

<i>SERFF Tracking Number:</i>	<i>ALST-126325059</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>American Heritage Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>43639</i>
<i>Company Tracking Number:</i>	<i>REPAMD</i>		
<i>TOI:</i>	<i>L08 Life - Other</i>	<i>Sub-TOI:</i>	<i>L08.000 Life - Other</i>
<i>Product Name:</i>	<i>REPAMD</i>		
<i>Project Name/Number:</i>	<i>REPAMD/</i>		

Filing at a Glance

Company: American Heritage Life Insurance Company

Product Name: REPAMD

SERFF Tr Num: ALST-126325059 State: Arkansas

TOI: L08 Life - Other

SERFF Status: Closed-Approved-
Closed State Tr Num: 43639

Sub-TOI: L08.000 Life - Other

Co Tr Num: REPAMD

State Status: Approved-Closed

Filing Type: Form

Reviewer(s): Linda Bird

Authors: Jennifer Aiello, Lynn
Bautista, Juli Clausen

Disposition Date: 10/05/2009

Date Submitted: 09/30/2009

Disposition Status: Approved-
Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: REPAMD

Status of Filing in Domicile: Not Filed

Project Number:

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Group Market Size:

Overall Rate Impact:

Group Market Type:

Filing Status Changed: 10/05/2009

Explanation for Other Group Market Type:

State Status Changed: 10/05/2009

Deemer Date:

Created By: Juli Clausen

Submitted By: Juli Clausen

Corresponding Filing Tracking Number:

Filing Description:

Please find enclosed the above referenced forms for your review and approval. They are new and do not replace any form currently approved by your department. Both amendments will be used with life insurance policies available for sale in your state and are filed to comply with Rule 97.

If an insured replaces a life insurance policy they have with us with a new life insurance policy with us, amendment REPAMD-1 will give credit for the expired portion of the contestability and suicide provisions of the replaced or previously existing policy or contract. Amendment REPAMD-2 will extend the free look period to 30 days if the policy is issued as a result of a replacement.

SERFF Tracking Number: ALST-126325059 State: Arkansas
Filing Company: American Heritage Life Insurance Company State Tracking Number: 43639
Company Tracking Number: REPAMD
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: REPAMD
Project Name/Number: REPAMD/

These forms will not be used in and have not been filed for approval in our domicile state of Florida.

Also enclosed are the above referenced applications for your review and approval. These forms are new and, when approved, will replace forms previously approved by your department according to the chart below.

New Form Number	Previous Form Number	Approval Date	File #
AWD900AR-2	AWD900AR-1	June 25, 2007	ALST-125124509
AWDINDAPPAR-2	AWDINDAPPAR-1	June 25, 2007	ALST-125124509

These forms are being revised to comply with the above stated regulation regarding the replacement of life insurance. We have added a question to the Producer's Statement portion of these applications to solicit information about existing insurance. All other information on these applications remains as previously filed with your department.

Please note that, at this time, we do not plan to use the citizenship question in our underwriting process. However, we wish to have the flexibility to add this question to the application without refiling for approval if federal or state regulations are passed which would require it. This question appears as a variable.

The application may be taken through electronic enrollment procedures by our licensed agents using a pen-based signature pad, PIN numbers, and any other valid electronic signature method. You have our assurance that appropriate encryption standards have been implemented to prohibit alteration of the application after the applicant has signed it.

These forms were approved by our domicile state of Florida on May 1, 2007.

Any logo, officer signature or Home Office address and telephone number that appears on these forms is subject to change.

We have included any forms required by your state. If I may be of further assistance, please feel free to contact me at (904) 992-2912 or by email at jclav@allstate.com. Thank you for your consideration.

Company and Contact

Filing Contact Information

Juli Clausen , Ettain Group jclav@allstate.com
Attn: Compliance Department 904-992-2912 [Phone]
1776 American Heritage Life Drive 904-992-2975 [FAX]
Jacksonville, FL 32224-6687

Filing Company Information

SERFF Tracking Number: ALST-126325059 State: Arkansas
 Filing Company: American Heritage Life Insurance Company State Tracking Number: 43639
 Company Tracking Number: REPAMD
 TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
 Product Name: REPAMD
 Project Name/Number: REPAMD/
 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 Group Name: Allstate State ID Number:
 Jacksonville, FL 32224-9983 FEIN Number: 59-0781901
 (904) 992-1776 ext. [Phone]

Filing Fees

Fee Required? Yes
 Fee Amount: \$80.00
 Retaliatory? No
 Fee Explanation: \$20 per form X 4 forms
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
American Heritage Life Insurance Company	\$80.00	09/30/2009	30952937

SERFF Tracking Number: ALST-126325059 State: Arkansas
Filing Company: American Heritage Life Insurance Company State Tracking Number: 43639
Company Tracking Number: REPAMD
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: REPAMD
Project Name/Number: REPAMD/

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	10/05/2009	10/05/2009

SERFF Tracking Number: ALST-126325059 State: Arkansas
Filing Company: American Heritage Life Insurance Company State Tracking Number: 43639
Company Tracking Number: REPAMD
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: REPAMD
Project Name/Number: REPAMD/

Disposition

Disposition Date: 10/05/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: ALST-126325059 State: Arkansas
 Filing Company: American Heritage Life Insurance Company State Tracking Number: 43639
 Company Tracking Number: REPAMD
 TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
 Product Name: REPAMD
 Project Name/Number: REPAMD/

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		Yes
Form	Amendment		Yes
Form	Amendment		Yes
Form	Application		Yes
Form	Application		Yes

SERFF Tracking Number: ALST-126325059 State: Arkansas
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 Company Tracking Number: REPAMD
 TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
 Product Name: REPAMD
 Project Name/Number: REPAMD/

Form Schedule

Lead Form Number: REPAMD-1

Schedule Item Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
	REPAMD-1	Policy/Cont Amendment ract/Fratern al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial		52.000	REPAMD-1.pdf
	REPAMD-2	Policy/Cont Amendment ract/Fratern al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial		52.000	REPAMD-2.pdf
	AWD900A R-2	Application/ Application Enrollment Form	Revised	Replaced Form #: AWD900AR-1 Previous Filing #: ALST-125124509	51.000	AWD900AR-2.pdf
	AWDINDA PPAR-2	Application/ Application Enrollment Form	Revised	Replaced Form #: AWDINDAPPAR-1 Previous Filing #: ALST-125124509	51.000	AWDINDAPPAR-2.pdf



Workplace Division

AMERICAN HERITAGE LIFE INSURANCE COMPANY

HOME OFFICE:

1776 AMERICAN HERITAGE LIFE DRIVE

JACKSONVILLE, FLORIDA 32224-6688

(904) 992-1776

A Stock Company

AMENDMENT

The policy to which this Amendment is attached is amended as follows:

If this policy is issued as a replacement of an existing life insurance policy or annuity of ours or a subsidiary or affiliate under common ownership or control, you are hereby given credit under this policy for the expired portion of the contestability and suicide provisions of the replaced or previously existing policy or contract. This credit shall not exceed that earned under the replaced or previously existing policy. It will not place you or the insured in a more favorable position than would have been the case had a replacement policy not been issued.

This credit shall not apply to any amount of insurance provided by the replacement policy which exceeds the amount of insurance provided by the replaced policy.

This Amendment will not change, alter, or amend the policy it is attached to, except as stated.

This Amendment becomes effective as of the policy date of the policy to which it is attached.

Secretary



AMERICAN HERITAGE LIFE INSURANCE COMPANY

HOME OFFICE:

1776 AMERICAN HERITAGE LIFE DRIVE

JACKSONVILLE, FLORIDA 32224-6688

(904) 992-1776

A Stock Company

NOTICE OF RIGHT TO RETURN POLICY

If this policy is issued as a replacement of an existing life insurance policy or annuity please note that you have the right to return the policy or contract within 30 days of delivery of the contract and receive an unconditional full refund of all premium or considerations paid on it, including any policy fees or charges.

This does not change, alter, or amend the policy it is attached to, except as stated.

Secretary

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 <input type="checkbox"/> F	Age	Birthdate	Height	Weight	Social Security Number	
Home Address		City		State	Zip		Home Phone Number	
Employer (if not same as case)				Occupation			Date Hired	
Payor (if other than Proposed Insured)				Social Security Number or Tax I.D. Number (Owner or Payor)			Employee ID	
Owner's Name and Address (if different than Proposed Insured's)					City	State	Zip	
Primary Beneficiary - Full Name Age Relationship				Contingent Beneficiary - Full Name Age Relationship				

DEPENDENTS PROPOSED FOR COVERAGE

Last Name	First Name	M.I.	Relationship	Date of Birth	Age	Sex

PLANS	Universal Life	Face Amount	Life Riders	Rider	Rider	Rider	Rider	Rider	Rider	Rider	Mode Premium
	<input type="checkbox"/> Simplified Issue <input type="checkbox"/> Select CGI	Death Benefit Option <input type="checkbox"/> 1 <input type="checkbox"/> 2	Units/Amt								\$
	Term Life	Face Amount	Life Riders	Rider	Rider	Rider	Rider	Rider	Rider	Mode Premium	
	<input type="checkbox"/> Simplified Issue <input type="checkbox"/> Select CGI		Units/Amt							\$	
	Disability	Monthly Salary \$	Elimination Period	On The Job Rider	Accident Rider	Section 125	Mode Premium				
	<input type="checkbox"/> Simplified Issue <input type="checkbox"/> Select CGI	Monthly Benefit \$	Days Acc. Days Sick.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$				
	Occupation Class <input type="checkbox"/> Preferred <input type="checkbox"/> Standard	Benefit Period	Units	<input type="checkbox"/> Individual <input type="checkbox"/> Family							
		Months									
	Cancer	Cancer Riders	Rider	Rider	Rider	Rider	Rider	Section 125	Mode Premium		
	(Units or Benefit Package) <input type="checkbox"/> Individual <input type="checkbox"/> Family	Units/Amts.						<input type="checkbox"/> Yes <input type="checkbox"/> No	\$		
Accident	Monthly Salary \$	Rider APDIR	Rider APBER	Rider APEXT	Rider APOPTR1	Rider APHCR1	Section 125	Mode Premium			
(Units or Benefit Package) <input type="checkbox"/> Simplified Issue <input type="checkbox"/> Select CGI <input type="checkbox"/> Individual <input type="checkbox"/> Family	Rider Units						<input type="checkbox"/> Yes <input type="checkbox"/> No	\$			
SHOP	Rider IHR1	Rider SAR1	Rider IPBR1	Rider OPBR1	Rider OEAR1	Rider AHRN	Rider TR1	Rider ADIR1	Rider SDIR1	Section 125	Mode Premium
<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										<input type="checkbox"/> Yes <input type="checkbox"/> No	\$
Heart/Stroke	HSP2 Riders	Rider CIDR1	Rider ICR	Rider WBR3	Rider	Rider	Section 125	Mode Premium			
Units or Benefit Level: <input type="checkbox"/> Individual <input type="checkbox"/> Family	Units/Amt						<input type="checkbox"/> Yes <input type="checkbox"/> No	\$			
Critical Illness	CI Riders	Rider	Rider	Rider	Rider	Rider	Section 125	Mode Premium			
Basic Benefit Amount: <input type="checkbox"/> Individual <input type="checkbox"/> Family <input type="checkbox"/> Single Parent Family	Units/Amt						<input type="checkbox"/> Yes <input type="checkbox"/> No	\$			
Cash With Application	Case Name		Case Number			Total Mode Premium:					
PAC Policies Transit Number	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		\$			
<input type="checkbox"/> Checking Account Number	Producer Number		Percentage Credit								
<input type="checkbox"/> Savings Draft Date											
Remarks											
Home Office Use											

AWD900AR-2

(2009)

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-2 (03/09)



Allstate
Workplace Division

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 QUESTION 1 ABOVE IS ANSWERED "NO" OR QUESTION 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	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
SI Life & 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 _____ Use additional paper if needed	
All Coverages	12. Replacement. Is this insurance to replace or change any existing life or health coverage? If yes, indicate product being replaced or changed and 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
[All Coverages	14. Citizenship. Is each person to be insured and others named in the application (i.e. payor, owner, beneficiaries) a U.S. citizen? If not, list person and country.	<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. I understand that I may revoke this authorization at any time by notifying American Heritage Life in writing of my desire to do so.

A person who is already covered by Medicaid should not purchase specified disease coverage.

Signed at: City/State: _____ Date Signed: _____

Signature of Proposed Insured _____ Signature of Owner, if other than Insured _____

Producer's Statement. 1. To your knowledge, does the proposed insured have existing coverage in force? Yes No
2. To your knowledge, is change or replacement involved? Yes No
3. I certify that to the best of my knowledge and belief the information in this application is complete, accurate and correctly recorded.

Signature of Producer _____ Print Producer's Name _____

AWD900AR-2

(2009)

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 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734, PH. #866-692-6901 (TTY 866-346-3642 for hearing impaired). American Heritage Life or its reinsurers may release information in its file to other insurance companies that you apply to for life or health insurance, or submit a claim to for benefits. 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-2 (03/09)

PLEASE PRINT WITH BLACK INK

APPLICATION FOR LIFE AND HEALTH INSURANCE TO:



AMERICAN HERITAGE LIFE INSURANCE COMPANY

1776 AMERICAN HERITAGE LIFE DRIVE
JACKSONVILLE, FLORIDA 32224-6687

Proposed Insured (Last, First, M.I.)		<input type="checkbox"/> Self	<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				Occupation				Date Hired	
Payor (if other than Proposed Insured)				Social Security Number or Tax I.D. Number (Owner or Payor)					
Owner's Name and Address (if different than Proposed Insured's)						City		State	Zip
Primary Beneficiary - Full Name Age Relationship					Contingent Beneficiary - Full Name Age Relationship				

DEPENDENTS PROPOSED FOR COVERAGE

Last Name	First Name	M.I.	Relationship	Date of Birth	Age	Sex

INSURANCE PLANS	Universal Life	Face Amount	Riders	Rider	Rider	Rider	Rider	Rider	Rider	Rider	Mode Premium		
		Death Benefit Option <input type="checkbox"/> 1 <input type="checkbox"/> 2	Units/Amt								\$		
	Term Life	Face Amount	Riders	Rider	Rider	Rider	Rider	Rider	Rider	Rider	Mode Premium		
			Units/Amt								\$		
	Cancer	<input type="checkbox"/> Individual <input type="checkbox"/> Family	Riders	Rider	Rider	Rider	Rider	Rider	Rider	Rider	Mode Premium		
	Benefit / Plan:		Units/Amts.								\$		
	Accident	<input type="checkbox"/> Individual <input type="checkbox"/> Family	Monthly Salary \$	Rider APDIR	Rider APBER	Rider APEXT	Rider APOPTR1	Rider APHCR1			Mode Premium		
	Benefit / Plan:		Units								\$		
	SHOP	<input type="checkbox"/> Individual <input type="checkbox"/> Individual & Children <input type="checkbox"/> Individual & Spouse <input type="checkbox"/> Family	Base Plan	Rider IHR1	Rider SAR1	Rider IPBR1	Rider OEAR1	Rider OPBR1	Rider AHNR	Rider TR1	Rider ADIR1	Rider SDIR1	Mode Premium
	Benefit / Plan:		Units	Units	Units	Units	Units	Units	Units	Units	Units	\$	
Heart/Stroke	<input type="checkbox"/> Individual <input type="checkbox"/> Family	Riders	Rider CIDR1	Rider ICR	Rider WBR3	Rider	Rider			Mode Premium			
Units or Benefit Level:		Units/Amt								\$			

Cash With Application <input type="checkbox"/> Yes <input type="checkbox"/> No		Premiums/Billing Mode <input type="checkbox"/> Annual <input type="checkbox"/> PAC				Total Mode Premium	
PAC Policies Transit Number _____						\$	
<input type="checkbox"/> Checking Account Number _____		Home Office Use				Producer Number	
<input type="checkbox"/> Savings Draft Date _____							
Remarks							

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? (If no, please explain in question 11 below or on supplement on next page.)	<input type="checkbox"/> Yes <input type="checkbox"/> No				
IF ANY QUESTIONS 2-8 BELOW ARE ANSWERED "YES," PLEASE LIST THE REQUIRED HEALTH HISTORY IN QUESTION 11 BELOW.						
All Coverages	2. a) Is any person to be insured now being treated, or ever been treated or diagnosed by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC), or has ever tested positive for antigens or antibodies to an AIDS virus? b) Has any person to be insured ever had any new insurance or reinstatement limited, postponed, or declined; or claimed or been refused disability income benefits?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No				
All Life	3. Has any person to be insured used tobacco in any form in the last 12 months? If so, who and what type? _____	<input type="checkbox"/> Yes <input type="checkbox"/> No				
All Life	4. a) In the last 3 years, has any person to be insured been seen by a physician, been hospitalized, been disabled or treated for a disorder? (This question can be answered no if the person was seen for colds, flu, normal pregnancy or a routine physical examination with no unfavorable results.) b) In the last 3 years, has any person to be insured had diagnostic or therapeutic procedure done? c) In the last 3 years, has any person to be insured been counseled for or excessively used alcohol or any type of drugs?	<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 & Riders) & Life	5. 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 & Life	6. a) Is any person to be insured now being treated for, or ever been treated for: a stroke; a heart attack; a heart condition; heart trouble; any abnormality of the heart (including artery disease); or diabetes? b) Has any person to be insured ever been diagnosed with hypertension or high blood pressure? c) If the answer to 6b above is yes, in the last year has that person had a systolic blood pressure reading higher than 150 more than once or a diastolic blood pressure reading higher than 100 more than once?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No				
Hosp. Ind. (SHOP) & Sickness Riders to Accident Policy	7. a) In the last 3 years, has any person to be insured had, been treated for, or been told by a member of the medical profession that he/she has: diabetes, emphysema, asthma, epilepsy, hepatitis, mental or nervous illness, ulcers, any disorder of the central nervous system (to include muscular dystrophy (MD) or multiple sclerosis (MS); Parkinson's disease; lupus; rheumatoid arthritis; fibromyalgia; chronic fatigue syndrome; any disorder of the heart, kidneys, liver, lungs, pancreas, or back (including neck); paralysis; optic neuritis; cancer (except basal cell skin cancer), malignant tumor, leukemia, Hodgkin's Disease; or a stroke? b) Has any person to be insured ever been diagnosed with hypertension or high blood pressure? c) If the answer to 7b above is yes, in the last year has that person had a systolic blood pressure reading higher than 150 more than once or a diastolic blood pressure reading higher than 100 more than once? 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? g) Is any person to be insured pregnant at this time?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No				
Life & All Accident policies & riders	8. In the last 3 years, has any person to be insured 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 in #11 below.	<input type="checkbox"/> Yes <input type="checkbox"/> No				
All Coverages	9. Replacement. Is this insurance to replace or change any existing life or health coverage? If yes, indicate product being replaced or changed and complete replacement form provided by your producer if required by your state. _____	<input type="checkbox"/> Yes <input type="checkbox"/> No				
All Coverages	10. Existing Insurance. Is there any other life, cancer, heart/stroke, hospital, or accident insurance in force or applied for on proposed insured? If yes, list company name, policy number, year issued, type of coverage, and amount of benefit. _____	<input type="checkbox"/> Yes <input type="checkbox"/> No				
Required Health History	11. Question#	Name	Disease or Injury-Dates	Duration	Result	Name & Address of Doctor
(Please Supply Additional Information On Supplement On Next Page If Needed)						
[All Coverages	12. Citizenship. Is each person to be insured and others named in the application (i.e. payor, owner, beneficiaries) a U.S. citizen? If not, list person and country. _____	<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 false or fraudulent claim for payment of a loss or benefit 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 insurance coverage(s) will be the policy date recorded on the Policy Specifications page. **The effective date of the policy(ies) is not the date the application is signed.** If the policy(ies) is (are) not issued, American Heritage Life will refund any premiums it receives. I also understand that no producer has authority to waive any answer or otherwise modify this application, or to bind this company in any way by making any promise or representation that is not set out in writing in this application. • **AUTHORIZATION.** I authorize any physician, medical practitioner, hospital, clinic or other medical facility, insurance company, the Medical Information Bureau or other organization, institution or person, that has records or knowledge of me or my health to give to American Heritage Life, its subsidiaries or its reinsurers any information. I acknowledge receipt of the Important Notice About Privacy and MIB Notice form. A copy of this authorization is as valid as the original. This authorization applies to any dependent on whom insurance is requested. This authorization is valid for a period of 24 months from the date signed. I understand that I may revoke this authorization at any time by notifying American Heritage Life in writing of my desire to do so.

A person who is already covered by Medicaid should not purchase specified disease coverage.

Signed at: City/State: _____ Date Signed: _____

Signature of Proposed Insured _____ Signature of Owner, if other than Insured _____

Producer's Statement. 1. To your knowledge, does the proposed insured have existing coverage in force? Yes No
2. To your knowledge, is change or replacement involved? Yes No
3. Did you receive money and give a Receipt for Cash with Application with this application? Yes No If yes, record amount here \$ _____
4. I certify that to the best of my knowledge and belief the information in this application is complete, accurate and correctly recorded.

Signature of Producer _____ Print Producer's Name _____

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

Proposed Insured _____

Quest. #	Name	Disease or Injury - Dates	Duration	Result	Name & Address of Doctor

Other Explanations:

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

Date: _____

Signature of Proposed Insured _____ Signature of Owner if other than Insured _____

RECEIPT FOR CASH WITH APPLICATION

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

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

Signature of Producer: _____ Date: _____

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

Signature of Applicant: _____ Date: _____

PRODUCER INSTRUCTIONS

1. Complete the entire application to the extent appropriate for the coverage applied for.
 2. Non-Medical Questionnaire - Always complete, even if a medical exam is required.
 3. Medical History - If more space is needed to explain answers to the non-medical questions, use the reverse side of this page (top) and get additional signatures requested.
 4. Multiple Plans Requested - You may use one application to apply for multiple products only if the primary insured and the owner are the same for all. Otherwise, use separate applications.
 5. Signatures - Each proposed insured and the owner (if different) must sign.
6. MIB and Important Notice - Always give this to the applicant.
 7. Receipt for Cash with Application - Give this only when the first full payment on the plan, mode of payment, and amount applied for is received. Read the terms of this receipt. Do not take money and give receipt without H.O. approval if life coverage exceeds \$100,000. Also, don't give this receipt or take cash if Question 1 is answered "No" and/or any of the Questions 2, 4-8 are answered "Yes." Instead, mark as a trial application and take cash on delivery if issued.
 8. Producer's Statement - Check the yes/no boxes appropriately and sign. Print your name legibly.
-

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.

MIB Notice:

Information regarding your insurability is treated as confidential. We or our reinsurers may, however, make a brief report to the Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates an information exchange for its members. If you apply to another Bureau member company for life or health insurance coverage or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information in its file. Upon receipt of a request from you, the Bureau arranges disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, contact the Bureau and seek a correction in accordance with the procedure set forth in the Federal Fair Credit Reporting Act. The address of the bureau's information office is 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734, PH. #866-692-6901 (TTY 866-346-3642 for hearing impaired). American Heritage Life or its reinsurers may release information in its file to other insurance companies that you apply to for life or health insurance, or submit a claim to for benefits. 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-2 (03/09)

SERFF Tracking Number: ALST-126325059 State: Arkansas
Filing Company: American Heritage Life Insurance Company State Tracking Number: 43639
Company Tracking Number: REPAMD
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: REPAMD
Project Name/Number: REPAMD/

Supporting Document Schedules

Item Status: **Status**
Date:

Satisfied - Item: Flesch Certification
Comments:
Attachment:
AR Certification of Compliance.pdf

Item Status: **Status**
Date:

Satisfied - Item: Application
Comments:
See Form Schedule

AMERICAN HERITAGE LIFE INSURANCE COMPANY
Jacksonville, Florida 32224-6687

To the Policy Review Section, ARKANSAS Department of Insurance.

Certification of Compliance

For Filing Including:

REPAMD-1
REPAMD-2
AWD900AR-2
AWDINDAPPAR-2

I hereby certify that, to the best of my knowledge and belief, the forms referenced above comply with the applicable provisions of the state of Arkansas.

Date: September 30, 2009



Diane Ierna
Assistant Vice-President
Compliance Department