

SERFF Tracking Number: AFDL-126021882 State: Arkansas
Filing Company: American Public Life Insurance Company State Tracking Number: 41471
Company Tracking Number: A08INDEEAR
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: A08INDEEAR
Project Name/Number: A08INDEEAR/A08INDEEAR

Filing at a Glance

Company: American Public Life Insurance Company

Product Name: A08INDEEAR SERFF Tr Num: AFDL-126021882 State: ArkansasLH
TOI: L08 Life - Other SERFF Status: Closed State Tr Num: 41471
Sub-TOI: L08.000 Life - Other Co Tr Num: A08INDEEAR State Status: Approved-Closed
Filing Type: Form Co Status: Reviewer(s): Linda Bird
Authors: Melissa Mahanes, Ashlie Snyder, Shari Vick, Janice Farmer Disposition Date: 02/09/2009
Date Submitted: 02/05/2009 Disposition Status: Approved-Closed
Implementation Date Requested: On Approval Implementation Date:

State Filing Description:

General Information

Project Name: A08INDEEAR Status of Filing in Domicile: Pending
Project Number: A08INDEEAR Date Approved in Domicile:
Requested Filing Mode: Review & Approval Domicile Status Comments: Filed with OK DOI on 2/4/09
Explanation for Combination/Other: Market Type: Individual
Submission Type: New Submission Group Market Size:
Overall Rate Impact: Group Market Type:
Filing Status Changed: 02/09/2009 Explanation for Other Group Market Type:
State Status Changed: 02/09/2009
Deemer Date: Corresponding Filing Tracking Number:
A08INDEEAR
Filing Description:
Submitted for Approval:
Form # A08INDEEAR Individual All-Product Application

Submission by: American Fidelity Assurance Company for American Public Life

SERFF Tracking Number: AFDL-126021882 State: Arkansas
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Project Name/Number: A08INDEEAR/A08INDEEAR

Enclosed for submission is the above-mentioned form. This is a new form and does not replace any previously approved forms. The form is completed in John Doe fashion. Variable information is marked in brackets []. This form will be marketed by American Public Life Insurance Company captive agents and licensed appointed brokers to individuals in our payroll market. We are filing this application under the L08.000 Life - Other type of insurance; however, this application will be used with all previously approved individual life and health products.

The above-mentioned form will be used to apply for all individual products previously exempted by your department. This application is designed to allow for customization of the final printed form. 3 options are available: 1) All product selections will print. Complete only those products applicable to the sale. 2) Print only the product selections the individual has applied for (subject to state approvals). 3) Print only the product selections being offered in the market/sale (subject to state approvals). The flesch score for this form is 50, excluding medical terminology.

This form may eventually be issued from an automated system. As denoted in our Statement of Variability, the final printed version of the form may vary. When printing the application in it's entirety, we will make every attempt to produce the automated version to duplicate this final printed format; however, fonts and word wrap can vary when going from one system or printer to another. We will not alter the wording and will try to duplicate all pages, including keeping the verbiage on each page as submitted for approval. The pages may print on different colors of paper depending upon the market.

I, Melissa Mahanes, am an employee of American Fidelity Assurance Company of Oklahoma City, Oklahoma. I am submitting this filing on behalf of American Public Life Insurance of Flowood, Mississippi. I have included the required authorization signed by an officer of American Public Life Insurance.

Company and Contact

Filing Contact Information

Melissa Mahanes, Compliance Analyst II
2000 Classen Blvd
Oklahoma City, OK 73106
melissa.mahanes@af-group.com
(800) 654-8489 [Phone]
(405) 523-5793[FAX]

Filing Company Information

American Public Life Insurance Company
2305 Lakeland Drive
CoCode: 60801
Group Code: 330
State of Domicile: Oklahoma
Company Type: LAH

SERFF Tracking Number: AFDL-126021882

State: Arkansas

Filing Company: American Public Life Insurance Company

State Tracking Number: 41471

Company Tracking Number: A08INDEEAR

TOI: L08 Life - Other

Sub-TOI: L08.000 Life - Other

Product Name: A08INDEEAR

Project Name/Number: A08INDEEAR/A08INDEEAR

Flowood, MS 39232
(601) 936-2157 ext. [Phone]

Group Name:
FEIN Number: 64-0349942

State ID Number:

SERFF Tracking Number: AFDL-126021882 State: Arkansas
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Filing Fees

Fee Required? Yes
Fee Amount: \$25.00
Retaliatory? Yes
Fee Explanation:
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
American Public Life Insurance Company	\$25.00	02/05/2009	25534128

SERFF Tracking Number: AFDL-126021882 State: Arkansas
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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	02/09/2009	02/09/2009

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Disposition

Disposition Date: 02/09/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: AFDL-126021882 State: Arkansas
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Item Type	Item Name	Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		Yes
Supporting Document	Compliance Certification		Yes
Supporting Document	Filing Fee Form		Yes
Supporting Document	Generic JD		Yes
Supporting Document	A08INDEE SoV		Yes
Supporting Document	APL09 Authorization Letter		Yes
Form	Individual Life & Health Payroll Application		Yes

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Form Schedule

Lead Form Number: A08INDEEAR

Review Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
	A08INDEEAR	Application/Individual Life & Enrollment Health Payroll Form Application	Initial		50	A08INDEEAR.pdf

FOR AGENT USE ONLY:

Requested Effective Date:

- New Enrollment
- Family Status Change
- Benefit Change



American Public Life Insurance Company

A member of the American Fidelity Group®

2305 Lakeland Drive • Flowood, Mississippi 39232

Phone: (601) 936-6600 or (800) 256-8606

Fax: (601) 936-2157

FOR HOME OFFICE USE ONLY:

Effective Date: _____

PRD #: _____

Group #: _____

Revised: _____

Individual Products • Application for Life and Health Insurance • Payroll Market/Direct Bill

PROPOSED INSURED'S INFORMATION

	Last Name	First Name	MI	Sex	Birthdate Mo/Day/Yr	Age	Height Feet/Inches	Weight Lbs.	Social Security #
Applicant				<input type="checkbox"/> M <input type="checkbox"/> F					
Spouse (must reside w/ applicant)				<input type="checkbox"/> M <input type="checkbox"/> F					
Child 1				<input type="checkbox"/> M <input type="checkbox"/> F					
Child 2				<input type="checkbox"/> M <input type="checkbox"/> F					
Child 3				<input type="checkbox"/> M <input type="checkbox"/> F					
Child 4				<input type="checkbox"/> M <input type="checkbox"/> F					

Resident Address: Number & Street City State Zip Home Phone Email Address

Mailing Address: (if different) Number & Street City State Zip

APPLICANT

EMPLOYER

Full Time? Yes No Hours Per Week: _____
 Salary: \$ _____ Hourly Weekly Monthly Annually
 Occupation: _____ Hire Date: _____

Name: _____
 City: _____ State: _____
 Work Phone: _____

Payroll Deduction Frequency: [12 13 24 26 52]
 Skip Mode: [8 9 10 11] Indicate Months: _____

Direct Bill Frequency: Monthly Bank Draft - Attach form
 Semi-Annual Annual

[Owner: (For life products, complete if other than applicant) Last Name, First Name, MI Social Security # Resident Address, City, State, Zip]

[Premium Payor: (Complete if other than applicant.) Last Name, First Name, MI Social Security # Resident Address, City, State, Zip]

BENEFICIARY INFORMATION

APPLICANT Primary _____ Relationship _____
 Contingent _____ Relationship _____
 Beneficiary of children's life coverage is, in all cases, the applicant.

[Beneficiary of Spouse's life coverage is the applicant unless named otherwise.
 SPOUSE (applicable to life products only): Primary _____ Relationship _____
 Contingent _____ Relationship _____]

CITIZENSHIP INFORMATION

Is/Are the person(s) to be insured, beneficiary(ies), premium payor, and policy owner(s) a citizen of the United States? Yes No (If No, give details.)

Full Name Country of Citizenship Permanent VISA (resident) card # or application receipt #

REPLACEMENT INFORMATION

For All: Does any person applying for coverage intend to replace, discontinue or change any health or individual life insurance policy? Yes No (If Yes, complete and return any required state specific forms for each applicable product and list policy information.)

Company Name Policy Number Product Type

[For LIFE Products Only: Does any person applying for life insurance have any existing coverage or pending applications for individual life insurance with this or any other company? Yes No (If Yes, complete state specific replacement form, if required.)]

PRODUCT SELECTION

	Premium
Accident Only [A-3] <input type="checkbox"/> Individual Only <input type="checkbox"/> Individual and Spouse <input type="checkbox"/> One Parent Family <input type="checkbox"/> Two Parent Family	
Unit(s): [<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4].....	\$
Optional Policy Benefits:	
[<input type="checkbox"/> Accidental Disability Income (Applicant Only) [<input type="checkbox"/> \$400 <input type="checkbox"/> \$500 <input type="checkbox"/> \$600 <input type="checkbox"/> \$700 <input type="checkbox"/> \$800 <input type="checkbox"/> \$900 <input type="checkbox"/> \$1,000.....	\$]
[<input type="checkbox"/> Accident Hospital Admission [<input type="checkbox"/> \$100 <input type="checkbox"/> \$200 <input type="checkbox"/> \$300 <input type="checkbox"/> \$400.....	\$]
[<input type="checkbox"/> Accident Only Intensive Care [<input type="checkbox"/> \$150 <input type="checkbox"/> \$300 <input type="checkbox"/> \$450 <input type="checkbox"/> \$600.....	\$]
Additional Benefit Riders:	
[<input type="checkbox"/> Total Disability - Sickness (Applicant Only) [<input type="checkbox"/> \$400 <input type="checkbox"/> \$500 <input type="checkbox"/> \$600 <input type="checkbox"/> \$700 <input type="checkbox"/> \$800 <input type="checkbox"/> \$900 <input type="checkbox"/> \$1,000]	
Sickness Elimination/Benefit Period [<input type="checkbox"/> 14 Days/3Months <input type="checkbox"/> 14 Days/6Months <input type="checkbox"/> 30 Days/6 Months.....	\$]
[<input type="checkbox"/> Gunshot Wound (Public Safety Personnel Only).....	\$]
Total Premium	\$]

[HEART DISEASE / HEART ATTACK / STROKE		Premium
Heart Disease/Heart Attack/Stroke [HD/A/S-2] <input type="checkbox"/> Individual Only <input type="checkbox"/> One Parent Family <input type="checkbox"/> Two Parent Family		
Daily Hospital Benefit: [<input type="checkbox"/> \$100 <input type="checkbox"/> \$200 <input type="checkbox"/> \$300].....		\$
Additional Benefit Riders:		
[<input type="checkbox"/> First Occurrence Lump Sum [<input type="checkbox"/> \$1,000 <input type="checkbox"/> \$2,000 <input type="checkbox"/> \$3,000 <input type="checkbox"/> \$4,000 <input type="checkbox"/> \$5,000].....		\$]
Total Premium		\$]

[DENTAL		Premium
Select Dental II <input type="checkbox"/> Individual Only <input type="checkbox"/> Individual and Spouse <input type="checkbox"/> One Parent Family <input type="checkbox"/> Two Parent Family		
Option: [<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D].....		\$
Additional Benefit Riders:		
[<input type="checkbox"/> Children's Orthodontic].....		\$]
Total Premium		\$]

TOTAL BILLED PREMIUM ALL PRODUCTS ALL POLICIES \$

[GENERAL UNDERWRITING AND MEDICAL QUESTIONS		Applicant	Spouse	Child(ren) (NAME, if Yes)
[[ALL COVERAGES]	Is the applicant actively at work and able to perform the regular duties of his/her occupation?	<input type="checkbox"/> Yes <input type="checkbox"/> No]]
[Any person answering YES to the following questions is not eligible for that coverage. If multiple children are to be covered, please list the first name of any child(ren) answering Yes on the line provided in that area.]				
[[ACCIDENT]	Is the insurance applied for to be in addition to any other Accident Only coverage with us or any other company?	<input type="checkbox"/> Yes <input type="checkbox"/> No]]
[[SICKNESS DISABILITY INCOME RIDER for ACCIDENT]	Within the last 3 years has any person to be insured received medical advice or sought treatment (including medication) for: heart or circulatory disease or disorder, diabetes treated with insulin, chronic liver condition or disease, stroke, transient ischemic attack, cancer (excluding non-melanoma skin cancer), back disorders, fibromyalgia, or chronic fatigue syndrome?	<input type="checkbox"/> Yes <input type="checkbox"/> No]]
[[CANCER] [LIFE] [HEART/STROKE] [INTENSIVE CARE] [HOSPITAL INDEMNITY]	Has any person to be insured had any positive test results indicating Human Immunodeficiency Virus (HIV), or been diagnosed as having Acquired Immunodeficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No]
[[HOSPITAL INDEMNITY]	Is the insurance applied for to be in addition to any other Hospital Indemnity coverage with us or any other company?	<input type="checkbox"/> Yes <input type="checkbox"/> No]]
	In the last 3 years has any person to be insured received medical advice or sought treatment (including medication) for: ulcerative colitis, Crohn's disease, Parkinson's disease, sickle-cell anemia, systemic lupus, Chronic Obstructive Pulmonary Disease (COPD), Alzheimer's disease or dementia, lymphatic disorder, paralysis, cirrhosis, rheumatoid arthritis, lung/respiratory disorder, tuberculosis, seizures, or thyroid disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No]
	Within the last year has any person to be insured been hospitalized (inpatient or outpatient), had surgery, or been recommended to be hospitalized, or have surgery for anything other than pregnancy?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No]
[[HOSPITAL INDEMNITY] [LIFE]	In the last 3 years has any person to be insured received medical advice or sought treatment (including medication) for: heart or circulatory disease or disorder, 3 or more medications taken at the same time for the control of high blood pressure; diabetes treated with insulin, chronic kidney disease (excluding stones), liver condition or disease, stroke, transient ischemic attack, cancer (excluding non-melanoma skin cancer), alcohol or drug problems?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No]
[[LIFE]	Within the last 3 years has any person to be insured been rated or declined for life insurance by any insurance company?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No]
[[LIFE]	If applying for spouse coverage, is the spouse currently disabled?		<input type="checkbox"/> Yes <input type="checkbox"/> No]]
	If applying for child coverage, is any child currently disabled?			<input type="checkbox"/> Yes <input type="checkbox"/> No]
	Within the last year has any person to be insured been hospitalized (inpatient or outpatient), or been recommended to be hospitalized, for anything other than routine well care, pregnancy or back problems?	<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]	Has any person to be insured received medical advice to have any diagnostic tests, examinations, or consultations to determine the existence of cancer that have not been completed; or had tests and results have not been received; or test results were abnormal and no follow-up or resolution has occurred?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No]
	Has any person to be insured received medical advice or sought treatment (including medication) for: Addison's disease, amyotrophic lateral sclerosis, grand mal epilepsy, systemic lupus erythematosus, multiple sclerosis, muscular dystrophy, myasthenia gravis, Niemann-Pick disease, osteomyelitis, Reye's syndrome, sickle-cell anemia, Tay-Sachs disease, toxic epidermal necrolysis, tuberculosis, or Whipple's disease in any form?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No]
	If YES, who and which disease(s)? _____			
	Any person(s) answering YES to this section will be excluded from coverage for the listed disease.			

[[CANCER]	In the last 10 years has any person to be insured received medical advice or sought treatment (including medication) for: cancer, including but not limited to, carcinoma, sarcoma, lymphoma, leukemia, Hodgkin's disease, melanoma or a malignant condition of any kind?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	In the last 3 years has any person to be insured received medical advice or sought treatment (including medication) for: skin cancer, including but not limited to basal cell carcinoma, squamous cell carcinoma, and carcinoma in-situ?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	If YES, who and which disease(s)? _____ Any person(s) answering YES to this section will be excluded from coverage for the listed disease.			
[[CRITICAL ILLNESS RIDER for CANCER] [INTENSIVE CARE] [HEART/STROKE]	Has any person to be insured ever received medical advice or sought treatment (including medication) for: heart attack or myocardial infarction, coronary angioplasty or artery bypass, any arterial disease, angina, cardiovascular disease, stroke, transient ischemic attack, or any abnormal condition or disease of the heart, arteries or circulatory system, or carotid artery disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Has any person to be insured received medical advice to have any diagnostic tests, examinations, or consultations for the heart or circulatory system that have not been completed; or had tests and results have not been received; or test results were abnormal and no follow-up or resolution has occurred?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
[[HEART/STROKE]	Has any person to be insured ever used or been told to use insulin for the treatment or control of diabetes?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No]]

SIGNATURE AND ACKNOWLEDGMENT

To the best of my knowledge and belief, the statements and answers given in this application are true, complete and correctly recorded. I understand that the company will issue this coverage in reliance upon the truthfulness of my responses to the questions contained in this application. I understand the company has the right to rescind coverage(s) or deny claims based on the failure to provide accurate information at the time of application. **I have received and reviewed a copy of consumer brochure(s) [# APSB**

And, if applying for [Term or Whole Life]insurance, the required Accelerated Benefit Summary and Disclosure Notice. In [Texas], if applying for health insurance, I have received and reviewed an [Outline of Coverage].]

[Whole/Cash Value Life product, Complete This Section:

I understand that I will be asked to show a government issued photo ID, such as a driver's license, in order to identify myself.

Type of ID Provided: Driver's License, State _____ Passport Other _____

For ID Provided: ID # _____ Issue Date (if applicable) _____ Expiration Date] _____

[Life Insurance: I understand coverage, as applied for, will be in force on the date of this application if the Applicant(s) is insurable for the requested insurance on the date the policy takes effect and the first monthly premium is applied. This Interim Coverage will cease when the policy applied for has been issued or declined; or a policy other than as applied for is offered to the Owner. I have considered my present insurance needs and determined that the purchase of this insurance is suitable for me.]

[Health Insurance: I understand that coverage as applied for will not take effect until a policy is issued and the first premium is applied. Any coverage(s) for which I am applying may have wording that may limit benefits for a preexisting medical condition for which treatment has been sought or received, medication has been taken, a diagnosis received, or an expense incurred. Any coverage(s) for which I am applying may also have wording that could limit or reduce benefits.]

[Cancer Insurance: No person to be covered by this policy is covered by Medicaid or any similar program.]

Warning: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes a claim for the proceeds of an insurance policy containing any false, incomplete or misleading information or knowingly presents false information in an application for insurance may be guilty of insurance fraud.

Signed At (City and State)

Date

Signature of Applicant

Signature of Owner (If other than Applicant)

[AGENT STATEMENT

To the best of my knowledge the person(s) to be insured do(es) do(es) not have any existing individual life insurance; and, the person(s) to be insured do(es) do(es) not intend to replace, discontinue or change any such individual life coverage.

[Whole/Cash Value Life product, I have verified that the identification shown is that of the owner and it corresponds with the information provided as a part of the application process. I understand that my signature verifies I have seen the identification and the information is correct.]

Signature of Licensed Agent

Agent's Printed Name and Agent Number

Soliciting Agents: (Please Print. If split with other Agents, include on a separate sheet.)	Agent Number	Split Percent (Total = 100%)
[Name: _____	Agent #: _____	Split %: _____
Name: _____	Agent #: _____	Split %: _____
Name: _____	Agent #: _____	Split %: _____
Name: _____	Agent #: _____	Split %:] _____

Agent's Special Request :]

REMINDER: Applications received by American Public Life Insurance Company more than [30] days following the date taken will have to be rewritten with a current date.

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Rate Information

Rate data does NOT apply to filing.

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Supporting Document Schedules

Review Status:
Satisfied -Name: Flesch Certification 02/04/2009
Comments:
Attachment:
AR Readability Certification.pdf

Review Status:
Satisfied -Name: Application 02/04/2009
Comments:
Included on Forms Schedule Tab

Review Status:
Satisfied -Name: Compliance Certification 02/05/2009
Comments:
Attachment:
AR Compliance Certification.pdf

Review Status:
Satisfied -Name: Filing Fee Form 02/05/2009
Comments:
Attachment:
AR Filing Fee Form.pdf

Review Status:
Satisfied -Name: Generic JD 02/05/2009
Comments:
Attachment:
A08INDEE JD Generic.pdf

Review Status:
Satisfied -Name: A08INDEE SoV 02/05/2009
Comments:

SERFF Tracking Number: *AFDL-126021882* *State:* *Arkansas*
Filing Company: *American Public Life Insurance Company* *State Tracking Number:* *41471*
Company Tracking Number: *A08INDEEAR*
TOI: *L08 Life - Other* *Sub-TOI:* *L08.000 Life - Other*
Product Name: *A08INDEEAR*
Project Name/Number: *A08INDEEAR/A08INDEEAR*

Attachment:

STATEMENT OF VARIABILITY - A08INDEE for AR.pdf

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Product Name: A08INDEEAR
Project Name/Number: A08INDEEAR/A08INDEEAR

Review Status:

Satisfied -Name: APL09 Authorization Letter

02/05/2009

Comments:

Attachment:

Authorization09.pdf



American Public Life Insurance Company

A member of the American Fidelity Group

STATE OF ARKANSAS READABILITY CERTIFICATION

This is to certify that the Flesch scores for this filing are as follows:

A08INDEEAR Individual Life and Health Application is 50, excluding medical terminology

These forms are printed in not less than ten point type, one point leaded.

The number of words contained in each form is as follows:

A08INDEEAR Individual Life and Health Application is 784

The policy has been scored by the Flesch method.

A handwritten signature in black ink, appearing to read 'Alex M. Bagby'.

Alex M. Bagby, ASA, MAAA
Vice President & Chief Risk Officer
American Public Life Insurance Company

February 5, 2009
Date



A member of the American Fidelity Group

STATE OF ARKANSAS

COMPLIANCE CERTIFICATION

Form Number and Name: **A08INDEEAR Individual Life and Health Payroll Application**

I hereby certify that this filing does not discriminate unfairly between Policyholders and that it meets requirements set forth in Arkansas Rule and Regulation 19. I further certify, that to the best of my knowledge and judgment this filing is complete and accurate, and in compliance with the applicable laws and regulations of the State of Arkansas.

A handwritten signature in black ink, appearing to read 'Alex M. Bagby', with a long horizontal flourish extending to the right.

Alex M. Bagby, ASA, MAAA
Vice President & Chief Risk Officer
American Public Life Insurance Company

February 5, 2009

Date

ARKANSAS INSURANCE DEPARTMENT

400 University Tower Building
1123 South University Ave.
Little Rock, Arkansas 72204

Lee Douglass
Insurance Commissioner

501-686-2900

ATTN: LIFE & HEALTH DIVISION, ARKANSAS INSURANCE DEPARTMENT

Company Name: American Public Life Insurance Company

Company NAIC Code: 60801

Company Contact Person & Telephone # Melissa Mahanes 800-654-8489 x 2035

* INSURANCE DEPARTMENT USE ONLY *
* *
* ANALYST: _____ AMOUNT: _____ ROUTE SLIP: _____ *

ALL FEES ARE PER EACH INSURER, PER ANNUAL STATEMENT LINE OF BUSINESS,
UNLESS OTHERWISE INDICATED.

FEE SCHEDULE FOR ADMITTED INSURERS

RATE/FORM FILINGS

Life and/or Disability policy form filing and review, per each policy, contract, annuity form, per each insurer, per each filing.	* _____ x\$ 50= _____
Life and/or Disability - Filing and review of each rate filing or loss ratio guarantee filing, per each insurer.	**Retaliatory _____
	* _____ x\$ 50= _____

Life and/or Disability Policy, Contract or Annuity Forms: Filing and review of each certificate, rider, endorsement or application if each is filed separately from the basic form.	_____ 1 x\$ 20= <u>20.00</u>
---	------------------------------

Life and/or Disability: Filing and review of Insurer's advertisements, per advertisement, per each insurer.	_____ x\$ 25= _____
	**Retaliatory <u>\$25.00</u>

AMEND CERTIFICATE OF AUTHORITY

Review and processing of information to amend an Insurer's Certificate of Authority.	_____ x\$400= _____
Filing to amend Certificate of Authority.	* _____ x\$100= _____

FOR AGENT USE ONLY:

Requested Effective Date:

- New Enrollment
- Family Status Change
- Benefit Change



A member of the American Fidelity Group®
 2305 Lakeland Drive • Flowood, Mississippi 39232
 Phone: (601) 936-6600 or (800) 256-8606
 Fax: (601) 936-2157

FOR HOME OFFICE USE ONLY:

Effective Date: _____
 PRD #: _____
 Group #: _____
 Revised: _____

Individual Products • Application for Life and Health Insurance • Payroll Market/Direct Bill

PROPOSED INSURED'S INFORMATION

Applicant	Last Name	First Name	MI	Sex	Birthdate Mo/Day/Yr	Age	Height Feet/Inches	Weight Lbs.	Social Security #
	Doe	John		XM <input type="checkbox"/> F <input type="checkbox"/>	1/1/1973	35	6'1"	185	111-11-1111
Spouse (must reside w/ applicant)				<input type="checkbox"/> M <input type="checkbox"/> F					
Child 1				<input type="checkbox"/> M <input type="checkbox"/> F					
Child 2				<input type="checkbox"/> M <input type="checkbox"/> F					
Child 3				<input type="checkbox"/> M <input type="checkbox"/> F					
Child 4				<input type="checkbox"/> M <input type="checkbox"/> F					

Resident Address: Number & Street City State Zip Home Phone Email Address
 1234 Anystreet Anywhere Anystate 70000 111-111-1111 jd@jd.com

Mailing Address: (if different) Number & Street City State Zip

APPLICANT	EMPLOYER
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Full Time? x Yes <input type="checkbox"/> No _____ Hours Per Week: 40 _____ Salary: \$ 40,000 _____ <input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly x Annually Occupation: teacher _____ Hire Date: 1-1-2000 _____	Name: ABC Schools _____ City: Anywhere _____ State: Anystate _____ Work Phone: 222-222-2222 _____
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Payroll Deduction Frequency: [x12 13 24 26 52] Direct Bill Frequency: x Monthly Bank Draft - Attach form
 Skip Mode: [8 9 10 x 11] Indicate Months: December _____ Semi-Annual Annual

[Owner: (For life products, complete if other than applicant) Last Name, First Name, MI Social Security # Resident Address, City, State, Zip]

[Premium Payor: (Complete if other than applicant) Last Name, First Name, MI Social Security # Resident Address, City, State, Zip]

BENEFICIARY INFORMATION

APPLICANT Primary Jane Doe _____ Relationship Spouse _____
 Contingent _____ Relationship _____
 Beneficiary of children's life coverage is, in all cases, the applicant.

[Beneficiary of Spouse's life coverage is the applicant unless named otherwise.
 SPOUSE (applicable to life products only): Primary _____ Relationship _____
 Contingent _____ Relationship _____]

CITIZENSHIP INFORMATION

Is/Are the person(s) to be insured, beneficiary(ies), premium payor, and policy owner(s) a citizen of the United States? x Yes No (If No, give details.)
 Full Name Country of Citizenship Permanent VISA (resident) card # or application receipt #

REPLACEMENT INFORMATION

For All: Does any person applying for coverage intend to replace, discontinue or change any health or individual life insurance policy?
 Yes x No (If Yes, complete and return any required state specific forms for each applicable product and list policy information.)
 Company Name Policy Number Product Type

[For LIFE Products Only: Does any person applying for life insurance have any existing coverage or pending applications for individual life insurance with this or any other company? Yes No (If Yes, complete state specific replacement form, if required.)]

PRODUCT SELECTION

	Premium
Accident Only [A-3] x Individual Only <input type="checkbox"/> Individual and Spouse <input type="checkbox"/> One Parent Family <input type="checkbox"/> Two Parent Family	
Unit(s): [x 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4]	\$ xxx.xx
Optional Policy Benefits:	
[<input type="checkbox"/> Accidental Disability Income (Applicant Only) [<input type="checkbox"/> \$400 <input type="checkbox"/> \$500 <input type="checkbox"/> \$600 <input type="checkbox"/> \$700 <input type="checkbox"/> \$800 <input type="checkbox"/> \$900 <input type="checkbox"/> \$1,000	\$]
[<input type="checkbox"/> Accident Hospital Admission [<input type="checkbox"/> \$100 <input type="checkbox"/> \$200 <input type="checkbox"/> \$300 <input type="checkbox"/> \$400	\$]
[<input type="checkbox"/> Accident Only Intensive Care [<input type="checkbox"/> \$150 <input type="checkbox"/> \$300 <input type="checkbox"/> \$450 <input type="checkbox"/> \$600	\$]
Additional Benefit Riders:	
[<input type="checkbox"/> Total Disability - Sickness (Applicant Only) [<input type="checkbox"/> \$400 <input type="checkbox"/> \$500 <input type="checkbox"/> \$600 <input type="checkbox"/> \$700 <input type="checkbox"/> \$800 <input type="checkbox"/> \$900 <input type="checkbox"/> \$1,000 Sickness Elimination/Benefit Period [<input type="checkbox"/> 14 Days/3Months <input type="checkbox"/> 14 Days/6Months <input type="checkbox"/> 30 Days/6 Months	\$]
[<input type="checkbox"/> Gunshot Wound (Public Safety Personnel Only)	\$]
Total Premium	\$ xxx.xx]

[HEART DISEASE / HEART ATTACK / STROKE		Premium
Heart Disease/Heart Attack/Stroke [HD/A/S-2] <input type="checkbox"/> Individual Only <input type="checkbox"/> One Parent Family <input type="checkbox"/> Two Parent Family		
Daily Hospital Benefit: [<input type="checkbox"/> \$100 <input type="checkbox"/> \$200 <input type="checkbox"/> \$300].....		\$
Additional Benefit Riders:		\$]
<input type="checkbox"/> First Occurrence Lump Sum [<input type="checkbox"/> \$1,000 <input type="checkbox"/> \$2,000 <input type="checkbox"/> \$3,000 <input type="checkbox"/> \$4,000 <input type="checkbox"/> \$5,000].....		\$]
	Total Premium	\$]

[DENTAL		Premium
Select Dental II <input type="checkbox"/> Individual Only <input type="checkbox"/> Individual and Spouse <input type="checkbox"/> One Parent Family <input type="checkbox"/> Two Parent Family		
Option: [<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D].....		\$
Additional Benefit Riders:		\$]
<input type="checkbox"/> Children's Orthodontic		\$]
	Total Premium	\$]

TOTAL BILLED PREMIUM ALL PRODUCTS ALL POLICIES \$

[GENERAL UNDERWRITING AND MEDICAL QUESTIONS		Applicant	Spouse	Child(ren) (NAME, if Yes)
[[ALL COVERAGES]]	Is the applicant actively at work and able to perform the regular duties of his/her occupation?	X Yes <input type="checkbox"/> No]
[Any person answering YES to the following questions is not eligible for that coverage. If multiple children are to be covered, please list the first name of any child(ren) answering Yes on the line provided in that area.]				
[[ACCIDENT]]	Is the insurance applied for to be in addition to any other Accident Only coverage with us or any other company?	<input type="checkbox"/> Yes x No]
[[SICKNESS DISABILITY INCOME RIDER for ACCIDENT]]	Within the last 3 years has any person to be insured received medical advice or sought treatment (including medication) for: heart or circulatory disease or disorder, diabetes treated with insulin, chronic liver condition or disease, stroke, transient ischemic attack, cancer (excluding non-melanoma skin cancer), back disorders, fibromyalgia, or chronic fatigue syndrome?	<input type="checkbox"/> Yes <input type="checkbox"/> No]
[[CANCER] [LIFE] [HEART/STROKE] [INTENSIVE CARE] [HOSPITAL INDEMNITY]]	Has any person to be insured had any positive test results indicating Human Immunodeficiency Virus (HIV), or been diagnosed as having Acquired Immunodeficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
[[HOSPITAL INDEMNITY]]	Is the insurance applied for to be in addition to any other Hospital Indemnity coverage with us or any other company?	<input type="checkbox"/> Yes <input type="checkbox"/> No]
	In the last 3 years has any person to be insured received medical advice or sought treatment (including medication) for: ulcerative colitis, Crohn's disease, Parkinson's disease, sickle-cell anemia, systemic lupus, Chronic Obstructive Pulmonary Disease (COPD), Alzheimer's disease or dementia, lymphatic disorder, paralysis, cirrhosis, rheumatoid arthritis, lung/respiratory disorder, tuberculosis, seizures, or thyroid disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Within the last year has any person to be insured been hospitalized (inpatient or outpatient), had surgery, or been recommended to be hospitalized, or have surgery for anything other than pregnancy?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
[[HOSPITAL INDEMNITY] [LIFE]]	In the last 3 years has any person to be insured received medical advice or sought treatment (including medication) for: heart or circulatory disease or disorder, 3 or more medications taken at the same time for the control of high blood pressure; diabetes treated with insulin, chronic kidney disease (excluding stones), liver condition or disease, stroke, transient ischemic attack, cancer (excluding non-melanoma skin cancer), alcohol or drug problems?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
[[LIFE]]	Within the last 3 years has any person to be insured been rated or declined for life insurance by any insurance company?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
[[LIFE]]	If applying for spouse coverage, is the spouse currently disabled?		<input type="checkbox"/> Yes <input type="checkbox"/> No]
	If applying for child coverage, is any child currently disabled?			<input type="checkbox"/> Yes <input type="checkbox"/> No
	Within the last year has any person to be insured been hospitalized (inpatient or outpatient), or been recommended to be hospitalized, for anything other than routine well care, pregnancy or back problems?	<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]]	Has any person to be insured received medical advice to have any diagnostic tests, examinations, or consultations to determine the existence of cancer that have not been completed; or had tests and results have not been received; or test results were abnormal and no follow-up or resolution has occurred?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Has any person to be insured received medical advice or sought treatment (including medication) for: Addison's disease, amyotrophic lateral sclerosis, grand mal epilepsy, systemic lupus erythematosus, multiple sclerosis, muscular dystrophy, myasthenia gravis, Niemann-Pick disease, osteomyelitis, Reye's syndrome, sickle-cell anemia, Tay-Sachs disease, toxic epidermal necrolysis, tuberculosis, or Whipple's disease in any form?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	If YES, who and which disease(s)? _____			
	Any person(s) answering YES to this section will be excluded from coverage for the listed disease.			

[[CANCER]	In the last 10 years has any person to be insured received medical advice or sought treatment (including medication) for: cancer, including but not limited to, carcinoma, sarcoma, lymphoma, leukemia, Hodgkin's disease, melanoma or a malignant condition of any kind?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	In the last 3 years has any person to be insured received medical advice or sought treatment (including medication) for: skin cancer, including but not limited to basal cell carcinoma, squamous cell carcinoma, and carcinoma in-situ? If YES, who and which disease(s)? _____ Any person(s) answering YES to this section will be excluded from coverage for the listed disease.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
[[CRITICAL ILLNESS RIDER for CANCER] [INTENSIVE CARE] [HEART/STROKE]	Has any person to be insured ever received medical advice or sought treatment (including medication) for: heart attack or myocardial infarction, coronary angioplasty or artery bypass, any arterial disease, angina, cardiovascular disease, stroke, transient ischemic attack, or any abnormal condition or disease of the heart, arteries or circulatory system, or carotid artery disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Has any person to be insured received medical advice to have any diagnostic tests, examinations, or consultations for the heart or circulatory system that have not been completed; or had tests and results have not been received; or test results were abnormal and no follow-up or resolution has occurred?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
[[HEART/STROKE]	Has any person to be insured ever used or been told to use insulin for the treatment or control of diabetes?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No]]

SIGNATURE AND ACKNOWLEDGMENT

To the best of my knowledge and belief, the statements and answers given in this application are true, complete and correctly recorded. I understand that the company will issue this coverage in reliance upon the truthfulness of my responses to the questions contained in this application. I understand the company has the right to rescind coverage(s) or deny claims based on the failure to provide accurate information at the time of application. **I have received and reviewed a copy of consumer brochure(s) [# APSB 1234**

And, if applying for [Term or Whole Life]insurance, the required Accelerated Benefit Summary and Disclosure Notice. In [Texas], if applying for health insurance, I have received and reviewed an [Outline of Coverage].]

[Whole/Cash Value Life product, Complete This Section:

I understand that I will be asked to show a government issued photo ID, such as a driver's license, in order to identify myself.

Type of ID Provided: Driver's License, State _____ Passport Other _____

For ID Provided: ID # _____ Issue Date (if applicable) _____ Expiration Date] _____

[Life Insurance: I understand coverage, as applied for, will be in force on the date of this application if the Applicant(s) is insurable for the requested insurance on the date the policy takes effect and the first monthly premium is applied. This Interim Coverage will cease when the policy applied for has been issued or declined, or a policy other than as applied for is offered to the Owner. I have considered my present insurance needs and determined that the purchase of this insurance is suitable for me.]

[Health Insurance: I understand that coverage as applied for will not take effect until a policy is issued and the first premium is applied. Any coverage(s) for which I am applying may have wording that may limit benefits for a preexisting medical condition for which treatment has been sought or received, medication has been taken, a diagnosis received, or an expense incurred. Any coverage(s) for which I am applying may also have wording that could limit or reduce benefits.]

Warning: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes a claim for the proceeds of an insurance policy containing any false, incomplete or misleading information or knowingly presents false information in an application for insurance may be guilty of insurance fraud.

Anywhere, Anystate _____ 2-5-09 _____

Signed At (City and State) _____ Date _____

John Doe _____

Signature of Applicant _____ Signature of Owner (If other than Applicant)

[AGENT STATEMENT

To the best of my knowledge the person(s) to be insured do(es) x do(es) not have any existing individual life insurance; and, the person(s) to be insured do(es) x do(es) not intend to replace, discontinue or change any such individual life coverage.

[Whole/Cash Value Life product, I have verified that the identification shown is that of the owner and it corresponds with the information provided as a part of the application process. I understand that my signature verifies I have seen the identification and the information is correct.]

Joe Q Agent _____ Joe Q Agent 12345 _____

Signature of Licensed Agent _____ Agent's Printed Name and Agent Number

Soliciting Agents: (Please Print. If split with other Agents, include on a separate sheet.)	Agent Number	Split Percent (Total = 100%)
Name: _____	Agent #: _____	Split %: _____
Name: _____	Agent #: _____	Split %: _____
Name: _____	Agent #: _____	Split %: _____
Name: _____	Agent #: _____	Split %: _____

Agent's Special Request :] _____

REMINDER: Applications received by American Public Life Insurance Company more than [30] days following the date taken will have to be rewritten with a current date.

STATEMENT OF VARIABILITY

The A08INDEE Individual All Product Payroll Application contains variable information. All forms are completed in John Doe format and variable information is enclosed in brackets []. All variable items will become fixed at time of policy approval. Any changes made to these items will be limited to new issues.

1. All dollar amounts, units, levels, age bands, options and percentages have been marked variable for product flexibility.
2. All policy form numbers may vary in accordance with the policy form currently being marketed (subject to state approvals.)
3. The Proposed Insured's information section is not variable and will always print on the application.

The Payroll Deduction Frequency and Skip Mode options are not likely to vary, but may change in the future based on changes in our markets. We have included all options currently available for the Payroll Deduction Frequencies and Skip Mode selections.

5. The Beneficiary section is variable. The Beneficiary information for the Employee is not variable and will always print. The Spouse Beneficiary information applies to life products only and will only print if the Life product selections are included on the application.
6. The Citizenship section is not variable and will always print on the application.
7. The Replacement Information section is variable. Question 1 applies to all products and will always print on the application. Question 2 relates to life products only and will print when the life product selections are included on the application.
8. The Product Selection section and all rider selections may vary depending on our markets. The application included with this filing contains all currently available product and rider selections. However, a product may only be applied for if approved by your department. The current product selections are as follows: Select Dental II (form # Select Dental II, Heart Disease/Heart Attack/Stroke (form # HD/A/S-2), Renewable and Convertible Term Life Policy (RCLT07), Whole Life Policy (WL10007), Young Advantage Life (MPWL08), Cancer Indemnity (CPA 2200), Cancer Monthly (CPM 2200), Cancer Lump Sum (CLS-1000), Cancer & Specified Disease (APL C-9), Accident Only (A-3), Hospital Indemnity (HI-2200), Intensive Care Coronary Care (IC/CC3).

We may offer rider selections on each of these products. Riders will only be available for sale if previously approved by your department. All riders have been marked variable to allow for customization of the application. Only those riders approved for use will be available for sale.

In the Cancer section, the \$1,000 and \$2,000 face amounts currently listed for the Critical Illness Rider on the CPM-2200 product are only available for conversions from the Group GC-3 product.

We have marked many pieces of this section variable to allow for optimal customization of the application. However, this section will always have at least one product selection. The final application may print in one of the following 3 options: 1) All product selections will print and the applicant/agent will only complete those products applicable to the sale. 2) We will print only the product selections the individual has applied for (subject to state approvals). 3) We will print only the product selections being offered in the market/sale (subject to state approvals).

In the future, we may opt to add or delete product selections based on new product approvals, marketing practices or changes in regulations. At that time, we will file an updated Statement of Variability with your department. Changes will be limited to new issues only.

9. The General Underwriting and Medical Question section will vary depending on the Product Selections included on the application. We will either print this section in its entirety or we will print only those General Underwriting and Medical Questions applicable to the sale. In the future we may add or delete underwriting/medical questions depending on changes in our market.

This section will always have at least the All Coverage question. However, if we opt to vary this section, 3 options are available: 1) All product selections (base plan including riders) and medical questions will print. Complete only those medical questions applicable to the sale. 2) Print only the product selections and medical questions the individual has applied for (subject to state approvals). 3) Print only the product selections and medical questions being offered in the market/sale (subject to state approvals).

The Instructions may vary due to changes in our underwriting guidelines or changes in product/marketing needs.

10. The Suitability and Acknowledgment section may also vary in accordance with the Product Selections included on the application. If all available products are included on the application, then the entire Suitability and Acknowledgement section will print on the application. If one, two or a combination of products is included on the application, then only those portions of the Suitability and Acknowledgment section will print as follows:
 - a. The first paragraph of the Suitability and Acknowledgment section is not variable and will always print on the application.
 - b. The last 2 sentences of this paragraph may vary. If life product selections are not included on the application, we may opt to delete the following language, **“and, if applying for [Term or Whole Life] insurance, the required Accelerated Benefit Summary and Disclosure Notice.”** Based on changes to product designs, we may be required to expand the Term or Whole Life product description to include additional products.
 - c. If the application is for a state other than Texas, we may opt to delete the last sentence, **“In [Texas], if applying for health insurance, I have received and reviewed an [Outline of Coverage].”** In the future, changes in state laws or regulations may require us to include to amend the Outline of Coverage statement to include additional states or disclosures be provided at time of application.
 - d. The paragraph specific to Life Insurance will only print if the Life Product selection section is included on the application.
 - e. The paragraph specific to Cash Value and Whole Life insurance will only print if the Cash Value and Whole Life product selections are included on the application.
 - f. The paragraph specific to health insurance will print if a health product selection is included on the application.
 - g. The paragraph specific to Cancer Insurance will print if a health product selection is included on the application.
 - h. The fraud warning is not variable and will always print on the application.
 - i. The applicant signature block is not variable and will always print on the application.



American Public Life Insurance Company

A member of the American Fidelity Group.

February 3, 2009

NAIC Number: 60801
FEIN Number: 64-0349942

To Whom It May Concern:

American Fidelity Assurance Company, located at 2000 N. Classen Boulevard, Oklahoma City, Oklahoma, 73125, is hereby authorized to submit forms for approval to the Department of Insurance on behalf of American Public Life Insurance Company. Changes to the forms, as may be necessary to gain approval, are included in this authorization.

Sincerely,

Alex M. Bagby, ASA, MAAA
Vice President & Chief Risk Officer