

SERFF Tracking Number: AFDL-126023456 State: Arkansas
Filing Company: American Public Life Insurance Company State Tracking Number: 41499
Company Tracking Number: A08GRPEEAR
TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other
Product Name: A08GRPEEAR
Project Name/Number: A08GRPEEAR/A08GRPEEAR

Filing at a Glance

Company: American Public Life Insurance Company

Product Name: A08GRPEEAR SERFF Tr Num: AFDL-126023456 State: ArkansasLH
TOI: H21 Health - Other SERFF Status: Closed State Tr Num: 41499
Sub-TOI: H21.000 Health - Other Co Tr Num: A08GRPEEAR State Status: Approved-Closed
Filing Type: Form Co Status: Reviewer(s): Rosalind Minor
Authors: Melissa Mahanes, Ashlie Snyder, Shari Vick, Janice Farmer Disposition Date: 02/12/2009
Date Submitted: 02/06/2009 Disposition Status: Approved-Closed
Implementation Date Requested: On Approval Implementation Date:

State Filing Description:

General Information

Project Name: A08GRPEEAR Status of Filing in Domicile: Authorized
Project Number: A08GRPEEAR Date Approved in Domicile: 02/05/2009
Requested Filing Mode: Review & Approval Domicile Status Comments: approved
Explanation for Combination/Other: Market Type: Group
Submission Type: New Submission Group Market Size: Small and Large
Overall Rate Impact: Group Market Type: Employer, Association
Filing Status Changed: 02/12/2009 Explanation for Other Group Market Type:
Deemer Date: State Status Changed: 02/12/2009
Filing Description: Corresponding Filing Tracking Number:

American Fidelity Assurance Company is filing the above listed forms for approval with your Department on behalf of American Public Life Insurance Company.

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 employer and

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association groups.

The above-mentioned form will be used to apply for all group products previously exempted by your department. This application is designed to allow for customization of the final printed form. Three 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 these forms 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, Shari Vick, 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.

I hereby certify that to the best of my knowledge the forms submitted herewith are in compliance in all respects with the provisions of the insurance laws, rules and regulations of your state and such forms contain no provisions previously disapproved by the Department.

Thank you for your assistance with this matter. If you have any questions, please feel free to call me at 1-800-654-8489, extension 7782. My email address is shari.vick@af-group.com.

Sincerely,

Company and Contact

Filing Contact Information

Shari Vick, Compliance Analyst II
2000 Classen Blvd

shari.vick@af-group.com
(800) 654-8489 [Phone]

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Product Name: A08GRPEEAR
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Oklahoma City, OK 73106 (405) 523-5793[FAX]

Filing Company Information

American Public Life Insurance Company CoCode: 60801 State of Domicile: Oklahoma
2305 Lakeland Drive Group Code: 330 Company Type: LAH
Flowood, MS 39232 Group Name: State ID Number:
(601) 936-2157 ext. [Phone] FEIN Number: 64-0349942

SERFF Tracking Number: AFDL-126023456 State: Arkansas
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Filing Fees

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

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
American Public Life Insurance Company	\$25.00	02/06/2009	25552544

SERFF Tracking Number: AFDL-126023456 State: Arkansas
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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	02/12/2009	02/12/2009

SERFF Tracking Number: *AFDL-126023456* *State:* *Arkansas*
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TOI: *H21 Health - Other* *Sub-TOI:* *H21.000 Health - Other*
Product Name: *A08GRPEEAR*
Project Name/Number: *A08GRPEEAR/A08GRPEEAR*

Disposition

Disposition Date: 02/12/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Item Type	Item Name	Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	No
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	John Doe	Approved-Closed	Yes
Supporting Document	Statement of Variability	Approved-Closed	Yes
Supporting Document	Authorization	Approved-Closed	Yes
Form	Group Application	Approved-Closed	Yes

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Form Schedule

Lead Form Number: A08GRPEEAR

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	A08GRPEEAR	Application/Group Application Enrollment Form		Initial		50	A08GRPEEAR.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: _____

Group Products • Application for Life and Health Insurance • Payroll Market

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: _____

Master Policyholder Name: _____

BENEFICIARY INFORMATION

APPLICANT: Primary _____ Relationship _____
 Contingent _____ Relationship _____

CITIZENSHIP INFORMATION

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

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

PRODUCT SELECTION

[MEDlink®]	Premium
MEDlink® <input type="checkbox"/> Individual Only <input type="checkbox"/> Individual and Spouse <input type="checkbox"/> One Parent Family <input type="checkbox"/> Two Parent Family Age Bands: [<input type="checkbox"/> 18-54 <input type="checkbox"/> 55-59 <input type="checkbox"/> 60+]	Total Premium \$]
[MEDlink® II]	Premium
MEDlink® II <input type="checkbox"/> Individual Only <input type="checkbox"/> Individual and Spouse <input type="checkbox"/> One Parent Family <input type="checkbox"/> Two Parent Family Age Bands: [<input type="checkbox"/> 18-54 <input type="checkbox"/> 55-59 <input type="checkbox"/> 60+]	Total Premium \$]
[MEDlink® III]	Premium
MEDlink® III <input type="checkbox"/> Individual Only <input type="checkbox"/> Individual and Spouse <input type="checkbox"/> One Parent Family <input type="checkbox"/> Two Parent Family Age Bands: [<input type="checkbox"/> 18-54 <input type="checkbox"/> 55+]	Total Premium \$]
[HOSPITAL INDEMNITY]	Premium
Hospital Indemnity [HI-4005] <input type="checkbox"/> Individual Only <input type="checkbox"/> Individual and Spouse <input type="checkbox"/> One Parent Family <input type="checkbox"/> Two Parent Family Age Band: [<input type="checkbox"/> 18-54 <input type="checkbox"/> 55-59 <input type="checkbox"/> 60+] Daily Hospital Confinement Benefit Amount: \$ _____ (Available from [\$30] to [\$1,000] in [\$10] units).....	\$
Additional Benefit Riders:	
<input type="checkbox"/> Intensive Care/Coronary Care (per day) \$ _____ (Available from [\$100] to [\$1,000] in [\$100] units)	\$]
<input type="checkbox"/> Annual First Occurrence Hospital \$ _____ (Available from [\$100] to [\$3,000] in [\$100] units)	\$]
<input type="checkbox"/> Surgical & Anesthesia \$ _____ (Available from [\$1,000] to [\$10,000] in [\$1,000] units)	\$]
<input type="checkbox"/> Outpatient Sickness [<input type="checkbox"/> \$25 <input type="checkbox"/> \$50 <input type="checkbox"/> \$75	\$]
<input type="checkbox"/> Emergency Accident [<input type="checkbox"/> \$100 <input type="checkbox"/> \$200 <input type="checkbox"/> \$300	\$]
<input type="checkbox"/> Wellness/Diagnostic Testing	\$]
<input type="checkbox"/> Outpatient Surgical Facility \$ _____ (Available from [\$100] to [\$1,000] in [\$100] units)	\$]
<input type="checkbox"/> Term Life [<input type="checkbox"/> \$10,000 <input type="checkbox"/> \$20,000	\$]
	Total Premium \$]
[ACCIDENT]	Premium
Accident [GA508] <input type="checkbox"/> Individual Only <input type="checkbox"/> Individual and Spouse <input type="checkbox"/> One Parent Family <input type="checkbox"/> Two Parent Family	Total Premium \$]

[SIMPLIFIED ISSUE UNDERWRITING AND MEDICAL QUESTIONS

[Any applicant answering YES to the following questions is not eligible for that coverage. If multiple child(ren) are to be covered, please list the first name of any child answering Yes on the line provided in that area.]		Applicant	Spouse	Child(ren) (NAME, if Yes)
[[CANCER] [DISABILITY] [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 _____
[[DISABILITY] [HOSPITAL INDEMNITY]	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), nervous system disease or disorder, liver condition or disease, lung/respiratory disorder, 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 _____
[[[HOSPITAL INDEMNITY]	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, 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 _____
[[TERM LIFE RIDER] [DISABILITY]	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 or 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 _____
[[DISABILITY]	Within the last 3 years has any person to be insured received medical advice or sought treatment (including medication) for: degenerative disc disease of the back or neck and/or other disorders of the back or neck, fibromyalgia, or chronic fatigue syndrome?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
[[[DISABILITY] [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 _____
	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 _____
[[[CANCER]	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? 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 _____
	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]	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 _____

Print Applicant's Name _____

Applicant's Initials _____

Date] _____

SERFF Tracking Number: *AFDL-126023456* *State:* *Arkansas*
Filing Company: *American Public Life Insurance Company* *State Tracking Number:* *41499*
Company Tracking Number: *A08GRPEEAR*
TOI: *H21 Health - Other* *Sub-TOI:* *H21.000 Health - Other*
Product Name: *A08GRPEEAR*
Project Name/Number: *A08GRPEEAR/A08GRPEEAR*

Rate Information

Rate data does NOT apply to filing.

<i>SERFF Tracking Number:</i>	<i>AFDL-126023456</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>American Public Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>41499</i>
<i>Company Tracking Number:</i>	<i>A08GRPEEAR</i>		
<i>TOI:</i>	<i>H21 Health - Other</i>	<i>Sub-TOI:</i>	<i>H21.000 Health - Other</i>
<i>Product Name:</i>	<i>A08GRPEEAR</i>		
<i>Project Name/Number:</i>	<i>A08GRPEEAR/A08GRPEEAR</i>		

Supporting Document Schedules

Satisfied -Name:	Flesch Certification	Review Status:	Approved-Closed	02/12/2009
Comments:				
Attachment:	AR FLESCH HEALTH.pdf			

Bypassed -Name:	Application	Review Status:	Approved-Closed	02/12/2009
Bypass Reason:	see forms tab			
Comments:				

Bypassed -Name:	Outline of Coverage	Review Status:	Approved-Closed	02/12/2009
Bypass Reason:	n/a			
Comments:				

Satisfied -Name:	John Doe	Review Status:	Approved-Closed	02/12/2009
Comments:				
Attachment:	A08GRPEE Generic JD.pdf			

Satisfied -Name:	Statement of Variability	Review Status:	Approved-Closed	02/12/2009
Comments:				
Attachment:	SOV.A08GRPEE.AR.pdf			

Satisfied -Name:	Authorization	Review Status:	Approved-Closed	02/12/2009
Comments:				
Attachment:				

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Authorization09.pdf



A member of the American Fidelity Group

ARKANSAS FLESCH CERTIFICATION

This is to certify that the Flesch scores for the enclosed forms are as follows:

Form Number	Flesch Score	Words Contained in Text
A08GRPEE Group Application	50	1809

The forms are printed in not less than 10 point type, one point leaded.

The application has been scored by the Flesch method.

A handwritten signature in black ink, appearing to read 'Alex M Bagby', is written over a horizontal line.

Alex M Bagby, A.S.A., M.A.A.A.
Vice President and Chief Risk Officer

January 6, 2009

Date

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: _____

Group Products • Application for Life and Health Insurance • Payroll Market

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		X M <input type="checkbox"/> F	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 10000 111-111-1111 jd@jd.com

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

APPLICANT

EMPLOYER

Full Time? Yes No Hours Per Week: 40
 Salary: \$ 40,000 Hourly Weekly Monthly Annually
 Occupation: Teacher Hire Date: 1-1-2000

Name: ABC Schools
 City: Anywhere State: Anystate
 Work Phone: 222-222-2222

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

Master Policyholder Name:

BENEFICIARY INFORMATION

APPLICANT: Primary Jane Doe Relationship Spouse
 Contingent Relationship

CITIZENSHIP INFORMATION

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

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

PRODUCT SELECTION

[MEDlink®]	Premium
MEDlink® <input checked="" type="checkbox"/> Individual Only <input type="checkbox"/> Individual and Spouse <input type="checkbox"/> One Parent Family <input type="checkbox"/> Two Parent Family Age Bands: [x 18-54 <input type="checkbox"/> 55-59 <input type="checkbox"/> 60+]	Total Premium \$]
[MEDlink® II]	Premium
MEDlink® II <input type="checkbox"/> Individual Only <input type="checkbox"/> Individual and Spouse <input type="checkbox"/> One Parent Family <input type="checkbox"/> Two Parent Family Age Bands: [<input type="checkbox"/> 18-54 <input type="checkbox"/> 55-59 <input type="checkbox"/> 60+]	Total Premium \$ xxx.xx]
[MEDlink® III]	Premium
MEDlink® III <input type="checkbox"/> Individual Only <input type="checkbox"/> Individual and Spouse <input type="checkbox"/> One Parent Family <input type="checkbox"/> Two Parent Family Age Bands: [<input type="checkbox"/> 18-54 <input type="checkbox"/> 55+]	Total Premium \$]
[HOSPITAL INDEMNITY]	Premium
Hospital Indemnity [HI-4005] <input type="checkbox"/> Individual Only <input type="checkbox"/> Individual and Spouse <input type="checkbox"/> One Parent Family <input type="checkbox"/> Two Parent Family Age Band: [<input type="checkbox"/> 18-54 <input type="checkbox"/> 55-59 <input type="checkbox"/> 60+] Daily Hospital Confinement Benefit Amount: \$ _____ (Available from [\$30] to [\$1,000] in [\$10] units).....	\$
Additional Benefit Riders: <input type="checkbox"/> Intensive Care/Coronary Care (per day) \$ _____ (Available from [\$100] to [\$1,000] in [\$100] units).....	\$]
<input type="checkbox"/> Annual First Occurrence Hospital \$ _____ (Available from [\$100] to [\$3,000] in [\$100] units).....	\$]
<input type="checkbox"/> Surgical & Anesthesia \$ _____ (Available from [\$1,000] to [\$10,000] in [\$1,000] units).....	\$]
<input type="checkbox"/> Outpatient Sickness [<input type="checkbox"/> \$25 <input type="checkbox"/> \$50 <input type="checkbox"/> \$75.....	\$]]
<input type="checkbox"/> Emergency Accident [<input type="checkbox"/> \$100 <input type="checkbox"/> \$200 <input type="checkbox"/> \$300.....	\$]]
<input type="checkbox"/> Wellness/Diagnostic Testing.....	\$]
<input type="checkbox"/> Outpatient Surgical Facility \$ _____ (Available from [\$100] to [\$1,000] in [\$100] units).....	\$]
<input type="checkbox"/> Term Life [<input type="checkbox"/> \$10,000 <input type="checkbox"/> \$20,000.....	\$]]
	Total Premium \$]
[ACCIDENT]	Premium
Accident [GA508] <input type="checkbox"/> Individual Only <input type="checkbox"/> Individual and Spouse <input type="checkbox"/> One Parent Family <input type="checkbox"/> Two Parent Family	Total Premium \$]

[SIMPLIFIED ISSUE UNDERWRITING AND MEDICAL QUESTIONS

[Any applicant answering YES to the following questions is not eligible for that coverage. If multiple child(ren) are to be covered, please list the first name of any child answering Yes on the line provided in that area.]		Applicant	Spouse	Child(ren) (NAME, if Yes)
[[[CANCER] [DISABILITY] [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 _____
[[[DISABILITY] [HOSPITAL INDEMNITY]	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), nervous system disease or disorder, liver condition or disease, lung/respiratory disorder, 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 _____
[[[HOSPITAL INDEMNITY]	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, 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 _____
[[[TERM LIFE RIDER] [DISABILITY]	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 or 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 _____
[[[DISABILITY]	Within the last 3 years has any person to be insured received medical advice or sought treatment (including medication) for: degenerative disc disease of the back or neck and/or other disorders of the back or neck, fibromyalgia, or chronic fatigue syndrome?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
[[[DISABILITY] [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 _____
	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 _____
[[[CANCER]	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? 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 _____
	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]	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 _____

Print Applicant's Name _____

Applicant's Initials _____

Date] _____

STATEMENT OF VARIABILITY - AR

The A08GRPEE Group 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 and percentages have been marked variable to allow for maximum product variability.
2. All policy form numbers may vary in accordance with the policy form currently being marketed (subject to state approvals.)
3. The Applicant, Beneficiary, and Citizenship Information sections are 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.

4. 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: Hospital Indemnity (form #HI-4005), Dental (D-4), Accident (GA508) Disability (DI-3300), Cancer (GC-3), Medlink, Medlink II and Medlink III. 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.

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 available. 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.

6. The General Underwriting and Medical Question section varies based 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. Please note that this section will always include at least the All Coverages question.

If we opt to print only those questions applicable to the sale the General Underwriting and Medical Question section may vary as follows: The All Coverages question will always print on the application and will always be completed in its entirety. The Accident and Hospital Indemnity questions may only print if the Accident or Hospital Indemnity product selection, respectively, is included on the application.

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

7. 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 contains variable information in the first sentence. We will either print the whole paragraph or omit the portions marked in variable brackets.
 - b. The second paragraph of the Suitability and Acknowledgment section is not variable and will always print on the application.
 - c. The paragraph specific to disability income insurance will print if the disability income product selection is included on the application.
 - d. The product specific to Medlink insurance will only print if a Medlink product selection is included on the application.
 - e. The product specific to Cancer insurance will only print if a Cancer product selection is included on the application.
 - f. The fraud warning is not variable and will always print on the application.
 - g. The applicant signature block is not variable and will always print on the application.
8. For agent involved applications, the Agent Statement and Soliciting Agents sections are not variable and will always print on the applications. For direct response applications, this section does not apply and may either include a pre-populated field stating that the application was completing using Direct Response methods or may not be included on the application.
9. Page 3 of this application contains a Simplified Underwriting Medical Question section, which will only be completed, when the application is being taken outside of the enrollment period or when simplified issue underwriting is required. This section will vary depending on the Product Selections included on the application and our underwriting guidelines as to the group size and participation requirements. The underwriting guidelines differ on a product-by-product basis. 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).



Shari Vick, AIRC, HIA
Compliance Analyst II



American Public Life Insurance Company

A member of the American Fidelity Group.

January 15, 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,

A handwritten signature in black ink, appearing to read 'Alex M. Bagby'. The signature is fluid and cursive, with a long horizontal stroke extending to the right.

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