

SERFF Tracking Number: ALST-126686211 State: Arkansas  
 Filing Company: American Heritage Life Insurance Company State Tracking Number: 46031  
 Company Tracking Number: AWD500AR1  
 TOI: H071 Individual Health - Specified Disease - Sub-TOI: H071.002 Dread Disease  
 Limited Benefit  
 Product Name: Cancer Insurance Application  
 Project Name/Number: Cancer Application/AWD500AR1

## Filing at a Glance

Company: American Heritage Life Insurance Company

Product Name: Cancer Insurance Application SERFF Tr Num: ALST-126686211 State: Arkansas  
 TOI: H071 Individual Health - Specified Disease SERFF Status: Closed-Approved- State Tr Num: 46031  
 - Limited Benefit Closed  
 Sub-TOI: H071.002 Dread Disease Co Tr Num: AWD500AR1 State Status: Approved-Closed  
 Filing Type: Form Reviewer(s): Rosalind Minor  
 Author: Juli Clausen Disposition Date: 06/30/2010  
 Date Submitted: 06/24/2010 Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

## General Information

Project Name: Cancer Application  
 Project Number: AWD500AR1  
 Requested Filing Mode: Review & Approval  
 Explanation for Combination/Other:  
 Submission Type: New Submission  
 Overall Rate Impact:  
 Filing Status Changed: 06/30/2010

Status of Filing in Domicile: Not Filed  
 Date Approved in Domicile:  
 Domicile Status Comments:  
 Market Type: Individual  
 Group Market Size:  
 Group Market Type:  
 Explanation for Other Group Market Type:  
 State Status Changed: 06/30/2010  
 Created By: Juli Clausen  
 Corresponding Filing Tracking Number:

Deemer Date:

Submitted By: Juli Clausen

Filing Description:

The above referenced form is attached for your review and approval. This form is new and does not replace any form previously approved by your department. This application will be used to apply for cancer coverage of previously approved forms used in the payroll deduction market.

This application will be used for applications taken through electronic means using a pen-based signature pad, PIN numbers, and any other valid electronic signature method. You have our assurance that appropriate encryption standards have been implemented to prohibit alteration of the application after the applicant has signed it.

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

## Company and Contact

### Filing Contact Information

Juli Clausen , Ettain Group jclav@allstate.com  
 Attn: Compliance Department 904-992-2912 [Phone]  
 1776 American Heritage Life Drive 904-992-2975 [FAX]  
 Jacksonville, FL 32224-6687

### Filing Company Information

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

## Filing Fees

Fee Required? Yes  
 Fee Amount: \$50.00  
 Retaliatory? No  
 Fee Explanation: \$50 per form X 1 form  
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
American Heritage Life Insurance Company	\$50.00	06/24/2010	37483429

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	06/30/2010	06/30/2010



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<b>Schedule</b>	<b>Schedule Item</b>	<b>Schedule Item Status</b>	<b>Public Access</b>
<b>Supporting Document</b>	Flesch Certification	Approved-Closed	Yes
<b>Supporting Document</b>	Application	Approved-Closed	Yes
<b>Supporting Document</b>	Health - Actuarial Justification	Approved-Closed	Yes
<b>Supporting Document</b>	Outline of Coverage	Approved-Closed	Yes
<b>Form</b>	Cancer Insurance Application	Approved-Closed	Yes

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## Form Schedule

**Lead Form Number: AWD500AR1**

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 06/30/2010	AWD500A R1	Application/Enrollment Form	Cancer Insurance Enrollment Application	Initial		48.400	AWD500AR1.pdf

(Please Print with Black Ink)

**APPLICATION FOR HEALTH INSURANCE TO:**

**AMERICAN HERITAGE LIFE INSURANCE COMPANY** 1776 American Heritage Life Drive, Jacksonville, FL 32224

Employee/Payor (if other than Proposed Insured)		Employee's DOB	Employee/Payor SSN		Employee's I.D. Number	
Proposed Insured (Last, First, M.I.)	<input type="checkbox"/> Emp. <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	<input type="checkbox"/> M <input type="checkbox"/> F	Age	Birthdate	Height	Weight
Resident Address	City	State	Zip	Resident Phone Number		
Social Security Number	Occupation	Date Hired	Email Address			

**DEPENDENTS PROPOSED FOR COVERAGE**

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

<b>Cancer</b> <input type="checkbox"/> Individual <input type="checkbox"/> Family	Cancer Riders Units						Section 125 <input type="checkbox"/> Yes <input type="checkbox"/> No	Mode Premium \$
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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?  Yes  No

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?  Yes  No

3. a) Has any person to be insured ever been diagnosed with or treated for any type of cancer, other than basal cell skin cancer?  Yes  No  
 b) If the answer to 3a is yes, has any person to be insured ever been diagnosed with or treated for leukemia, Hodgkin's Disease, lymphoma or cancer with any lymph node involvement or more than one metastasis?  Yes  No  
 c) Has any person to be insured been diagnosed with or received treatment for any other type of cancer (other than those listed in 3b and/or basal cell skin cancer) during the last 5 years?  Yes  No

4. a) Has any person to be insured had or is now being treated for: a stroke; a heart attack; a heart condition; heart trouble or any abnormality of the heart (including artery disease)?  Yes  No  
 b) Has any person to be insured in the last year had a systolic blood pressure reading higher than 150 more than once or a diastolic blood pressure reading higher than 100 more than once?  Yes  No

**Required Health History (Complete if questions 2-4 are answered "Yes." Use additional paper if necessary.)**

Name	Nature of Illness/Injury	Date	Name/Address of Physician

**Replacement.** Is this insurance to replace or change any existing health coverage? If yes, indicate product being replaced or changed.  Yes  No

**Existing.** Is there any other cancer insurance in force or applied for on any person to be insured? If yes, list company name, policy number, year issued, type of coverage, and amount of benefit.  Yes  No

**REPRESENTATION.** I have read or had read to me the completed application and understand that any misstatement or misrepresentation in the application may result in loss of coverage. I represent that statements and answers given on this application are true, complete, and correctly recorded. • **UNDERSTANDING.** I understand that the "effective date" of the policy will be the policy date recorded on the policy, not the date the application is signed. I also understand that, if premiums for the policy are to be paid by payroll deduction, these deductions may start before the "effective date" of the policy and that this does not change the effective date of coverage. If the policy is 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. • **FRAUD WARNING.** Any person who knowingly presents a false or fraudulent claim for a payment of loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. **Any person who is already covered by Medicaid should not purchase specified disease coverage.**

Signed at City/State	Date Signed
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Signature of Proposed Insured

Account Name	Account Number	Premium Mode	Requested Issue Date	Date of First Deduction	Producer Number	Percentage Credit

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## Supporting Document Schedules

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Flesch Certification <b>Comments:</b> <b>Attachment:</b> AR Readability Certificate.pdf	Approved-Closed	06/30/2010

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Bypassed - Item:</b> Application <b>Bypass Reason:</b> Not applicable to this filing <b>Comments:</b>	Approved-Closed	06/30/2010

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Bypassed - Item:</b> Outline of Coverage <b>Bypass Reason:</b> Not applicable to this filing <b>Comments:</b>	Approved-Closed	06/30/2010

**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>
AWD500AR1	48.4

Date: June 22, 2010

  
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Diane Ierna  
Assistant Vice President, Compliance Department