

SERFF Tracking Number: ALST-126102431 State: Arkansas
 Filing Company: American Heritage Life Insurance Company State Tracking Number: 42156
 Company Tracking Number: CABR1
 TOI: H071 Individual Health - Specified Disease - Limited Benefit Sub-TOI: H071.002 Dread Disease
 Product Name: CABR1
 Project Name/Number: /

Filing at a Glance

Company: American Heritage Life Insurance Company

Product Name: CABR1 SERFF Tr Num: ALST-126102431 State: ArkansasLH

TOI: H071 Individual Health - Specified Disease SERFF Status: Closed State Tr Num: 42156

- Limited Benefit

Sub-TOI: H071.002 Dread Disease

Co Tr Num: CABR1

State Status: Approved-Closed

Filing Type: Form/Rate

Co Status: Complete

Reviewer(s): Rosalind Minor

Authors: Jennifer Aiello, Juli

Disposition Date: 05/11/2009

Clausen, Shayla Washington

Date Submitted: 04/20/2009

Disposition Status: Approved-

Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name:

Status of Filing in Domicile: Not Filed

Project Number:

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Group Market Size:

Overall Rate Impact:

Group Market Type:

Filing Status Changed: 05/11/2009

Explanation for Other Group Market Type:

State Status Changed: 05/11/2009

Deemer Date:

Corresponding Filing Tracking Number:

Filing Description:

Re: American Heritage Life Insurance Company, NAIC No. 60534

Cancer Additional Benefits Rider, form number CABR1

Outline of Coverage for CABR1, form numbers OCCABR1AR

SERFF Tracking Number: ALST-126102431 State: Arkansas
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We submit the above referenced forms for your review and approval. These forms are new and do not replace any forms currently approved by your department.

Rider form CABR1 provides additional benefits for the necessary treatment of covered cancer or specified diseases. This rider will be attached to specified disease policies previously approved in your state.

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

We have included the rates, an actuarial memorandum, the readability certification and any filing fees and/or forms required by your state. If you have any questions, feel free to call me at (904) 992-2541. I can also be reached by email at jhop4@allstate.com.

Company and Contact

Filing Contact Information

Jennifer Aiello, Filing Analyst jhop4@allstate.com
Attn: Legal/Compliance (904) 992-2541 [Phone]
Jacksonville, FL 32224-9983 (904) 992-2975[FAX]

Filing Company Information

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

Filing Fees

Fee Required? Yes
Fee Amount: \$90.00
Retaliatory? No
Fee Explanation: \$20 per form X 2 forms = \$40

SERFF Tracking Number: ALST-126102431 State: Arkansas
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Company Tracking Number: CABRI
TOI: H071 Individual Health - Specified Disease - Sub-TOI: H071.002 Dread Disease
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Product Name: CABRI
Project Name/Number: /
\$50 per rate X 1 rate = \$50
Total: \$90
Per Company: No

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Limited Benefit
Product Name: CABRI
Project Name/Number: /

| COMPANY | AMOUNT | DATE PROCESSED | TRANSACTION # |
|--|---------|----------------|---------------|
| American Heritage Life Insurance Company | \$90.00 | 04/20/2009 | 27266073 |

SERFF Tracking Number: ALST-126102431 State: Arkansas
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TOI: H071 Individual Health - Specified Disease - Sub-TOI: H071.002 Dread Disease
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Product Name: CABRI
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Correspondence Summary

Dispositions

| Status | Created By | Created On | Date Submitted |
|-----------------|----------------|------------|----------------|
| Approved-Closed | Rosalind Minor | 05/11/2009 | 05/11/2009 |

SERFF Tracking Number: ALST-126102431 State: Arkansas
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Limited Benefit
Product Name: CABRI
Project Name/Number: /

Disposition

Disposition Date: 05/11/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: ALST-126102431 State: Arkansas
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 Product Name: CABRI
 Project Name/Number: /

| 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 |
| Form | Cancer and Specified Disease Additional Benefit Rider | Approved-Closed | Yes |
| Rate | Rate Page | Approved-Closed | Yes |

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Form Schedule

Lead Form Number: CABR1

| Review Status | Form Number | Form Type | Form Name | Action | Action Specific Data | Readability | Attachment |
|-----------------|-------------|-------------|--|--------|----------------------|-------------|------------|
| Approved-Closed | CABR1 | Policy/Cont | Cancer and Specified Initial Benefit Rider Certificate: Amendmen t, Insert Page, Endorseme nt or Rider | | | 57 | CABR1.pdf |

AMERICAN HERITAGE LIFE INSURANCE COMPANY
1776 American Heritage Life Drive, Jacksonville, Florida 32224-6687
CANCER AND SPECIFIED DISEASE ADDITIONAL BENEFIT RIDER

This rider is issued in consideration of the rider premium and the application for the rider. The benefits are paid in addition to the benefits of the policy subject to the Waiting Period/Exceptions provision and all other terms, conditions, and provisions of the policy and this rider.

All terms defined and used in the policy apply to this rider, unless otherwise provided in this rider.

DEFINITIONS

Actual Cost. The amount actually paid by or on behalf of the covered person and accepted by the provider as full payment for the particular goods or services provided.

Rider Date. The effective date of coverage under this rider. The rider date is the policy date, unless this rider is applied for at a later date. If this rider is applied for at a later date, the rider date is the date the application for this rider is approved by us.

Policy. The policy to which this rider is attached.

Unit. The benefits in this rider. The number of units of this rider is shown on the Policy Specifications (page 3). All benefit amounts are calculated according to the number of units purchased.

We, us, our. American Heritage Life Insurance Company.

You, your. The person named as primary insured in the application for this rider.

SCHEDULE OF BENEFITS

We pay the following benefits when a covered person receives the following necessary services and products for a covered cancer or specified disease.

A. Hospital Confinement. We pay \$50 per day, per unit of coverage, for each day a covered person is admitted to and confined as an inpatient in a hospital. The maximum number of days payable is 70 days for each period of continuous hospital confinement.

B. Inpatient Drugs and Medicine. We pay \$10 per day, per unit of coverage, for drugs and medicine charged by the hospital while hospital confined, for each day of continuous hospital confinement.

C. Second Surgical Opinion. We pay \$50 per unit of coverage, if surgery is recommended by a physician due to the diagnosis of cancer or specified disease and the covered person obtains the opinion of a second physician. This second opinion must be: rendered prior to surgery being performed; and obtained from a physician not in practice with the physician rendering the original recommendation.

D. Physician's Attendance. We pay \$10 per day, per unit of coverage, for a visit by a physician during hospital confinement. This benefit is limited to one visit by one physician per day of hospital confinement. A visit means personal attendance by the physician. Admission to the hospital as an inpatient is required.

E. Private Duty Nursing Services. We pay \$50 per day, per unit of coverage, for private nursing care and attendance by a nurse, while hospital confined. Nursing services must

be required and authorized by the attending physician. Nursing services in a facility other than a hospital are not covered.

F. Radiation Therapy, Radioactive Isotopes Therapy, Chemotherapy, or Immunotherapy. This benefit increases the Radiation Therapy, Radioactive Isotopes Therapy, Chemotherapy or Immunotherapy benefit in the policy by \$5,000 per 12 month period, per unit of coverage.

This 12 month period begins with the first day of benefit under the Radiation Therapy, Radioactive Isotopes Therapy, Chemotherapy or Immunotherapy benefit in the policy. This benefit is only payable after the limit per 12 month period in the policy has been reached. We then pay the actual cost up to \$5,000 per unit of coverage in that 12 month benefit period.

G. Blood, Plasma and Platelets. This benefit increases the Blood, Plasma and Platelets benefit in the policy by \$5,000 per 12 month period, per unit of coverage. This 12 month period begins with the first day of benefit under the Blood, Plasma and Platelets benefit in the policy. This benefit is only payable after the limit per 12 month period in the policy has been reached. We then pay the actual cost up to \$5,000 per unit of coverage in that 12 month benefit period.

H. Non-Local Transportation. We pay the following benefit for treatment at a Hospital (inpatient or outpatient); Radiation Therapy Center; Chemotherapy or Oncology Clinic; or any other specialized freestanding treatment center nearest to the covered person's home, provided the same or similar treatment cannot be obtained locally: \$.05 per mile per unit of coverage, up to 700 miles, for round trip personal vehicle transportation. Mileage is measured from the covered person's home to the nearest treatment facility as described above.

"Non-Local" means a round trip of more than 70 miles from the covered person's home to the nearest treatment facility. We do not pay for: transportation for someone to accompany or visit the person receiving treatment; visits to a physician's office or clinic; or for services other than actual treatment.

I. Family Member Transportation. We pay the following benefit for one adult member of the covered person's family to be near the covered person, when a covered person is confined in a non-local hospital for specialized treatment: a personal vehicle allowance of \$.05 per mile per unit of coverage, up to 700 miles per continuous hospital confinement. Mileage is measured from the visiting family member's home to the hospital where the covered person is confined. We do not pay the Family Member Transportation benefit if the personal vehicle transportation benefit is paid under Non-Local Transportation (Benefit H), when the family member lives in the same city or town as the covered person.

J. Ambulatory Surgical Center. We pay \$125 per day, per unit of coverage, for surgical center charges when surgery is performed at an Ambulatory Surgical Center.

K. Hospice Care. We pay one of the following two benefits for hospice care:

- (1) *Freestanding Hospice Care Center.* We pay \$50 per day, per unit of coverage, for confinement in a licensed freestanding hospice care center. The covered person must be diagnosed by a physician as terminally ill and the attending physician must approve the confinement. This benefit is payable only if a covered person is admitted to a freestanding hospice care center within 14 days after a period of inpatient hospital confinement. Benefits payable for hospice centers that are designated areas of hospitals will be paid the same as inpatient hospital confinement; or
- (2) *Hospice Care Team.* We pay \$50 per visit, per unit of coverage, limited to 1 visit per day, for home care services by a hospice care team. Home care services are hospice services provided in the patient's home. This benefit is payable only if: the covered person has been diagnosed as terminally ill; the attending physician has approved such services; and home care services begin within 14 days after a period of hospital confinement. We do not pay for: food services or meals other than dietary counseling; services related to well-baby care; services provided by volunteers; or support for the family after the death of the covered person.

L. Physical or Speech Therapy. We pay \$25 per day, per unit of coverage, for physical or speech therapy for restoration of normal body function.

M. Extended Benefits. If a covered person is confined in a hospital for more than 70 days of continuous hospital confinement, we pay \$100 per day, per unit of coverage. This benefit begins on the 71st day of continuous hospital confinement. This benefit is payable in lieu of all other benefits payable under the Schedule of Benefits. This benefit continues as long as the covered person is continuously hospital confined.

N. Medical Imaging. We pay the actual cost up to \$250 per calendar year, per unit of coverage, if a covered person receives an initial diagnosis or follow-up evaluation based upon one of the following medical imaging exams: CT scan; Magnetic Resonance Imaging (MRI) scan; bone scan; thyroid scan; Multiple Gated Acquisition (MUGA) scan; Positron Emission Tomography (PET) scan; transrectal ultrasound; or abdominal ultrasound. This benefit is limited to 1 payment per calendar year per covered person.

O. Comfort/Anti-Nausea. We pay the actual cost up to \$100 per calendar year, per unit of coverage, for anti-nausea medication prescribed and administered on an outpatient basis. We will not pay this benefit for medication administered while the covered person is an inpatient.

P. Hematological Drugs. We pay the actual cost up to \$100 per calendar year, per unit of coverage for drugs intended to boost cell lines such as white blood cell counts, red blood cell counts and platelets. This benefit is paid only when the Radiation Therapy, Radioactive Isotopes Therapy, Chemotherapy or Immunotherapy benefit (Benefit F) is paid. This benefit is limited to 1 payment per calendar year per covered person.

Q. Hair Prosthesis. We pay \$25 every 2 years, per unit of coverage, for a wig or hairpiece if the covered person experiences hair loss.

R. Nonsurgical External Breast Prosthesis. We pay the actual cost up to \$50 per unit of coverage, for the initial, nonsurgical breast prosthesis following a covered mastectomy or partial mastectomy that is paid for under the policy.

WAITING PERIOD/EXCEPTIONS

This rider has a 30 day waiting period that begins on the rider date. No benefits are payable for any covered person who has cancer or a specified disease diagnosed before coverage has been in force 30 days from the rider date, except as provided below. If a covered person has cancer or a specified disease first diagnosed after you sign the application and before the end of the waiting period, benefits for treatment of that cancer or specified disease will apply only to loss commencing after 2 years from the rider date.

The Exceptions/Limitations provision of the policy applies to this rider.

TERMINATION

This rider terminates:

- 1. at the end of the grace period for the payment of the premium for the policy or this rider; or
- 2. if the policy terminates; or
- 3. on the next renewal date after a request for termination.

RENEWABILITY

The Renewability provision of the policy applies to this rider.

Signed for AMERICAN HERITAGE LIFE INSURANCE COMPANY at its Home Office.

ABCDEFGHI

ABCDEFGH

Secretary

President

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 Project Name/Number: /

Rate/Rule Schedule

| Review Status: | Document Name: | Affected Form Numbers: (Separated with commas) | Rate Action: | Rate Action Information: | Attachments |
|-----------------|----------------|---|--------------|--------------------------|------------------------|
| Approved-Closed | Rate Page | CABR1 | New | | Rate Page CABR1.pdf |

Appendix A

Rider Form CABR1

Annual Premium per unit: Individual: \$55.56 Family: \$111.12

Subject to rounding procedures, the following are premium modalization rules for this form:

Semiannual premiums equal 0.52 multiplied by the annual premium.

Quarterly premiums equal 0.265 multiplied by the annual premium.

Monthly premiums equal 0.09 multiplied by the annual premium.

Semi-monthly, bi-weekly, weekly, ninthly and tenthly premiums are calculated on a pro-rata basis from the monthly premium.

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Supporting Document Schedules

| | | |
|--|---------------------------------------|------------|
| Satisfied -Name: Flesch Certification | Review Status: Approved-Closed | 05/11/2009 |
| Comments: | | |
| Attachments: | | |
| AR Readability Certificate.pdf | | |
| AR Certification of Compliance.pdf | | |
| Satisfied -Name: Application | Review Status: Approved-Closed | 05/11/2009 |
| Comments: | | |
| Form AWD900AR-1 was previously approved on June 25, 2007 under State Tracking # 35803. | | |
| Attachment: | | |
| AWD900AR-1.pdf | | |
| Satisfied -Name: Outline of Coverage | Review Status: Approved-Closed | 05/11/2009 |
| Comments: | | |
| Attachment: | | |
| OCCABR1AR.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> |
|-------------|--------------|
| CABR1 | 56.7 |
| OCCABR1AR | 55.2 |

Date: April 20, 2009



Diane Ierna
Assistant Vice President, Compliance Department

AMERICAN HERITAGE LIFE INSURANCE COMPANY
Jacksonville, Florida 32224-6687

To the Policy Review Section, ARKANSAS Department of Insurance.

Certification of Compliance

For Filing Including:

CABR1
OCCABR1

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

Date: April 20, 2009



Diane Ierna
Assistant Vice-President
Compliance Department

PLEASE PRINT WITH BLACK INK

APPLICATION FOR LIFE AND HEALTH INSURANCE TO:

American Heritage Life Insurance Company

1776 American Heritage Life Drive, Jacksonville, Florida 32224

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

DEPENDENTS PROPOSED FOR COVERAGE

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

| | | | | | | | | | | | | |
|--|---|--|----------------------|--|---|--|--|--|--------------|--|--------------|--------------|
| PLANS | Universal Life | Face Amount | Life Riders | Rider | Rider | Rider | Rider | Rider | Rider | Rider | Rider | Mode Premium |
| | <input type="checkbox"/> Simplified Issue <input type="checkbox"/> Select CGI | Death Benefit Option <input type="checkbox"/> 1 <input type="checkbox"/> 2 | Units/Amt | | | | | | | | | \$ |
| | Term Life | Face Amount | Life Riders | Rider | Rider | Rider | Rider | Rider | Rider | Rider | Mode Premium | |
| | <input type="checkbox"/> Simplified Issue <input type="checkbox"/> Select CGI | | Units/Amt | | | | | | | | \$ | |
| | Disability | Monthly Salary \$ | Elimination Period | On The Job Rider | Accident Rider | Section 125 | Mode Premium | | | | | |
| | <input type="checkbox"/> Simplified Issue <input type="checkbox"/> Select CGI | | Days Acc. Days Sick. | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | \$ | | | | | |
| | Occupation Class <input type="checkbox"/> Preferred <input type="checkbox"/> Standard | Monthly Benefit \$ | Benefit Period | Units | <input type="checkbox"/> Individual <input type="checkbox"/> Family | | | | | | | |
| | | | Months | | | | | | | | | |
| | Cancer | Cancer Riders | Rider | Rider | Rider | Rider | Rider | Section 125 | Mode Premium | | | |
| | (Units or Benefit Package) <input type="checkbox"/> Individual <input type="checkbox"/> Family | Units/Amts. | | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | \$ | | | |
| Accident | Monthly Salary \$ | Rider APDIR | Rider APBER | Rider APEXT | Rider APOPTR1 | Rider APHCR1 | Section 125 | Mode Premium | | | | |
| (Units or Benefit Package) <input type="checkbox"/> Simplified Issue <input type="checkbox"/> Select CGI <input type="checkbox"/> Individual <input type="checkbox"/> Family | Rider Units | | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | \$ | | | | |
| SHOP | Rider IHR1 | Rider SAR1 | Rider IPBR1 | Rider OPBR1 | Rider OEAR1 | Rider AHRN | Rider TR1 | Rider ADIR1 | Rider SDIR1 | Section 125 | Mode Premium | |
| <input type="checkbox"/> Simplified Issue <input type="checkbox"/> Individual <input type="checkbox"/> Ind. & Children <input type="checkbox"/> Select CGI <input type="checkbox"/> Ind. & Spouse <input type="checkbox"/> Family | | | | | | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | \$ | |
| Heart/Stroke | HSP2 Riders | Rider CIDR1 | Rider ICR | Rider WBR3 | Rider | Rider | Section 125 | Mode Premium | | | | |
| Units or Benefit Level: <input type="checkbox"/> Individual <input type="checkbox"/> Family | Units/Amt | | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | \$ | | | | |
| Critical Illness | CI Riders | Rider | Rider | Rider | Rider | Rider | Section 125 | Mode Premium | | | | |
| Basic Benefit Amount: <input type="checkbox"/> Individual <input type="checkbox"/> Family <input type="checkbox"/> Single Parent Family | Units/Amt | | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | \$ | | | | |

| | | | |
|--|--|----------------------|---------------------|
| Cash With Application | Case Name | Case Number | Total Mode Premium: |
| PAC Policies Transit Number | Premiums/Billing Mode <input type="checkbox"/> Monthly <input type="checkbox"/> Semi-Monthly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Weekly <input type="checkbox"/> Other | Requested Issue Date | \$ |
| <input type="checkbox"/> Checking Account Number | Date of First Deduction | | |
| <input type="checkbox"/> Savings Draft Date | | | |
| Remarks | Producer Number | Percentage Credit | |
| Home Office Use | | | |

AWD900AR-1

(2007)

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 (03/07)



Allstate

Workplace Division

NON-MEDICAL QUESTIONNAIRE

| | | |
|--|---|--|
| All Coverages | 1. Is the proposed insured actively at work now and has he/she worked at least 20 hours each week performing all duties at his/her regular occupation at his/her regular place of employment for the last 3 months except for minor illness or injury of 1 week or less, or normal pregnancy? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| IF QUESTION 1 ABOVE IS ANSWERED "NO" OR QUESTION 2-10 BELOW ARE ANSWERED "YES," PLEASE LIST THE REQUIRED HEALTH HISTORY IN QUESTION 11 BELOW. | | |
| All Coverages | 2. Is any person to be insured now being treated, or ever been treated or diagnosed by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC), or has ever tested positive for antigens or antibodies to an AIDS virus? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| All Life & Critical Illness | 3. Has any person to be insured smoked cigarettes in the last 12 months? If so, who? _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| All Select CGI (Life, Hosp. Ind., Disability & Accident) | 4. Has any person to be insured been disabled or hospitalized in the last 6 months? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Simplified Issue Life \$150,000 Or Below | 5. a) In the last 3 years, has any person to be insured: had a chronic disease (including but not limited to heart disorder, stroke, cancer, diabetes, etc.); been hospitalized; seen a physician (other than for colds, flu or normal pregnancy or a routine physical with no unfavorable results); or been counseled for or excessively used alcohol or any type of drugs? b) Is any person to be insured currently under the care of a physician? c) Has any person to be insured ever been rated or declined for life insurance? | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer (policies and riders), SI Hosp. Ind. & Critical Illness | 6. Is any person to be insured currently undergoing any diagnostic test for, now being treated for, or ever been treated for, cancer or any malignancy which includes: carcinoma; sarcoma; Hodgkin's Disease; leukemia; lymphoma; or any malignant tumor? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Heart/Stroke, ICU, SI Hosp. Ind. & Critical Illness | 7. a) Is any person to be insured now being treated for, or ever been treated for: a stroke; a heart attack; a heart condition; heart trouble; any abnormality of the heart (including artery disease); or diabetes? b) Has any person to be insured ever been diagnosed with hypertension or high blood pressure? c) If the answer to 7b is yes, in the last year has that person had a systolic blood pressure reading higher than 150 more than once or a diastolic blood pressure reading higher than 100 more than once? | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Simplified Issue Disability, Critical Illness & SI Sickness Riders to Accident Policy | 8. a) Has any person to be insured, in the last 2 years, had, been treated for, or been told by a member of the medical profession that he/she has: diabetes, emphysema, asthma, epilepsy, hepatitis, mental or nervous illness, ulcers, any disorder of the central nervous system (to include muscular dystrophy or multiple sclerosis); Parkinson's disease; lupus; rheumatoid arthritis; fibromyalgia; chronic fatigue syndrome; any disorder of the heart, kidneys, liver, lungs, pancreas, or back (including neck); paralysis; optic neuritis; cancer (except basal cell skin cancer), malignant tumor, leukemia, Hodgkin's Disease; or stroke? b) Has any person to be insured ever been diagnosed with hypertension or high blood pressure? c) If the answer to 8b is yes, in the last year has that person had a systolic blood pressure reading higher than 150 more than once or a diastolic blood pressure reading higher than 100 more than once? d) Has any person to be insured, in the last 2 years, been treated for or counseled for alcohol or drug abuse? e) Has any person to be insured had any medical or surgical procedures (including major organ transplant) advised or recommended by a doctor but not done at this time? f) Has any person to be insured received any advice, treatment, or consultation for Alzheimer's disease, dementia, senility, or organic brain syndrome? | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No |
| SI Life & All SI Accident policies and riders | 9. Has any person to be insured, in the last 3 years, had his/her driver's license suspended or revoked or been arrested for reckless or drunken driving and/or been involved in 3 or more motor vehicle accidents? If yes, provide additional details below. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Critical Illness | 10. Has any person to be insured or ANY 2 of their natural parents or natural siblings been diagnosed with the same disease before age 60, based on this list: heart disease, stroke, diabetes, cancer, kidney disease, or multiple sclerosis? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Required Health History (For Critical Illness, list primary physician's name, address and telephone number) | 11. Name _____ Nature of Illness/Injury or Medical Attention/Reason Last Consulted _____ Date and/or Duration _____ Name and Address of Physician or Hospital/Clinic _____ Use additional paper if needed | |
| All Coverages | 12. Replacement. Is this insurance to replace or change any existing life or health coverage? If yes, indicate product being replaced or changed and complete replacement form provided by your producer if required by your state. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| All Coverages | 13. Existing Insurance. Is there any other life, cancer, heart/stroke, disability, hospital, critical illness or accident insurance in force or applied for on proposed insured? If yes, list company name, policy number, year issued, type of coverage, and amount of benefit. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| [All Coverages | 14. Citizenship. Is each person to be insured and others named in the application (i.e. payor, owner, beneficiaries) a U.S. citizen? If not, list person and country. | <input type="checkbox"/> Yes <input type="checkbox"/> No |

REPRESENTATION. I have read or had read to me the completed application and understand that any misstatement or misrepresentation in the application may result in loss of coverage. I represent that statements and answers given on this application are true, complete, and correctly recorded. **FRAUD WARNING:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. • **UNDERSTANDING.** I understand that the "effective date" of the policy for health insurance coverages will be the policy date recorded on the Policy Specifications page, not the date the application is signed. I also understand that, if premiums for the policy(ies) is (are) to be paid by payroll deduction, these deductions may start before the "effective date" of the policy(ies) and that this does not change the effective date of coverage. If the policy(ies) is (are) not issued, American Heritage Life will refund any deductions it receives. I also understand that no producer (agent) has authority to waive any answer or otherwise modify this application, or to bind this company in any way by making any promise or representation that is not set out in writing in this application. • **AUTHORIZATION.** I authorize any physician, medical practitioner, hospital, clinic or other medical facility, insurance company, the Medical Information Bureau or other organization, institution or person, that has records or knowledge of me or my health to give to American Heritage Life, its subsidiaries or its reinsurers any information. I acknowledge receipt of the Important Notice About Privacy and MIB Notice form. A copy of this authorization is as valid as the original. This authorization applies to any dependent on whom insurance is requested. This authorization is valid for a period of 24 months from the date signed. I understand that I may revoke this authorization at any time by notifying American Heritage Life in writing of my desire to do so.

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

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

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

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

Signature of Producer _____ Print Producer's Name _____

AWD900AR-1

(2007)

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 P.O. Box 105, Essex Station, Boston, MA 02112, 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 (03/07)



Workplace Division

AMERICAN HERITAGE LIFE INSURANCE COMPANY

HOME OFFICE:

1776 AMERICAN HERITAGE LIFE DRIVE

JACKSONVILLE, FLORIDA 32224-6687

(904) 992-1776

A Stock Company

REQUIRED OUTLINE OF COVERAGE FOR CANCER AND SPECIFIED DISEASE ADDITIONAL BENEFIT RIDER CABR1

RETAIN THIS FOR YOUR RECORDS!

This coverage is not MEDICARE SUPPLEMENT coverage. If you are eligible for Medicare, review the *Medicare Supplement Buyer's Guide*, which is available from the Company.

READ YOUR CONTRACT CAREFULLY- This outline provides a brief description of some of the important features of the rider attached to your policy. This is not the insurance contract and only the actual policy and rider provisions control. The policy and rider set forth, in detail, the rights and obligations of both you and the Company. It is therefore, important that you **READ YOUR POLICY AND RIDER CAREFULLY!**

Supplemental Benefit Coverage. Coverages of this category are designed to provide persons insured limited or supplemental coverage. This rider is designed to provide you with coverage paying benefits only when certain losses occur as a result of cancer and specified diseases first diagnosed on or after the rider date. Coverage is provided for the benefits outlined in the BENEFITS section. The benefits described in the BENEFITS section may be limited by the Waiting Period/Exceptions provision.

BENEFITS

We pay the following benefits when a covered person receives the following necessary services and products for a covered cancer or specified disease.

Hospital Confinement \$50 per day, per unit of coverage, for each day, when hospital confined, up to 70 days for each period of continuous hospital confinement.

Inpatient Drugs and Medicine. \$10 per day, per unit of coverage, while hospital confined, for each day of continuous hospital confinement.

Second Surgical Opinion. \$50 per unit of coverage, after diagnosis and before surgery.

Physician's Attendance. \$10 per day, per unit of coverage, while hospital confined. Limited to one visit per day by one doctor.

Private Duty Nursing Services. \$50 per day, per unit of coverage, while hospital confined.

Radiation Therapy, Radioactive Isotopes Therapy, Chemotherapy, or Immunotherapy. Increases the Radiation Therapy, Radioactive Isotopes Therapy, Chemotherapy, or Immunotherapy benefit in the policy by \$5,000 per 12 month period, per unit of coverage. Payable only after the limit per 12 month period in the policy has been reached.

Blood, Plasma and Platelets. Increases the Blood, Plasma and Platelets benefit in the policy by \$5,000 per 12 month period, per unit of coverage. Payable only after the limit per 12 month period in the policy has been reached.

Non-Local Transportation. \$.05 per mile per unit of coverage for round trip personal vehicle transportation over 70 miles, not to exceed 700 miles.

Family Member Transportation. \$.05 per mile per unit of coverage for round trip personal vehicle transportation over 70 miles, not to exceed 700 miles. Family Member Transportation is not paid if personal vehicle transportation benefit is paid under the Non-Local Transportation benefit when the family member lives in the same city or town as the covered person.

Ambulatory Surgical Center. \$125 per day, per unit of coverage, when surgery is performed.

Hospice Care. One of the following for persons diagnosed as terminally ill:

- (1) *Freestanding Hospice Care Center.* \$50 per day, per unit of coverage for confinement in a licensed hospice care center; or
- (2) *Hospice Care Team.* \$50 per visit, per unit of coverage, limited to 1 visit per day, for hospice care services in patient's home.

Physical or Speech Therapy. \$25 per day, per unit of coverage.

Extended Benefits. \$100 per day, per unit of coverage, beginning on the 71st day of confinement until discharge. This benefit is paid in lieu of all other benefits.

Medical Imaging. Actual cost up to \$250, per calendar year, per unit of coverage. Limited to 1 payment per calendar year per covered person.

Comfort/Anti-Nausea. Actual cost up to \$100, per calendar year, per unit of coverage. We will not pay this benefit while the covered person is an inpatient.

Hematological Drugs. Actual cost up to \$100, per calendar year, per unit of coverage. Paid only when the Radiation Therapy, Radioactive Isotopes Therapy, Chemotherapy, or Immunotherapy benefit is paid. Limited to 1 payment per calendar year per covered person.

Hair Prosthesis. \$25 every 2 years, per unit of coverage.

Nonsurgical External Breast Prosthesis. Actual cost up to \$50 per unit of coverage, following a covered mastectomy or partial mastectomy that is paid for under the policy.

WAITING PERIOD/EXCEPTIONS

This rider has a 30 day waiting period. No benefits are payable for 2 years from the rider date, if cancer or a specified disease is diagnosed after you sign the application for this rider and before the end of the waiting period.

The Exceptions/Limitations provision of the policy applies to this rider.

TERMINATION

The rider terminates: at the end of the grace period for the payment of the premium for the policy or the rider; or when the policy terminates; or on the next renewal date after a request for termination. If we accept a premium that extends coverage past the termination date, coverage continues until the end of that premium period.

RENEWABILITY

The renewability provision of the policy applies to the rider, subject to the termination provision of the rider.