

SERFF Tracking Number: AFDL-126267744 State: Arkansas
Filing Company: American Public Life Insurance Company State Tracking Number: 43275
Company Tracking Number: A1159APL.R609
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: A1159APL.R609
Project Name/Number: A1159APL.R609/A1159APL.R609

Filing at a Glance

Company: American Public Life Insurance Company

Product Name: A1159APL.R609

TOI: L08 Life - Other

Sub-TOI: L08.000 Life - Other

Filing Type: Form

SERFF Tr Num: AFDL-126267744 State: Arkansas

SERFF Status: Closed-Accepted State Tr Num: 43275

For Informational Purposes

Co Tr Num: A1159APL.R609

Authors: Shari Vick, Melissa Mahanes, Ashlie Snyder, Tonya Bittle

Date Submitted: 08/20/2009

State Status: Approved-Closed

Reviewer(s): Linda Bird

Disposition Date: 09/02/2009

Disposition Status: Accepted For Informational Purposes

Implementation Date:

Implementation Date Requested: On Approval

State Filing Description:

General Information

Project Name: A1159APL.R609

Project Number: A1159APL.R609

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 09/02/2009

Status of Filing in Domicile: Authorized

Date Approved in Domicile: 08/14/2009

Domicile Status Comments:

Market Type: Individual

Group Market Size:

Group Market Type:

Explanation for Other Group Market Type:

State Status Changed: 08/21/2009

Created By: Tonya Bittle

Corresponding Filing Tracking Number:

Deemer Date:

Submitted By: Tonya Bittle

Filing Description:

Enclosed for submission is the above referenced form. This is a new form and does not replace any previously approved form. This application will be used to apply for reinstatement of all individual life and health policies previously approved for use in your state. The form is completed in John Doe fashion. Variable information is marked in brackets []. The flesch score application is 48, excluding state mandated language and medical terminology.

We are filing this application under L08 Health - Other Type of Insurance; however, this application filing will apply to all of our previously approved individual products, even if those products are other than Individual Health Other Type of

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Insurance.

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 its 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 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.

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.

Thank you for your assistance with this matter. If you have any questions, please feel free to contact me at the telephone or fax numbers, or e-mail address listed under the Contact Information tab.

Company and Contact

Filing Contact Information

Melissa Mahanes, Compliance Analyst II melissa.mahanes@af-group.com
2000 Classen Blvd 800-654-8489 [Phone] 2035 [Ext]
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

Filing Fees

Fee Required? Yes
Fee Amount: \$25.00
Retaliatory? Yes

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Fee Explanation: \$25.00/Application
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
American Public Life Insurance Company	\$25.00	08/20/2009	29994858

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Accepted For Informational Purposes	Linda Bird	09/02/2009	09/02/2009
Approved-Closed	Linda Bird	08/21/2009	08/21/2009

Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Form	A1159APL.R609	Tonya Bittle	09/02/2009	09/02/2009

Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Request to Reopen Filing	Note To Filer	Linda Bird	09/02/2009	09/02/2009
Request to Reopen Filing	Note To Reviewer	Tonya Bittle	09/01/2009	09/01/2009

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Disposition

Disposition Date: 09/02/2009

Implementation Date:

Status: Accepted For Informational Purposes

Comment: Correction of typographical error.

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Supporting Document	APL09 Authorization Letter		Yes
Supporting Document	Filing Fee Form		Yes
Form (revised)	A1159APL.R609		Yes
Form	A1159APL.R609	Replaced	Yes

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Disposition

Disposition Date: 08/21/2009

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Status: Approved-Closed

Comment:

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Amendment Letter

Submitted Date: 09/02/2009

Comments:

The updated form has been attached to this amendment. The only change was to correct the company name, under the Signature and Authorization section, from American Family Assurance to American Public Life Insurance Company. Thank you.

Changed Items:

Form Schedule Item Changes:

Form Schedule Item Changes:

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
A1159APL.R609	Application/Enrollment Form	EA1159APL.R Initial 609					48.000	A1159APL.R609 APL Reinstatement.pdf

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Note To Filer

Created By:

Linda Bird on 09/02/2009 08:59 AM

Last Edited By:

Linda Bird

Submitted On:

09/02/2009 08:59 AM

Subject:

Request to Reopen Filing

Comments:

Filing has been reopened in order for typographical error to be corrected.

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Note To Reviewer

Created By:

Tonya Bittle on 09/01/2009 10:28 AM

Last Edited By:

Tonya Bittle

Submitted On:

09/01/2009 10:28 AM

Subject:

Request to Reopen Filing

Comments:

Due to a typographical error in the form which has come to our attention, we are requesting this filing be reopened in order to allow us to resubmit the corrected document. The only change was to correct the company name, under the Signature and Authorization section, from American Family Assurance to American Public Life Insurance Company. Thank you.

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Form Schedule

Lead Form Number: A1159APL.R609

Schedule Item Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
	A1159APL.R609	Application/ Enrollment Form	Initial		48.000	A1159APL.R609 APL Reinstatement.pdf

REINSTATEMENT APPLICATION

AMERICAN PUBLIC LIFE INSURANCE COMPANY

2305 Lakeland Drive • Flowood, Mississippi • 39232

POLICY NUMBER

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Last Name _____ First Name _____ Full Middle Name _____ Suffix _____

Number and Street _____ Work Phone # _____ Best time to call _____ Home Phone # _____ Best time to call _____
 () _____ am pm () _____ am pm

City _____ State _____ Zip _____ Date of Birth _____ State/Place of Birth _____
 / /

Height _____ Weight _____ Social Security Number _____
 ft. in. lbs.

Employer _____ Employer Address _____ Occupation _____ Date Employed _____

Additional Insured Name _____ Height _____ Weight _____
 ft. in. lbs.

Additional Insured Name _____ Height _____ Weight _____
 ft. in. lbs.

Additional Insured Name _____ Height _____ Weight _____
 ft. in. lbs.

1. a. Name, address and phone number of your personal physician? (If none, so state) _____
- b. Patient ID Number. (If applicable) _____
- c. Date and reason last consulted. _____
- d. Treatment given or recommended. _____
- e. List all current medications. _____

2. In the last 5 years has ANY person to be covered:

	YES	NO
a. applied for life or health insurance or reinstatement which was declined, postponed, rated, or modified in any way?	<input type="checkbox"/>	<input type="checkbox"/>
b. been convicted of a felony, or awaiting trial for a felony?	<input type="checkbox"/>	<input type="checkbox"/>
c. used any illegal, restricted, or controlled substance except as prescribed by a physician?	<input type="checkbox"/>	<input type="checkbox"/>
d. been counseled, or advised to undergo counseling or treatment for alcohol or drug use, addiction or abuse?	<input type="checkbox"/>	<input type="checkbox"/>
e. engaged in aviation activities or any hazardous sports, avocations or hobbies, or do you expect to do so?	<input type="checkbox"/>	<input type="checkbox"/>

3. In the last 12 months has ANY person to be covered used nicotine or nicotine products in any form? YES NO

4. In the last 5 years has ANY person to be covered received treatment, consulted a physician or been hospitalized for any medical condition shown below? If the YES box is checked, write the name of the person and the number of the condition in the provided section on the back of this application. Provide a description of the condition, date of diagnosis, indicate any treatment or medications, the name, address, and phone number of physician and current status or outcome of condition. If additional space is needed, please use a separate sheet of paper dated and signed by the applicant.

<table border="0"> <tr> <th style="text-align: left;">YES</th> <th style="text-align: left;">NO</th> <th></th> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>1. Adrenal/Pituitary Disorders</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>2. Aneurysm/Stroke</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>3. Arthritis/Gout/Joint Disorder</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>4. Asthma/Chronic Bronchitis</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>5. Back Disorder</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>6. Birth Defects/Congenital Abnormality</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>7. 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- | | | |
|---|---------------------------------|--------------------------------|
| 5. Has ANY person to be covered had any positive test results indicating Human Immunodeficiency Virus (HIV), or been medically diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS related complex (ARC)? | YES
<input type="checkbox"/> | NO
<input type="checkbox"/> |
| 6. Has ANY person to be insured received medical advice to have any diagnostic tests, examinations, or consultations for any condition that have not been completed; or had tests and results that have not been received; or test results were abnormal and no follow-up or resolution has occurred? | <input type="checkbox"/> | <input type="checkbox"/> |

Give details in the space below to any "YES" answers for questions 2, 3, 4, 5 and 6.

SIGNATURE AND AUTHORIZATION

I hereby apply to American Public Life Insurance Company for reinstatement of the above numbered policy (policies) and any attached riders. I understand and agree that if the policy (policies) is (are) reinstated, then it (they) will be contestable for two years from the date shown below with respect to answers and statements in this application. This application and/or riders will be attached to and become a part of any policy (policies) reinstated and will constitute the entire contract between the parties. No statement shall void this reinstated policy or be used in defense of a claim unless contained in the written reinstatement application. The policy to which this application is attached shall be incontestable after two years from the date of issue except for non-payment of premiums or provisions and conditions relating to disability benefits and those granting additional insurance in the event of death or as specific loss by accident or accidental means when contained in or issued in connection with this reinstated policy.

Signed at _____
(City and State)

this _____ day of _____, 20 _____

Notary Public	Seal	Commission Expires
Notary Public	Seal	Commission Expires
Notary Public	Seal	Commission Expires

Signature of Proposed Insured
Signature of Additional Insured (if any)
Signature of Owner (if other than Proposed Insured) (If owner is a Corporation, please affix Corporate Seal with Signature and Title of Authorized Officer)

FRAUD WARNING

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

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NEW MEXICO: 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 civil fines and criminal penalties.

OHIO: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

TENNESSEE: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines and denial of coverage.

WASHINGTON: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

SERFF Tracking Number: AFDL-126267744 State: Arkansas
 Filing Company: American Public Life Insurance Company State Tracking Number: 43275
 Company Tracking Number: A1159APL.R609
 TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
 Product Name: A1159APL.R609
 Project Name/Number: A1159APL.R609/A1159APL.R609

Supporting Document Schedules

	Item Status:	Status Date:
<p>Satisfied - Item: Flesch Certification Comments: Attachments: AR Compliance Certification.pdf FleschCert.pdf</p>		
<p>Bypassed - Item: Application Bypass Reason: N/A Comments:</p>		
<p>Satisfied - Item: APL09 Authorization Letter Comments: Attachment: Authorization09.pdf</p>		
<p>Satisfied - Item: Filing Fee Form Comments: Attachment: AR Filing Fee Form.pdf</p>		



American Public Life Insurance Company

A member of the American Fidelity Group

STATE OF ARKANSAS

COMPLIANCE CERTIFICATION

Form Number and Name: **A1159APL.R609 Reinstatement 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'.

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

August 19, 2009

Date



A member of the American Fidelity Group®

READABILITY CERTIFICATION

I, Melissa Mahanes, hereby certify that form A1159.R609 Individual Life and Health Reinstatement Application meets the minimum reading ease score required by the Insurance Code in your state. The Flesch Score for this form is a 48 excluding medical terminology and state mandated language.

For AR and VA: the word count for the A1159.R609 is 404.

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

Alex M Bagby, A.S.A., M.A.A.A.
Senior Vice President & Director of Products
American Fidelity Assurance Company

August 12, 2009
Date



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

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 _____
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.	* _____ x\$ 50= _____
Life and/or Disability: Filing and review of Insurer's advertisements, per advertisement, per each insurer.	_____ x\$ 20= <u>20.00</u>
	**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= _____

SERFF Tracking Number: AFDL-126267744 State: Arkansas
 Filing Company: American Public Life Insurance Company State Tracking Number: 43275
 Company Tracking Number: A1159APL.R609
 TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
 Product Name: A1159APL.R609
 Project Name/Number: A1159APL.R609/A1159APL.R609

Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date:	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
08/14/2009	Form	A1159APL.R609	09/02/2009	A1159APL.R609 APL Reinstatement.pdf (Superseded)

REINSTATEMENT APPLICATION

AMERICAN PUBLIC LIFE INSURANCE COMPANY

2305 Lakeland Drive • Flowood, Mississippi • 39232

POLICY NUMBER

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Last Name _____ First Name _____ Full Middle Name _____ Suffix _____

Number and Street _____ Work Phone # _____ Best time to call _____ Home Phone # _____ Best time to call _____
 () _____ am pm () _____ am pm

City _____ State _____ Zip _____ Date of Birth _____ State/Place of Birth _____
 / /

Height _____ Weight _____ Social Security Number _____
 ft. in. lbs.

Employer _____ Employer Address _____ Occupation _____ Date Employed _____

Additional Insured Name _____ Height _____ Weight _____
 ft. in. lbs.

Additional Insured Name _____ Height _____ Weight _____
 ft. in. lbs.

Additional Insured Name _____ Height _____ Weight _____
 ft. in. lbs.

1. a. Name, address and phone number of your personal physician? (If none, so state) _____
- b. Patient ID Number. (If applicable) _____
- c. Date and reason last consulted. _____
- d. Treatment given or recommended. _____
- e. List all current medications. _____

2. In the last 5 years has ANY person to be covered:

	YES	NO
a. applied for life or health insurance or reinstatement which was declined, postponed, rated, or modified in any way?	<input type="checkbox"/>	<input type="checkbox"/>
b. been convicted of a felony, or awaiting trial for a felony?	<input type="checkbox"/>	<input type="checkbox"/>
c. used any illegal, restricted, or controlled substance except as prescribed by a physician?	<input type="checkbox"/>	<input type="checkbox"/>
d. been counseled, or advised to undergo counseling or treatment for alcohol or drug use, addiction or abuse?	<input type="checkbox"/>	<input type="checkbox"/>
e. engaged in aviation activities or any hazardous sports, avocations or hobbies, or do you expect to do so?	<input type="checkbox"/>	<input type="checkbox"/>

3. In the last 12 months has ANY person to be covered used nicotine or nicotine products in any form? YES NO

4. In the last 5 years has ANY person to be covered received treatment, consulted a physician or been hospitalized for any medical condition shown below? If the YES box is checked, write the name of the person and the number of the condition in the provided section on the back of this application. Provide a description of the condition, date of diagnosis, indicate any treatment or medications, the name, address, and phone number of physician and current status or outcome of condition. If additional space is needed, please use a separate sheet of paper dated and signed by the applicant.

YES	NO		YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	1. Adrenal/Pituitary Disorders	<input type="checkbox"/>	<input type="checkbox"/>	18. Kidney/Bladder/Prostate Disorder
<input type="checkbox"/>	<input type="checkbox"/>	2. Aneurysm/Stroke	<input type="checkbox"/>	<input type="checkbox"/>	19. Liver Disorder/Hepatitis/Cirrhosis
<input type="checkbox"/>	<input type="checkbox"/>	3. Arthritis/Gout/Joint Disorder	<input type="checkbox"/>	<input type="checkbox"/>	20. Lung Disorder/Respiratory/Tuberculosis
<input type="checkbox"/>	<input type="checkbox"/>	4. Asthma/Chronic Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	21. Lupus
<input type="checkbox"/>	<input type="checkbox"/>	5. Back Disorder	<input type="checkbox"/>	<input type="checkbox"/>	22. Lymphatic Disorder
<input type="checkbox"/>	<input type="checkbox"/>	6. Birth Defects/Congenital Abnormality	<input type="checkbox"/>	<input type="checkbox"/>	23. Mental Illness/Emotional Disorder
<input type="checkbox"/>	<input type="checkbox"/>	7. Blood Disorder/Transfusion/Hemorrhage	<input type="checkbox"/>	<input type="checkbox"/>	24. Neurological Disorder/Multiple Sclerosis
<input type="checkbox"/>	<input type="checkbox"/>	8. Cancer/Leukemia/Hodgkins	<input type="checkbox"/>	<input type="checkbox"/>	25. Pancreatitis
<input type="checkbox"/>	<input type="checkbox"/>	9. Circulatory/Vascular Disorder	<input type="checkbox"/>	<input type="checkbox"/>	26. Paralysis/Polio Residuals
<input type="checkbox"/>	<input type="checkbox"/>	10. Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	27. Proctitis/Rectal Disorder
<input type="checkbox"/>	<input type="checkbox"/>	11. Dizziness/Loss of Consciousness	<input type="checkbox"/>	<input type="checkbox"/>	28. Reproductive/Breast Disorder
<input type="checkbox"/>	<input type="checkbox"/>	12. Epilepsy/Convulsions/Seizure Disorder	<input type="checkbox"/>	<input type="checkbox"/>	29. Sexually Transmitted Disease
<input type="checkbox"/>	<input type="checkbox"/>	13. Gastrointestinal Disorder/Ulcer/Crohn's/Colitis	<input type="checkbox"/>	<input type="checkbox"/>	30. Surgery
<input type="checkbox"/>	<input type="checkbox"/>	14. Headaches	<input type="checkbox"/>	<input type="checkbox"/>	31. Thyroid/Goiter
<input type="checkbox"/>	<input type="checkbox"/>	15. Heart Disease/Heart Disorder/Angina	<input type="checkbox"/>	<input type="checkbox"/>	32. Tumor/Abscess/Cyst
<input type="checkbox"/>	<input type="checkbox"/>	16. High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	33. Varicose Veins
<input type="checkbox"/>	<input type="checkbox"/>	17. Immunodeficiency Disorder	<input type="checkbox"/>	<input type="checkbox"/>	34. Any Health Condition Not Listed

- | | | |
|---|---------------------------------|--------------------------------|
| 5. Has ANY person to be covered had any positive test results indicating Human Immunodeficiency Virus (HIV), or been medically diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS related complex (ARC)? | YES
<input type="checkbox"/> | NO
<input type="checkbox"/> |
| 6. Has ANY person to be insured received medical advice to have any diagnostic tests, examinations, or consultations for any condition that have not been completed; or had tests and results that have not been received; or test results were abnormal and no follow-up or resolution has occurred? | <input type="checkbox"/> | <input type="checkbox"/> |

Give details in the space below to any "YES" answers for questions 2, 3, 4, 5 and 6.

SIGNATURE AND AUTHORIZATION

I hereby apply to American Fidelity Assurance Company for reinstatement of the above numbered policy (policies) and any attached riders. I understand and agree that if the policy (policies) is (are) reinstated, then it (they) will be contestable for two years from the date shown below with respect to answers and statements in this application. This application and/or riders will be attached to and become a part of any policy (policies) reinstated and will constitute the entire contract between the parties. No statement shall void this reinstated policy or be used in defense of a claim unless contained in the written reinstatement application. The policy to which this application is attached shall be incontestable after two years from the date of issue except for non-payment of premiums or provisions and conditions relating to disability benefits and those granting additional insurance in the event of death or as specific loss by accident or accidental means when contained in or issued in connection with this reinstated policy.

Signed at _____
(City and State)

this _____ day of _____, 20 _____

Notary Public Seal Commission Expires

Signature of Proposed Insured

Notary Public Seal Commission Expires

Signature of Additional Insured (if any)

Notary Public Seal Commission Expires

Signature of Owner (if other than Proposed Insured)
(If owner is a Corporation, please affix Corporate Seal with Signature and Title of Authorized Officer)

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