

SERFF Tracking Number: ALST-126388655 State: Arkansas  
 Filing Company: American Heritage Life Insurance Company State Tracking Number: 44122  
 Company Tracking Number: AWD1900  
 TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other  
 Product Name: Life and Health Payroll Application  
 Project Name/Number: AWD1900/AWD1900

## Filing at a Glance

Company: American Heritage Life Insurance Company

Product Name: Life and Health Payroll SERFF Tr Num: ALST-126388655 State: Arkansas

Application

TOI: L08 Life - Other SERFF Status: Closed-Approved- State Tr Num: 44122  
 Closed

Sub-TOI: L08.000 Life - Other Co Tr Num: AWD1900 State Status: Approved-Closed

Filing Type: Form Reviewer(s): Linda Bird

Authors: Jennifer Aiello, Lynn Disposition Date: 11/19/2009

Bautista, Leslie Blandford, Juli

Clausen

Date Submitted: 11/18/2009 Disposition Status: Approved-Closed

Implementation Date Requested: On Approval Implementation Date:

State Filing Description:

## General Information

Project Name: AWD1900

Status of Filing in Domicile: Pending

Project Number: AWD1900

Date Approved in Domicile:

Requested Filing Mode:

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: 11/19/2009

Explanation for Other Group Market Type:

State Status Changed: 11/19/2009

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. These forms are new and, when approved, will replace application AWD900AR-2, approved by your department on October 5, 2009 under Tracking # 43639. These applications will be used to apply for coverage of previously approved forms used in the payroll deduction market.

AWD1900EAR will be used for applications taken through electronic means using a pen-based signature pad, PIN

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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.

AWD1900PAR will be used in traditional paper application situations using ink signatures.

EDEL will be used to allow the policyholder to choose to receive their policy and related correspondence electronically or by paper.

Please see the enclosed Statement of Variability explaining areas within the application that are bracketed.

We have included any filing fees and/or forms required by your state. If you have any questions, feel free to call me at (904) 992-2912. I can also be reached by email at jclav@allstate.com.

## 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

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: \$60.00  
 Retaliatory? No  
 Fee Explanation: \$20 per form X 3 forms  
 Per Company: No

| COMPANY | AMOUNT | DATE PROCESSED | TRANSACTION # |
|---------|--------|----------------|---------------|
|---------|--------|----------------|---------------|

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American Heritage Life Insurance Company \$60.00 11/18/2009 32133675

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Product Name: Life and Health Payroll Application  
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## Correspondence Summary

### Dispositions

| Status          | Created By | Created On | Date Submitted |
|-----------------|------------|------------|----------------|
| Approved-Closed | Linda Bird | 11/19/2009 | 11/19/2009     |

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Project Name/Number: AWD1900/AWD1900

## Disposition

Disposition Date: 11/19/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: ALST-126388655 State: Arkansas  
 Filing Company: American Heritage Life Insurance Company State Tracking Number: 44122  
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 Product Name: Life and Health Payroll Application  
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| Schedule            | Schedule Item                     | Schedule Item Status | Public Access |
|---------------------|-----------------------------------|----------------------|---------------|
| Supporting Document | Flesch Certification              |                      | Yes           |
| Supporting Document | Application                       |                      | No            |
| Supporting Document | Statement of Variability          |                      | Yes           |
| Form                | Payroll Application               |                      | Yes           |
| Form                | Payroll Application               |                      | Yes           |
| Form                | Electronic Delivery Election Form |                      | Yes           |

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## Form Schedule

### Lead Form Number: AWD1900EAR

| Schedule Item Status | Form Number    | Form Type                          | Form Name                            | Action  | Action Specific Data | Readability | Attachment         |
|----------------------|----------------|------------------------------------|--------------------------------------|---------|----------------------|-------------|--------------------|
|                      | AWD1900E<br>AR | Application/<br>Enrollment<br>Form | Payroll Application                  | Initial |                      | 52.000      | AWD1900EA<br>R.pdf |
|                      | AWD1900P<br>AR | Application/<br>Enrollment<br>Form | Payroll Application                  | Initial |                      | 52.000      | AWD1900PA<br>R.pdf |
|                      | EDEL           | Application/<br>Enrollment<br>Form | Electronic Delivery<br>Election Form | Initial |                      | 0.000       | EDEL.pdf           |

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

|   |   |                          |     |   |   |                        |   |                                   |
|---|---|--------------------------|-----|---|---|------------------------|---|-----------------------------------|
| Employee/Payor (if other than Proposed Insured) |   | Employee's Date of Birth |     | Employee/Payor Social Security Number                           |   | Employee's I.D. Number |   |                                   |
| <b>PROPOSED INSURED</b>                         | Proposed Insured (Last, First, M.I.)                            |                          |     | <input type="checkbox"/> Emp.<br><input type="checkbox"/> Child | <input type="checkbox"/> Spouse<br><input type="checkbox"/> Other | Height                 | Weight  | Social Security Number (if known) |
|   | Resident Address  |                          |     | City  | State   | Zip                    | Resident Phone Number                             |                                   |
|   | Employer  |                          |     | Occupation  |   |                        | Date Hired  |                                   |
|   | Owner's Name and Address (if different than Proposed Insured's) |                          |     | City  | State   | Zip                    | Social Security Number or Tax I.D. Number (Owner) | Owner's Email Address             |
|   | Primary Beneficiary - Full Name                                 |                          | Age | Relationship  | Contingent Beneficiary - Full Name                                |                        | Age   | Relationship                      |

**Please complete this section for persons to be insured**

| Relationship to Employee | CODE | Last Name | First Name | Date of Birth | Sex | Actively at Work*  | Full Time Student  | Used tobacco in any form in last 12 months?              |
|--------------------------|------|-----------|------------|---------------|-----|--|--|--|
| Employee                 | E    |           |            |               |     | <input type="checkbox"/> Yes <input type="checkbox"/> No | N/A  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Spouse                   | S    |           |            |               |     | <input type="checkbox"/> Yes <input type="checkbox"/> No | N/A  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Dependent                |      |           |            |               |     | N/A  | <input type="checkbox"/> Yes <input type="checkbox"/> No | N/A  |
| Dependent                |      |           |            |               |     | N/A  | <input type="checkbox"/> Yes <input type="checkbox"/> No | N/A  |
| Dependent                |      |           |            |               |     | N/A  | <input type="checkbox"/> Yes <input type="checkbox"/> No | N/A  |

\*Actively at work means that he/she is actively at work now for wage or profit and has 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.

List additional dependents on separate sheet. Relationship Codes: E-Employee, S-Spouse, C-Child (Son or Daughter), G-Grandchild, O-Other. Please provide details of "Other" in Remarks section.

|   |  |  |   |   |   |  |  |  |              |  |              |              |
|---|--|--|---|---|---|--|--|--|--------------|--|--------------|--------------|
| <b>INSURANCE PLAN S</b>   | <b>Universal Life</b> _____<br><input type="checkbox"/> SI<br><input type="checkbox"/> CGI   | Face Amount  | Riders  | Rider   | Rider   | Rider  | Rider  | Rider  | Rider        | Rider  | Rider        | Mode Premium |
|   |  | Death Benefit Option <input type="checkbox"/> 1 <input type="checkbox"/> 2 | Units/Amt   |   |   |  |  |  |              |  |              | \$           |
|   | <b>Term Life</b> _____<br><input type="checkbox"/> SI<br><input type="checkbox"/> CGI  | Face Amount  | Riders  | Rider   | Rider   | Rider  | Rider  | Rider  | Rider        | Rider  | Rider        | Mode Premium |
|   |  |  | Units/Amt   |   |   |  |  |  |              |  |              | \$           |
|   | <b>Disability</b> _____<br><input type="checkbox"/> SI<br><input type="checkbox"/> CGI   | Monthly Salary \$ _____  | Elimination Period _____ Days Acc. _____ Days Sick. | On The Job Rider <input type="checkbox"/> Yes <input type="checkbox"/> No | Accident Rider <input type="checkbox"/> Yes <input type="checkbox"/> No | Section 125 <input type="checkbox"/> Yes <input type="checkbox"/> No | Mode Premium   |  |              |  |              |              |
|   | <b>Occupation Class</b> <input type="checkbox"/> Preferred <input type="checkbox"/> Standard   | Monthly Benefit \$ _____   | Benefit Period _____ Months                         | Units _____   | <input type="checkbox"/> Individual <input type="checkbox"/> Family     |  | \$   |  |              |  |              |              |
|   | <b>Cancer</b> _____<br>(Plan Type)<br><input type="checkbox"/> Individual <input type="checkbox"/> Family  | Riders   | Rider   | Rider   | Rider   | Rider  | Rider  | Section 125 <input type="checkbox"/> Yes <input type="checkbox"/> No | Mode Premium |  |              |              |
|   |  | Units/Amts.  |   |   |   |  |  | \$   |              |  |              |              |
|   | <b>Accident</b> _____<br>(Plan Type and Units)<br><input type="checkbox"/> SI <input type="checkbox"/> CGI <input type="checkbox"/> Individual <input type="checkbox"/> Family | Monthly Salary \$ _____  | Rider APDIR   | Rider APBER   | Rider APEXT   | Rider APOPTR1  | Rider APHCR1   | Section 125 <input type="checkbox"/> Yes <input type="checkbox"/> No | Mode Premium |  |              |              |
|   |  | Rider Units  |   |   |   |  |  | \$   |              |  |              |              |
| <b>SHOP (Hospital Indemnity)</b> _____ Units: _____<br><input type="checkbox"/> SI <input type="checkbox"/> CGI <input type="checkbox"/> Individual <input type="checkbox"/> Ind. & Children <input type="checkbox"/> Ind. & Spouse <input type="checkbox"/> Family | Rider IHR1   | Rider SAR1   | Rider IPBR1   | Rider OPBR1   | Rider OEAR1   | Rider AHNH   | Rider TR1  | Rider ADIR1  | Rider SDIR1  | Section 125 <input type="checkbox"/> Yes <input type="checkbox"/> No | Mode Premium |              |
|   |  |  |   |   |   |  |  |  |              | \$   |              |              |
| <b>Heart/Stroke</b> _____ <input type="checkbox"/> Individual <input type="checkbox"/> Family<br>Units: _____   | Riders   | Rider CIDR1  | Rider ICR   | Rider WBR   | Rider   | Rider  | Section 125 <input type="checkbox"/> Yes <input type="checkbox"/> No | Mode Premium   |              |  |              |              |
|   | Units/Amt  |  |   |   |   |  | \$   |  |              |  |              |              |
| <b>Critical Illness</b> _____ <input type="checkbox"/> Individual <input type="checkbox"/> Family <input type="checkbox"/> Single Parent Family<br>Basic Benefit Amount: _____  | Riders   | Rider CICR1  | Rider WBR   | Rider   | Rider   | Rider  | Section 125 <input type="checkbox"/> Yes <input type="checkbox"/> No | Mode Premium   |              |  |              |              |
|   | Units/Amt  |  |   |   |   |  | \$   |  |              |  |              |              |

|  |  |                    |                      |                              |
|--|--|--------------------|----------------------|------------------------------|
| PAC <input type="checkbox"/> Checking <input type="checkbox"/> Savings | Transit Number _____<br>Routing Number _____ | Account Name _____ | Account Number _____ | Total Mode Premium: \$ _____ |
|--|--|--------------------|----------------------|------------------------------|

|               |  |   |
|---------------|--|---|
| Remarks _____ | <b>Premiums/Billing Mode</b><br><input type="checkbox"/> Monthly<br><input type="checkbox"/> Semi-Monthly<br><input type="checkbox"/> Bi-weekly<br><input type="checkbox"/> Weekly<br><input type="checkbox"/> Other | Requested Issue Date _____<br>Date of First Deduction _____ |
|---------------|--|---|



**[ELECTRONIC DELIVERY (Please check YES or NO)]**

By checking the "Yes" box below, I agree to electronic delivery of my insurance policy(ies), describing my coverages and any accompanying notices ("my Policy"), and all future correspondence regarding my Policy, to include claim correspondence, explanations of benefit, periodic notices (such as privacy notices) and policy administration correspondence. If electronically delivered, I will be provided instructions on how to receive my Policy and correspondence regarding my Policy via the following address: [www.allstateatwork.com/mybenefits](http://www.allstateatwork.com/mybenefits).

I understand that to access these documents electronically, I will need a personal computer with internet access and appropriate browser software, and Adobe® Acrobat® Reader® software.

My consent is valid while I am covered under my Policy. At any time, I may withdraw my consent for any reason and receive future correspondence in paper, to include a paper copy of my Policy 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 my Policy and all correspondence regarding my Policy electronically via the internet.  
 NO, I prefer to receive paper copies of my Policy and all correspondence regarding my Policy.]

**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 the "effective date" of the policy for health insurance coverages will be the policy date recorded on the policy, 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 FOR SI LIFE AND CRITICAL ILLNESS.** 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. • **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.

**Any 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.** I certify that to the best of my knowledge and belief the information in this application is complete, accurate and correctly recorded.

| Servicing Agent: | Producer Number | Percentage Credit |
|------------------|-----------------|-------------------|
|                  |                 | %                 |
|                  |                 | %                 |
|                  |                 | %                 |
|                  |                 | %                 |
|                  |                 | %                 |

Signature of Producer \_\_\_\_\_ Print Producer's Name \_\_\_\_\_

**Important Notice About Privacy:**

In processing your application, an investigative report may be made. Information is obtained through interviews with third parties, such as family members, business associates, financial sources, friends, neighbors, or others with whom you are acquainted. This inquiry includes information as to your character, general information and personal characteristics. You have the right to make a written request within a reasonable period of time for a complete and accurate disclosure of additional information concerning the nature and scope of the investigation. No information obtained from the Medical Information Bureau pertaining to Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS) will affect the issuance or the underwriting of this policy except, upon written consent, to be medically tested for HIV or AIDS and the results of such testing proved positive.

**IN/MIB-1 (03/09)****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-1 (03/09)**

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

|   |   |                          |              |   |   |   |              |                                   |  |
|---|---|--------------------------|--------------|---|---|---|--------------|-----------------------------------|--|
| Employee/Payor if other than Proposed Insured |   | Employee's Date of Birth |              | Employee/Payor Social Security Number                           |   | Employee's I.D. Number                            |              |                                   |  |
| <b>PROPOSED INSURED</b>                       | Proposed Insured (Last, First, M.I.)                            |                          |              | <input type="checkbox"/> Emp.<br><input type="checkbox"/> Child | <input type="checkbox"/> Spouse<br><input type="checkbox"/> Other | Height  | Weight       | Social Security Number (if known) |  |
|   | Resident Address  |                          | City         | State   | Zip   | Resident Phone Number                             |              |                                   |  |
|   | Employer  |                          |              | Occupation  |   |   | Date Hired   |                                   |  |
|   | Owner's Name and Address (if different than Proposed Insured's) |                          | City         | State   | Zip   | Social Security Number or Tax I.D. Number (Owner) |              | Owner's Email Address             |  |
| Primary Beneficiary - Full Name               |   | Age                      | Relationship | Contingent Beneficiary - Full Name                              |   | Age   | Relationship |                                   |  |

**Please complete this section for persons to be insured (except information already provided above)**

| Relationship to Employee | CODE | Last Name | First Name | Date of Birth | Sex | Actively at Work*  | Full Time Student  | Used tobacco in any form in last 12 months?              |
|--------------------------|------|-----------|------------|---------------|-----|--|--|--|
| Employee                 | E    |           |            |               |     | <input type="checkbox"/> Yes <input type="checkbox"/> No | N/A  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Spouse                   | S    |           |            |               |     | <input type="checkbox"/> Yes <input type="checkbox"/> No | N/A  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Dependent                |      |           |            |               |     | N/A  | <input type="checkbox"/> Yes <input type="checkbox"/> No | N/A  |
| Dependent                |      |           |            |               |     | N/A  | <input type="checkbox"/> Yes <input type="checkbox"/> No | N/A  |
| Dependent                |      |           |            |               |     | N/A  | <input type="checkbox"/> Yes <input type="checkbox"/> No | N/A  |

\*Actively at work means that he/she is actively at work now for wage or profit and has 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.

List additional dependents on separate sheet. Relationship Codes: E-Employee, S-Spouse, C-Child (Son or Daughter), G-Grandchild, O-Other. Please provide details of "Other" in Remarks section.

|   |   |           |  |   |   |   |  |  |  |  |              |  |              |
|---|---|-----------|--|---|---|---|--|--|--|--|--------------|--|--------------|
| <b>PLANS</b>  | <b>Universal Life</b> _____<br><input type="checkbox"/> SI<br><input type="checkbox"/> CGI  |           | Face Amount  | Riders  | Rider   | Rider   | Rider  | Rider  | Rider  | Rider  | Rider        | Rider  | Mode Premium |
|   |   |           | Death Benefit Option <input type="checkbox"/> 1 <input type="checkbox"/> 2 | Units/Amt   |   |   |  |  |  |  |              |  | \$           |
|   | <b>Term Life</b> _____<br><input type="checkbox"/> SI<br><input type="checkbox"/> CGI   |           | Face Amount  | Riders  | Rider   | Rider   | Rider  | Rider  | Rider  | Rider  | Rider        | Rider  | Mode Premium |
|   |   |           |  | Units/Amt   |   |   |  |  |  |  |              |  | \$           |
|   | <b>Disability</b> _____<br><input type="checkbox"/> SI<br><input type="checkbox"/> CGI  |           | Monthly Salary \$ _____  | Elimination Period _____ Days Acc. _____ Days Sick. | On The Job Rider <input type="checkbox"/> Yes <input type="checkbox"/> No | Accident Rider <input type="checkbox"/> Yes <input type="checkbox"/> No | Section 125 <input type="checkbox"/> Yes <input type="checkbox"/> No | Mode Premium   |  |  |              |  |              |
|   | <b>Occupation Class</b> <input type="checkbox"/> Preferred <input type="checkbox"/> Standard  |           | Monthly Benefit \$ _____   | Benefit Period _____ Months                         | Units _____   | <input type="checkbox"/> Individual <input type="checkbox"/> Family     |  | \$   |  |  |              |  |              |
|   | <b>Cancer</b> _____<br>(Plan Type) <input type="checkbox"/> Individual <input type="checkbox"/> Family  |           | Riders   | Rider   | Rider   | Rider   | Rider  | Rider  | Rider  | Section 125 <input type="checkbox"/> Yes <input type="checkbox"/> No | Mode Premium |  |              |
|   |   |           | Units/Amts.  |   |   |   |  |  |  | \$   |              |  |              |
|   | <b>Accident</b> _____<br>(Plan Type and Units) <input type="checkbox"/> SI <input type="checkbox"/> CGI <input type="checkbox"/> Individual <input type="checkbox"/> Family   |           | Monthly Salary \$ _____  | Rider APDIR   | Rider APBER   | Rider APEXT   | Rider APOPTR1  | Rider APHCR1   | Section 125 <input type="checkbox"/> Yes <input type="checkbox"/> No | Mode Premium   |              |  |              |
|   |   |           | Rider Units  |   |   |   |  |  | \$   |  |              |  |              |
|   | <b>SHOP (Hospital Indemnity)</b> _____ Units: _____<br><input type="checkbox"/> SI <input type="checkbox"/> CGI <input type="checkbox"/> Ind. & Children <input type="checkbox"/> Ind. & Spouse <input type="checkbox"/> Family |           | Rider IHR1   | Rider SAR1  | Rider IPBR1   | Rider OPBR1   | Rider OEAR1  | Rider AHNH   | Rider TR1  | Rider ADIR1  | Rider SDIR1  | Section 125 <input type="checkbox"/> Yes <input type="checkbox"/> No | Mode Premium |
|   |   |           |  |   |   |   |  |  |  |  |              | \$   |              |
| <b>Heart/Stroke</b> _____ <input type="checkbox"/> Individual <input type="checkbox"/> Family   |   | Riders    | Rider CIDR1  | Rider ICR   | Rider WBR   | Rider   | Rider  | Section 125 <input type="checkbox"/> Yes <input type="checkbox"/> No | Mode Premium   |  |              |  |              |
| Units: _____  |   | Units/Amt |  |   |   |   |  | \$   |  |  |              |  |              |
| <b>Critical Illness</b> _____ <input type="checkbox"/> Individual <input type="checkbox"/> Family <input type="checkbox"/> Single Parent Family |   | Riders    | Rider CICR1  | Rider WBR   | Rider   | Rider   | Rider  | Section 125 <input type="checkbox"/> Yes <input type="checkbox"/> No | Mode Premium   |  |              |  |              |
| Basic Benefit Amount: _____   |   | Units/Amt |  |   |   |   |  | \$   |  |  |              |  |              |

|   |  |                  |                   |                        |
|---|--|------------------|-------------------|------------------------|
| PAC <input type="checkbox"/> Checking<br><input type="checkbox"/> Savings | Transit Number _____<br>Routing Number _____   | Account Name     | Account Number    | Total Mode Premium: \$ |
| Remarks   | Premiums/Billing Mode<br><input type="checkbox"/> Monthly <input type="checkbox"/> Semi-Monthly <input type="checkbox"/> Bi-weekly<br><input type="checkbox"/> Weekly <input type="checkbox"/> Other | Producer Number  | Percentage Credit |                        |
|   | Requested Issue Date _____   | Servicing Agent: |                   |                        |
|   | Date of First Deduction _____  |                  |                   |                        |
|   |  |                  |                   |                        |
|   |  |                  |                   |                        |

AWD1900PAR

(2010)

**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-1 (03/09)**



**Allstate**®

Workplace Division

**IF QUESTIONS 1-7 BELOW ARE ANSWERED "YES," PLEASE LIST THE REQUIRED HEALTH HISTORY IN QUESTION 8 BELOW.**

|   |  |  |
|---|--|--|
| All except Accident   | 1) 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 CGI   | 2) Has any person to be insured been disabled or hospitalized on an inpatient basis or had outpatient surgery in the last 6 months?  | <input type="checkbox"/> Yes <input type="checkbox"/> No   |
| Cancer (policies and riders) & SI Hospital Indemnity  | 3) a) Has any person to be insured ever been diagnosed with or treated for any type of cancer, other than basal cell skin cancer?<br>b) If the answer to 3a is yes, has any person to be insured ever been diagnosed with or treated for leukemia, Hodgkin's Disease, lymphoma or cancer with any lymph node involvement or more than one metastasis?<br>c) Has any person to be insured been diagnosed with or received treatment for any other type of cancer (other than those listed in 3b and/or basal cell skin cancer) during the last 5 years?   | <input type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |
| Heart/Stroke, Intensive Care, SI Hospital Indemnity & Critical Illness                                      | 4) a) Has any person to be insured had or is now being treated for: a stroke; a heart attack; a heart condition; heart trouble or any abnormality of the heart (including artery disease)?<br>b) Has any person to be insured in the last year 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<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |
| SI Life, Disability, Critical Illness & SI Sickness (DI) Riders to Accident                                 | 5) a) Has any person to be insured in the last 2 years, seen a physician (other than for colds, flu, normal pregnancy or a routine physical with no unfavorable results), had, been treated for, or been told by a member of the medical profession that he/she has: diabetes, emphysema, 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, or pancreas; paralysis; optic neuritis; cancer (except basal cell skin cancer), malignant tumor, leukemia, Hodgkin's Disease; or stroke?<br>b) Has any person to be insured in the last 2 years had or been treated for asthma or any disorder of the back, neck or stomach?<br>If yes, complete exclusion endorsement if applying for disability products.<br>c) Has any person to be insured in the last year had a systolic blood pressure reading higher than 150 more than once or a diastolic blood pressure reading higher than 100 more than once?<br>d) Has any person to be insured, in the last 2 years, been treated for or counseled for alcohol or drug abuse?<br>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?<br>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<br><input type="checkbox"/> Yes <input type="checkbox"/> No |
| Critical Illness  | 6) 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   |
| SI Life   | 7) 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   |
| Required Health History (For Critical Illness, list primary physician's name, address and telephone number) | 8) Name _____ Nature of Illness/Injury or Medical Attention/Reason Last Consulted _____ Date and/or Duration _____ Name and Address of Physician or Hospital/Clinic _____<br><br>Use additional paper if needed  |  |
| All - Replacement   | 9) a) <b>Proposed Insured.</b> Is this insurance to replace or change any existing life (if applied for) or health (if applied for) coverage?<br>If yes, indicate product being replaced or changed and complete replacement form provided by your producer if required by your state.<br>_____<br>b) <b>Producer.</b> To your knowledge, is change or replacement involved?   | <input type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |
| All - Existing  | 10) a) <b>Proposed Insured.</b> If you are applying for the type of coverage listed above, is there any other (not listed in question 9) life, cancer, heart/stroke, disability, hospital, critical illness or accident insurance in force or applied for on any person to be insured? If yes, list company name, policy number, year issued, type of coverage, and amount of benefit.<br>_____<br>_____<br>b) <b>Producer.</b> To your knowledge, does any person to be insured have existing coverage in force?  | <input type="checkbox"/> Yes <input type="checkbox"/> No<br><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. • **UNDERSTANDING.** I understand that the "effective date" of the policy for health insurance coverages will be the policy date recorded on the policy, 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 FOR SI LIFE AND CRITICAL ILLNESS.** 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. • **FRAUD WARNING.** Any person who knowingly presents a false or fraudulent claim for a payment of 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.

**Any 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. (Must Complete)** 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 \_\_\_\_\_

**AWD1900PAR**

**(2010)**

**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-1 (03/09)**

**[ELECTRONIC DELIVERY (Please check YES or NO)**

By checking the "Yes" box below, I agree to electronic delivery of my insurance policy(ies), describing my coverages and any accompanying notices ("my Policy"), and all future correspondence regarding my Policy, to include claim correspondence, explanations of benefit, periodic notices (such as privacy notices) and policy administration correspondence. If electronically delivered, I will be provided instructions on how to receive my Policy and correspondence regarding my Policy via the following address: [www.allstateatwork.com/mybenefits](http://www.allstateatwork.com/mybenefits).

I understand that to access these documents electronically, I will need a personal computer with internet access and appropriate browser software, and Adobe® Acrobat® Reader® software.

My consent is valid while I am covered under my Policy. At any time, I may withdraw my consent for any reason and receive future correspondence in paper, to include a paper copy of my Policy 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 my Policy and all correspondence regarding my Policy electronically via the internet.

NO, I prefer to receive paper copies of my Policy and all correspondence regarding my Policy.]

Signature of Proposed Insured: \_\_\_\_\_ Signature of Owner, if other than Insured: \_\_\_\_\_

Signature of Producer: \_\_\_\_\_ Print Producer's Name: \_\_\_\_\_

Date Signed: \_\_\_\_\_

SERFF Tracking Number: ALST-126388655 State: Arkansas  
Filing Company: American Heritage Life Insurance Company State Tracking Number: 44122  
Company Tracking Number: AWD1900  
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other  
Product Name: Life and Health Payroll Application  
Project Name/Number: AWD1900/AWD1900

## Supporting Document Schedules

|  | Item Status: | Status Date: |
|--|--------------|--------------|
| <b>Satisfied - Item:</b> Flesch Certification<br><b>Comments:</b><br><b>Attachment:</b><br>AR Readability Certificate.pdf      |              |              |
| <b>Bypassed - Item:</b> Application<br><b>Bypass Reason:</b> Not applicable to this filing<br><b>Comments:</b>                 |              |              |
| <b>Satisfied - Item:</b> Statement of Variability<br><b>Comments:</b><br><b>Attachment:</b><br>AR Statement of Variability.pdf |              |              |

**AMERICAN HERITAGE LIFE INSURANCE COMPANY**  
Jacksonville, Florida 32224-6687

To the Policy Review Section, Arkansas Department of Insurance.

I certify that I have carefully reviewed the form(s) listed below and to the best of my knowledge and ability, find that the form(s) meet the minimum reading ease score on the test used.

| <u>Form</u>            | <u>Score</u> |
|------------------------|--------------|
| AWD1900EAR             | 52.0         |
| AWD1900PAR (with EDEL) | 52.0         |

Date: November 18, 2009

  
\_\_\_\_\_  
Diane Ierna  
Assistant Vice President, Compliance Department

**AMERICAN HERITAGE LIFE INSURANCE COMPANY  
STATEMENT OF VARIABILITY**

**Form Number – AWD1900EAR  
Description – Payroll Application**

| <b>Variable is reflected on page</b> | <b>Variable Language</b>           | <b>Variable Text</b>   |
|--------------------------------------|------------------------------------|--|
| 1, 4                                 | Logo, Address and Telephone Number | Subject to change if this company information changes.   |
| 3                                    | Electronic Delivery                | This language may change if the telephone number, address, website, requirements or other information changes. Also, this portion of the application may be omitted entirely for situations where we do not intend to provide electronic delivery. |

**Form Number – AWD1900PAR  
Description - Payroll Application**

| <b>Variable is reflected on page</b> | <b>Variable Language</b>           | <b>Variable Text</b>                                   |
|--------------------------------------|------------------------------------|--|
| 1                                    | Logo, Address and Telephone Number | Subject to change if this company information changes. |

**Form Number – EDEL  
Description – Supplement to Application**

|   |                                   |  |
|---|-----------------------------------|--|
| 1 | Electronic Delivery Election Form | This language may change if the telephone number, address, website, requirements or other information changes. |
|---|-----------------------------------|--|