/> No	Total Mode Premium \$ _____
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Were you covered under your Employer's prior Dental Plan? Yes No **Home Office Use Only**
 If "Yes", please enter the date coverage effective (MM/DD/YR) _____
 SET ID **ACTIV** or **EMPLR** or _____
 PLAN ID **P1NG1 P1NG2 P1NG3]**

[Indemnity Minimedical] <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Employee Only <input type="checkbox"/> Employee + Child(ren) <input type="checkbox"/> Employee + Spouse <input type="checkbox"/> Family	Section 125 <input type="checkbox"/> Yes <input type="checkbox"/> No	Total Mode Premium \$ _____
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Benefits	Hospital Related	Surgery / Inpatient Physician	Outpatient Related	Diagnostic / Wellness Option <input type="checkbox"/>	Prescription Drug Option <input type="checkbox"/>	Disability Rider <input type="checkbox"/>	Life Rider <input type="checkbox"/>
Units							

Do you currently have an individual Hospital Indemnity product with AHL? Yes No
 If "Yes", please enter the Policy Number _____
 Do you wish to terminate this coverage? Yes No If "Yes", please enter the effective date of termination _____]

ENROLLMENT AND EVIDENCE OF INSURABILITY FORM

EVIDENCE OF INSURABILITY SECTION - PLEASE COMPLETE

(Coverage will not be considered unless ALL questions are answered. [Does not apply to AHL minimedical® or Dental])

1. For ALL persons applying for coverage who require evidence of insurability, please answer the following:

Name (Last, First, M.I.)	Relationship to Employee	Height (ft. & in.)	Weight (lbs.)	Occupation	Date of Birth (MM/DD/YEAR)	Sex
	Self					
	Spouse					
	Child					
	Child					
	Child					

Please explain all "Yes" answers in the space provided on page 6. In your explanations, identify the question number, the person(s) it applies to, and the name(s), address(es) and phone number(s) of applicable physician(s) and/or hospital(s).

Evidence of Insurability - All Coverages

2. Has any person to be insured ever tested positive for exposure to the HIV virus or been diagnosed as having ARC or AIDS caused by the HIV infection or other sickness or condition derived from such infection? Yes No

Additional Evidence of Insurability - Life & Disability only

3. a) Has any person to be insured had any change in weight in the past year? If "Yes", give the amount of gain or loss and the cause of change. Yes No

b) Has any person to be insured been absent from work or unable to carry on normal activities due to illness or injury during the past 6 months? Yes No

c) Has any person to be insured had this coverage before? Yes No

d) Has any person to be insured ever been or currently insured under any other policy issued by American Heritage Life Insurance Company? If "Yes", give the Group No. or other Policy No. _____ Yes No

e) Has any person to be insured ever had a request for coverage declined, postponed, canceled, or been charged an extra rate for life, accident or health insurance or received such a policy of insurance other than exactly as applied for? Yes No

f) Has any person to be insured ever made claim for, or received benefits from a pension, or other payment because of an injury, sickness or disability? Yes No

4. a) Has any person to be insured been advised or recommended by a physician of a surgical or medical treatment that has not been done yet? Yes No

b) Does any person to be insured have an appointment to visit a physician within the next 30 days? Yes No

c) If any person is female, is she now pregnant?
Will any female to be insured visit a physician within the next 14 days to determine if she is pregnant? Yes No

5. a) Has any person to be insured been treated for, or been told by a member of the medical profession that he/she has or had: a stroke; rheumatic fever; heart murmur; heart attack; a heart condition; heart trouble or other disorder of the heart or blood vessels (including artery disease)? Yes No

b) Has any person to be insured been diagnosed with hypertension or high blood pressure? Yes No

c) If the answer to 5b is "Yes", in the last year has he/she had either: (1) a systolic blood pressure reading higher than 150 more than once; or (2) a diastolic blood pressure reading higher than 100 more than once? Yes No

d) Has any person to be insured been treated for, or been told by a member of the medical profession that he/she has or had: bronchitis; pleurisy; asthma; emphysema; tuberculosis or other chronic respiratory disorder; or a tonsillectomy or adenoidectomy? Yes No

e) Has any person to be insured been treated for, or been told by a member of the medical profession that he/she has or had: epilepsy; muscular dystrophy; polio; osteomyelitis; or multiple sclerosis? Yes No

f) Has any person to be insured been treated for, or been told by a member of the medical profession that he/she has or had: jaundice; ulcer; hernia; hemorrhoids, appendicitis; colitis; Crohn's disease; diverticulitis; or other disorder of the stomach, intestines, liver or gallbladder? Yes No

g) Has any person to be insured been treated for, or been told by a member of the medical profession that he/she has or had: Chronic Fatigue Syndrome, fibromyalgia, or Epstein-Barr Virus? Yes No

ENROLLMENT AND EVIDENCE OF INSURABILITY FORM

EVIDENCE OF INSURABILITY SECTION - CONTINUED

(Coverage will not be considered unless ALL questions are answered. [Does not apply to AHL minimedical® or Dental])

Please explain all "Yes" answers in the space provided on page 6. In your explanations, identify the question number, the person(s) it applies to, and the name(s), address(es) and phone number(s) of applicable physician(s) and/or hospital(s).

5. h) Has any person to be insured been treated for, or been told by a member of the medical profession that he/she has or had: Oral Candidiasis (Thrush) or Lymphadenopathy (enlarged or swollen glands)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
i) Has any person to be insured been treated for, or been told by a member of the medical profession that he/she has or had: sugar, albumin, blood or pus in urine, venereal disease, hepatitis, stone or other disorder of the kidney, bladder, prostate or reproductive organs?	<input type="checkbox"/> Yes <input type="checkbox"/> No
j) Has any person to be insured been treated for, or been told by a member of the medical profession that he/she has or had: diabetes, thyroid or other endocrine disorders?	<input type="checkbox"/> Yes <input type="checkbox"/> No
k) Has any person to be insured been treated for, or been told by a member of the medical profession that he/she has or had: neuritis, sciatica, rheumatism, arthritis, gout or disorder of the muscles or bones, including spine, back, neck or joints?	<input type="checkbox"/> Yes <input type="checkbox"/> No
l) Is any person to be insured currently undergoing any diagnostic test for, now being treated for, or ever been treated for, disorders of the skin, or lymph glands, cyst, tumor, 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
m) Has any person to be insured been treated for, or been told by a member of the medical profession that he/she has or had: allergies, anemia, sickle cell anemia or any other disorder of the blood?	<input type="checkbox"/> Yes <input type="checkbox"/> No
n) Has any person to be insured been treated for, or been told by a member of the medical profession that he/she has or had: a mental or nervous disorder to include depression, and/or anxiety, or a disorder of the central nervous system?	<input type="checkbox"/> Yes <input type="checkbox"/> No
o) Has any person to be insured been treated for, or been told by a member of the medical profession that he/she has or had: excessive use of alcohol, or any habit forming drug, or is currently taking any drug or drugs not prescribed by a physician?	<input type="checkbox"/> Yes <input type="checkbox"/> No

6. For any person to be insured, list the name, address and phone number of their physicians, the date last seen, and the reason last seen. Also, if any person to be insured has had an examination, consultation or treatment by a member of the medical profession or been a patient in a hospital or other institution within the past 5 years, please provide details. Use the additional space provided at the bottom of this page if needed.

PERSON	REASON LAST SEEN Nature of any illness, injury, diagnosis, or wellness visit	DATES Including duration of illness	DEGREE OF RECOVERY	NAMES, ADDRESSES AND PHONE NUMBERS OF PHYSICIANS AND/OR HOSPITALS

7. Has any person ever engaged in, or does he/she contemplate engaging in, underwater diving; piloting an airplane; parachuting; hang gliding; bungee jumping; rodeo; mountaineering; professional sports; auto, drag or motorcycle racing; or stunt driving? If "Yes," circle all that are applicable and explain the extent to which he/she is engaged in the activity: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Has any person to be insured used tobacco in any form in the last 12 months? If "Yes," indicate type and date last used. Type used _____ Date last used (MM/DD/YR) _____	<input type="checkbox"/> Yes <input type="checkbox"/> No]
9. Citizenship. Is each person to be insured a U.S. citizen? If "No", list the person and country. Person _____ Country _____	<input type="checkbox"/> Yes <input type="checkbox"/> No]

ENROLLMENT AND EVIDENCE OF INSURABILITY FORM

Use this space to explain any "Yes" answers to the questions in the Evidence of Insurability section. In your explanations identify the question number, the person(s) it applies to, and the name(s), address(es) and phone number(s) of any applicable physician(s) and/or hospital(s). Use additional paper if needed.

[ELECTRONIC ACCEPTANCE

By checking the "Yes" box below, I agree to electronic delivery of my certificate of insurance, describing my coverage under the group policy, and its accompanying notices ("my Certificates"). If electronically delivered, I will be provided instructions on how to receive my Certificate via the following address: [www.allstateatwork.com/mybenefits].

To electronically receive my Certificate, I must use a computer that meets the following minimum requirements: [(1) Operating system with a minimum of: (a) Pentium or higher processor, (b) 16 MB random access memory (RAM), (c) 20 MB of free hard drive space; (2) Operating system Windows® XP or higher or Windows® 2000 or higher; (3) Microsoft® Internet Explorer 6.x or greater; (4) Adobe® Reader 6.x or greater; (5) Internet connection].

My consent is valid while I am covered under the Group Policy. At any time, I may withdraw my consent for any reason and receive a paper copy of my Certificate, 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 the Certificate and Notices electronically via the internet.

NO, I prefer to receive paper copies of the Certificate and Notices.]

CERTIFICATION, UNDERSTANDING AND AUTHORIZATIONS

I CERTIFY that the statements and answers contained on this form are made by me, are complete and true, are correctly and fully recorded and that no important circumstance or information has been withheld or omitted. These statements and answers are offered to American Heritage Life Insurance Company as an inducement to grant insurance, and I understand that American Heritage Life Insurance Company may use misstatements or misrepresentations to contest the validity of any coverage provided on the basis of this Enrollment and Evidence of Insurability Form. **FRAUD NOTICE: Any person who knowingly presents a false or fraudulent claim for payment of loss or benefit or knowingly presents false information in an enrollment for insurance is guilty of a crime and may be subject to fines and confinement in prison.** · I UNDERSTAND that the "effective date" of my elected coverages will be the effective date recorded on the Certificate, not the date this Enrollment and Evidence of Insurability Form is signed. · 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 Insurance Company, its subsidiaries or its reinsurers, any information. I acknowledge receipt of the Important Notice About Privacy and MIB Notice. 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 Insurance Company in writing of my desire to do so. · I ALSO AUTHORIZE my employer to deduct from my salary or wages, if applicable, the necessary premium for the coverage(s) requested above. This signature also verifies the accuracy of the information on this Enrollment and Evidence of Insurability Form. 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 enroll for it at a later date. Any such enrollment may be declined on the basis of such proof.

Employee's Signature _____ Signed at _____ Date Signed _____
(City and State)

[Dependent's Signature _____ Signed at _____ Date Signed _____]
(Required for Spouse or Child over 18) (City and State)

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 coverage except, upon written consent, to be medically tested for HIV or AIDS and the results of such testing prove positive.

GIN/MIB (03/08)

MIB NOTICE:

Information regarding your insurability will be treated as confidential. We or our reinsurers may, however, make a brief report to the Medical Information Bureau (Bureau), a non-profit 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 Insurance Company 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.

GIN/MIB (03/08)

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Rate Information

Rate data does NOT apply to filing.

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Supporting Document Schedules

Satisfied -Name: Certification/Notice **Review Status:** Approved-Closed 06/10/2008
Comments:
Compliant

Bypassed -Name: Application **Review Status:** Approved-Closed 06/10/2008
Bypass Reason: This form filing includes the Enrollment and Evidence of Insurability in the Form Schedule tab of this filing.
Comments:

Satisfied -Name: Cover letter **Review Status:** Approved-Closed 06/10/2008
Comments:
Attachment:
EOI Coverletter Arkansas.pdf



Allstate®

Workplace Division

Patti Hicks
Senior Filing Analyst
Group Products
Compliance Department

June 5, 2008

Life & Health Division
Arkansas Insurance Department
1200 West Third Street
Little Rock, AR 72201

Re: Filing for American Heritage Life Insurance Company
NAIC No. 60534
Form AWD4500AR-2
SERFF Tracknig #: ALST-125680422

To Whom It May Concern:

The above form is being submitted for your approval. AWD4500AR-2 replaces form AWD4500AR-1, which was filed and approved by your department on 6/23/2005. This form will be used to apply for group products already approved by your department. The products are as follows:

Marketing name	Form Number	Approval date
AHL minimedical	G-3000-P, et al	04/27/2005
Dental	G-DEN(AR)-P	04/05/2001
Indemnity Minimed	GVSP1AR	10/18/2004
Short Term Disability	GVD-4000-P, et al	01/18/2001
Long Term Disability	GVD-4000-P, et al	01/18/2001
Life/Accidental Death	GVL-4000-P, et al	02/11/2004

The logo, address and phone number on this form will be the current logo, address and phone number of American Heritage Life Insurance Company. The bracketing on this form will allow us the ability to customize the form for particular groups by removing products the employer has chosen to not offer to their employees. In certain circumstances, we may not require full underwriting with our life and/or disability products; thus some of the medical questions will be deleted and the remaining ones re-numbered. This will result in a more streamlined and less confusing form for the employees to complete. Additional bracketing includes the following: the marketing names of these products will also be updated to match the marketing names used in the brochures the employees will be referencing when they enroll; the Notice of Preexisting Conditions Exclusion on page 2 is bracketed to allow for changes to Federal HIPAA regulations; and the Electronic Delivery of Certificates language is bracketed to allow for changes to the system requirements needed to receive certificates of insurance electronically. These are the only variations to this form. The language in the medical questions used on the forms will not be altered from their filed versions. They will simply be removed or left on as needed for a specific group.

If you have any questions regarding this filing, please contact me at patti.hicks@allstate.com, or (904) 992-3424.

Sincerely,

Patti Hicks
Senior Filing Analyst

American Heritage Life Insurance Company

1776 American Heritage Life Drive Jacksonville, FL 32224 Phone 904.992.3424 Fax 904.992.2975 E-mail: patti.hicks@allstate.com

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Compliance Department