

SERFF Tracking Number: ALST-126989580 State: Arkansas
 Filing Company: American Heritage Life Insurance Company State Tracking Number: 47778
 Company Tracking Number: GVDIP
 TOI: H11G Group Health - Disability Income Sub-TOI: H11G.002 Short Term
 Product Name: Group Disability Insurance
 Project Name/Number: /

Filing at a Glance

Company: American Heritage Life Insurance Company

Product Name: Group Disability Insurance SERFF Tr Num: ALST-126989580 State: Arkansas
 TOI: H11G Group Health - Disability Income SERFF Status: Closed-Approved- State Tr Num: 47778
 Closed

Sub-TOI: H11G.002 Short Term Co Tr Num: GVDIP State Status: Approved-Closed
 Filing Type: Form Reviewer(s): Rosalind Minor
 Authors: Angie Redden, Jennifer Disposition Date: 02/14/2011
 Aiello, Lynn Bautista, Patti Hicks,
 Leslie Blandford, Sara Welch
 Date Submitted: 01/25/2011 Disposition Status: Approved-
 Closed
 Implementation Date Requested: On Approval Implementation Date:
 State Filing Description:

General Information

Project Name: Status of Filing in Domicile: Pending
 Project Number: Date Approved in Domicile:
 Requested Filing Mode: Review & Approval Domicile Status Comments:
 Explanation for Combination/Other: Market Type: Group
 Submission Type: New Submission Group Market Size: Small and Large
 Group Market Type: Employer, Association, Trust, Other Explanation for Other Group Market Type:
 Unions
 Overall Rate Impact: Filing Status Changed: 02/14/2011
 State Status Changed: 02/14/2011
 Deemer Date: Created By: Sara Welch
 Submitted By: Sara Welch Corresponding Filing Tracking Number:
 Filing Description:

The above referenced forms are being submitted for your review and approval. These forms are new and do not replace any forms previously approved by your department. These products are solicited by agents licensed to do business within your state and will be marketed to employer, association, trust or union groups.

Forms GVDIP; GVDIC; GVDIAPPAR; GVDIP-AMD; GT-PA1AR; and ABJ4520AR will be used to issue and enroll in Group Disability Insurance.

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Form ERAPPAR is a multi-product employer application that may be used with this Group Disability Insurance as well as any other group products that are approved for use in your state. This form was previously approved in your state on 3/29/10 under filing number 45128.

Material may vary, but will always be in accordance with your state laws.

The enrollment may be taken through electronic enrollment procedures by our licensed agents 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.

A Statement of Variability is enclosed, which outlines the variables for the submitted forms. Any logo, officer signature, or Home Office address and telephone number that appears on these forms is subject to change.

If you have any questions regarding this filing, feel free to contact me at jhop4@allstate.com, or (904) 992-2541. Thank you for your continued consideration.

Sincerely,

Jennifer R. Aiello, ALMI, ACS, AIRC

Company and Contact

Filing Contact Information

Jennifer Aiello, Filing Analyst jhop4@allstate.com
Attn: Legal/Compliance 904-992-2541 [Phone]
1776 American Heritage Life Drive 904-992-2975 [FAX]
Jacksonville, FL 32224-9983

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

SERFF Tracking Number: ALST-126989580 State: Arkansas
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Fee Required? Yes
Fee Amount: \$50.00
Retaliatory? No
Fee Explanation: \$50.00 per submission (not per form) X 1 submission = \$50.00 total
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
American Heritage Life Insurance Company	\$50.00	01/25/2011	44061701

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	02/14/2011	02/14/2011
Approved-Closed	Rosalind Minor	02/02/2011	02/02/2011

Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Form	Evidence of Insurability and Enrollment Form	Sara Welch	02/11/2011	02/11/2011
Form	Evidence of Insurability and Enrollment Form	Sara Welch	01/26/2011	01/26/2011

SERFF Tracking Number: ALST-126989580 *State:* Arkansas
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Disposition

Disposition Date: 02/14/2011

Implementation Date:

Status: Approved-Closed

Comment:

This submission was re-opened in order for you to make a minor change to Form ABJ4520AR. This form is being approved effective on this date, 2/14/11. The remainder of the filing will retain its original approval date of 2/2/11.

If we could be of further assistance, please let me know.

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Statement of Variability	Approved-Closed	Yes
Supporting Document	Actuarial Memorandum	Approved-Closed	No
Supporting Document	List of Forms	Approved-Closed	Yes
Form	Group Disability Insurance Policy	Approved-Closed	Yes
Form	Group Disability Certificate of Insurance	Approved-Closed	Yes
Form	Employer Application	Approved-Closed	Yes
Form	Policy Amendment	Approved-Closed	Yes
Form (revised)	Evidence of Insurability and Enrollment Form	Approved-Closed	Yes
Form	Evidence of Insurability and Enrollment Form	Replaced	Yes
Form	Evidence of Insurability and Enrollment Form	Replaced	Yes
Form	Participation Agreement	Approved-Closed	Yes

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Comment:

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Supporting Document	Statement of Variability	Approved-Closed	Yes
Supporting Document	Actuarial Memorandum	Approved-Closed	No
Supporting Document	List of Forms	Approved-Closed	Yes
Form	Group Disability Insurance Policy	Approved-Closed	Yes
Form	Group Disability Certificate of Insurance	Approved-Closed	Yes
Form	Employer Application	Approved-Closed	Yes
Form	Policy Amendment	Approved-Closed	Yes
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Amendment Letter

Submitted Date: 02/11/2011

Comments:

Thank you for reopening our filing.

After initially filing this policy, we realized that we inadvertently omitted a field from ABJ4520AR, our Enrollment and Evidence of Insurability form. The form was in need of question #5 on page 2 to give a place for explanation of answers to questions #1 through #4. This is the only change that has been made. As we have not begun using this form in your state yet, we have not changed the form number from the previously approved version. The new form is attached for your review.

We apologize for any confusion; please let us know if there are any questions. Thank you for your continued consideration.

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
ABJ4520AR	Application/Enrollment Form	Evidence of Insurability and Enrollment Form	Initial				0.000	ABJ4520AR.pdf

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 Product Name: Group Disability Insurance
 Project Name/Number: /

Amendment Letter

Submitted Date: 01/26/2011

Comments:

After filing these forms on January 25, 2011, we realized that we inadvertently omitted a field from Form ABJ4520AR. We have attached a revised copy for your review. We apologize for any confusion; please let us know if there are any questions. Thank you for your consideration.

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
ABJ4520AR	Application/Enrollment Form	Evidence of Insurability and Enrollment Form	Initial				0.000	ABJ4520AR.pdf

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Form Schedule

Lead Form Number: GVDIP

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 02/02/2011	GVDIP	Policy/Cont ract/Fratern al Certificate	Group Disability Insurance Policy	Initial		57.700	GVDIP Policy .pdf
Approved-Closed 02/02/2011	GVDIC	Certificate	Group Disability Certificate of Insurance	Initial		53.600	GVDIC Certificate.pdf
Approved-Closed 02/02/2011	GVDIAPPA R	Application/ Enrollment Form	Employer Application	Initial		0.000	GVDIAPPAR Employer Application.pdf
Approved-Closed 02/02/2011	GVDIP- AMD	Policy/Cont ract/Fratern al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Policy Amendment	Initial		0.000	GVDIP- AMD.pdf
Approved-Closed 02/14/2011	ABJ4520A R	Application/ Enrollment Form	Evidence of Insurability and Enrollment Form	Initial		0.000	ABJ4520AR.p df
Approved-Closed 02/02/2011	GT-PA1AR	Application/ Enrollment Form	Participation Agreement	Initial		0.000	GT-PA1AR Participation Agreement.pdf

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AMERICAN HERITAGE LIFE INSURANCE COMPANY

HOME OFFICE:
1776 AMERICAN HERITAGE LIFE DRIVE
JACKSONVILLE, FLORIDA 32224-6687
(904) 992-1776

A Stock Company

GROUP DISABILITY INSURANCE POLICY

NON-PARTICIPATING

American Heritage Life Insurance Company (referred to as we, us, or our) will provide benefits under this policy. We make this promise subject to all of the provisions of this policy.

The policyholder should read this group policy carefully and contact us promptly with any questions. This group policy is delivered in and is governed by the laws of the governing jurisdiction and, to the extent applicable, by the Employee Retirement Income Security Act of 1974 (ERISA), and consists of:

1. all policy provisions and any amendments and/or attachments issued; and
2. the employer's signed application.

This policy may be changed in whole or in part. The approval must be in writing, signed by one of our executive officers and endorsed on or attached to this policy. No other person, including an agent, may change this policy or waive any part of it.

Signed for American Heritage Life Insurance Company at its Home Office in Jacksonville, Florida on the policy effective date.

2

[*Cam Stewart*]

Secretary

[*David A. Beard*]

President

**THIS IS A GROUP DISABILITY ONLY POLICY WHICH PROVIDES
BENEFITS FOR DISABILITIES AS STATED WITHIN THIS POLICY**

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POLICY SPECIFICATIONS

- 4 **POLICYHOLDER:** [XYZ COMPANY, INC.] [XYZ LOCAL UNION NUMBER] [TRUSTEES OF THE XYZ TRUST]
- POLICY NUMBER:** [G-XXXXX]
- POLICY EFFECTIVE DATE:** [January 1, 2011]
- POLICY ANNIVERSARY DATE:** [January 1, 2012] and the [first] day of [January] each calendar year thereafter.
- GOVERNING JURISDICTION:** The [state of Florida] and subject to the laws of that jurisdiction.

- 5 **ELIGIBLE CLASS(ES):**
[All full-time active employees or members [of employers participating in the Trust] who work [30] or more hours a week for the employer.]

- 6 **ELIGIBILITY WAITING PERIOD:**
[Three Months]
[Eligible Salaried employees or members have no waiting period and are eligible for coverage on the first day of active employment. Eligible Hourly employees or members have a 90 day waiting period.]
[Eligible employees or members have a 30 day waiting period.]
[If employment ends and the person is rehired within one year, previous full-time active work will apply toward the eligibility waiting period. All other policy provisions apply.]

- 7 **MONTHLY BENEFIT:**
[The amount* elected by each insured employee or member, not to exceed [60%] of monthly earnings, subject to a minimum of [\$400] and a maximum of [\$6,000].]
[60% of monthly earnings to a maximum of [\$2,500] per month.*]
[\$1,000 per month.*]
[*Payment may be reduced by deductible sources of income and disability earnings.] [Some disabilities may not be covered under this policy.] [This policy does not cover disabilities due to an occupational sickness or injury.]

- 8 **OPTIONAL RIDERS:**
[None]

- 9 **[GUARANTEED ISSUE LIMIT:**
We may ask for evidence of insurability if a person proposed for insurance applies for a monthly benefit amount over [\$1,200].]

- 10 **ELIMINATION PERIOD:**
[14] days for disability due to an injury
[14] days for disability due to a sickness
[Benefits begin the day after the elimination period is completed. If the insured employee or member is hospital confined as an inpatient, benefits begin on the first day of hospital confinement, if this is earlier than the end of the elimination period.]

- 11 **MAXIMUM PERIOD OF PAYMENT:**
[24 months]

POLICY SPECIFICATIONS (Continued)

12

[WAIVER OF PREMIUM:

Premium payments are required while the insured employee or member is receiving payments under this policy during the first [30] days of disability.]

13

INITIAL RATE:

[Monthly rate of [\$XX.XX] per insured employee or member.]

[Monthly rate of [XX.XX%] of total covered payroll.

Total covered payroll means the total amount of monthly earnings for which employee or member are insured under the policy.]

[Monthly rate of [\$X.XX] per \$100 of monthly benefit.]

[Monthly rate is determined on the policy effective date [and re-determined on the policy anniversary date each year thereafter,] based on the insured employee or member's [attained] [issue] age on such dates, as follows:

<u>[Attained] [Issue] Age</u>	<u>Monthly rate per \$100 of monthly benefit</u>
18 to 49	\$.xx
50 to 59	\$.xx
60 to 64	\$.xx
65 to 69	\$.xx
70 and over	\$.xx]

14

RATE GUARANTEE DATE:

[01/01/2011]

15

PREMIUM DUE:

[01/01/2011] and the [first day] of each [calendar month] thereafter.

All premiums must be sent on or before the premium due date to us. The premium must be paid in United States dollars.

16

COST OF COVERAGE:

[The [policyholder] [employer] pays the cost of the insured employee or member's coverage.]

[The insured employee or member and the [policyholder] [employer] share the cost of coverage.]

[The insured employee or member pays the cost of coverage.]

[DIVISIONS, SUBSIDIARIES OR AFFILIATED COMPANIES

These are the policyholder's divisions, subsidiaries, or affiliates listed below. The policyholder may act for and on behalf of any and all of these in all matters that pertain to this policy. Every act done by, agreement made with, or notice given to the policyholder will be binding on them.

17

Name

Location (City and State)]

[None]

POLICYHOLDER PROVISIONS

RATE GUARANTEE

18 A change in premium rate will not take effect before the Rate Guarantee Date, except for reasons which affect the risk assumed, including the reasons shown below:

1. a change occurs in this policy design; or
2. [a division, subsidiary, or affiliated company is added or deleted; or]
- [3.] the number of insured employees or members increases or decreases by [25%] or more; or
- [4.] a new law or a change in any existing law is enacted which applies to this policy; or
- [5.] less than [15%] of those eligible for coverage are participating.

We will notify the policyholder [and each employer participating in the Trust] in writing at least [31 days] before a premium rate is changed. A change may take effect on an earlier date when both we and the policyholder agree.

PREMIUM INCREASES OR DECREASES

Premium increases or decreases may take effect any time subject to the RATE GUARANTEE provision. If they take effect during a policy month, they are adjusted and due on the next premium due date following the change. Changes will not be pro-rated daily.

If premiums are paid on other than a monthly basis, premiums for increases and decreases will result in a monthly pro-rated adjustment on the next premium due date.

[WAIVER OF PREMIUM

19 We do not require premium payment for an insured employee or member after being disabled the longer of [30] days or completion of the elimination period for the duration of that disability. The waiver of the premium will not exceed the maximum benefit period.

We do not require premium payment for an insured employee or member while he or she is receiving disability payments.]

INFORMATION REQUIRED FROM THE POLICYHOLDER

20 The policyholder [or employer] must provide us with the following on a regular basis:

1. information about employees or members:
 - a. who are eligible to become insured; and
 - b. whose amounts of coverage change; and
 - c. whose coverage ends; and
2. occupational information and any other information that may be required to manage a claim; and
3. any other information that may be reasonably required.

Policyholder [or employer] records that have a bearing, in our opinion, on this policy must be made available for review by us at any reasonable time.

[WHEN EVIDENCE OF INSURABILITY IS REQUIRED

21 [Evidence of insurability is required if participation is not met as described in the RATE GUARANTEE provision.]

[Evidence of insurability is [also] required if the employee or member:

1. voluntarily canceled coverage and is reapplying; or
2. is applying for an amount of coverage over the Guaranteed Issue Limit; or
3. is applying for the coverage [at any time after] the initial enrollment period]; or
4. is applying for an increase in the amount of coverage, during the re-enrollment period.]

INCONTESTABILITY

22 After 2 years from the effective date of this policy, no misstatement of the policyholder [or any employer], made in any applications [or employer agreements to participate under the Trust], can be used to void the policy.

POLICYHOLDER PROVISIONS (Continued)

23 CLERICAL ERROR

Clerical error on the part of the policyholder[, by any employer] or us will not invalidate insurance otherwise in force nor continue insurance otherwise terminated. Upon discovery of any error, an adjustment will be made in the premiums and/or benefits available. Complete proof must be supplied by the policyholder [or any employer] documenting any clerical errors.

CANCELING POLICY

This policy can be canceled:

1. by us; or
2. by the policyholder.

24 We may cancel or offer to modify this policy, with at least [31 days] written notice to the policyholder, if:

1. less than [25%] of those eligible for coverage are participating; or
2. this policy has been in effect more than [12] months; or
3. the policyholder does not promptly provide us with information that is reasonably required; or
4. the policyholder fails to perform any of its obligations that relate to this policy; or
5. fewer than [10] people are insured; or
6. the policyholder fails to pay any premium within the [31] day grace period.

If the premium is not paid during the grace period, the policy will terminate automatically at the end of the grace period. The policyholder is liable for the premium for coverage during the grace period. The policyholder must send us all premiums due for the full period this policy is in force.

The policyholder may cancel this policy by written notice delivered to us at least [31] days prior to the cancellation date. When both we and the policyholder agree, this policy can be canceled on an earlier date. If canceled, coverage will end at 12:00 midnight on the last day of coverage.

If this policy is canceled, the cancellation will not affect a payable claim incurred prior to cancellation.

[Coverage with respect to an employer participating in the Trust will terminate according to the terms of the Participation Agreement signed by the employer.]

ENTIRE CONTRACT

25 The contract consists of the following items:

1. the group policy; and
2. any amendments and endorsements; and
3. the applications and other written statements of the policyholder; and
4. any individual applications, enrollments[, evidence of insurability] or other statements of the insured employee or member[; and
5. the Participation Agreements signed by the employers participating under the Trust].

Any statements made by the policyholder or by an insured employee or member [or any employer participating under the Trust], in the absence of fraud, are representations and not warranties. Only written statements signed by the policyholder or insured employee or member [or any employer] will be used in defense of a claim. A copy of any written statement, if applicable, will be furnished to the policyholder or [the employer or] the insured employee or member or his or her personal representative, if any, if such written statement will be used in defense of a claim.

If any of the statements are not complete and/or not true at the time they are made, we can:

1. reduce or deny any claim; or
2. cancel coverage from the original effective date.

POLICYHOLDER PROVISIONS (Continued)

26 CERTIFICATES OF INSURANCE

We will furnish to the policyholder [or each employer participating under the Trust] a certificate of insurance for delivery to each insured employee or member. The certificate will provide a description of the insurance provided by this policy and will state:

1. the essential features of the insurance coverage; and
2. to whom benefits are payable.

If there is any discrepancy between the provisions of any certificate and the provisions of this policy, the provisions of this policy govern.

WORKERS' COMPENSATION OR STATE DISABILITY INSURANCE

This policy does not replace or affect the requirements for coverage by any workers' compensation or state disability insurance.

CERTIFICATE PROVISIONS MADE PART OF THIS GROUP POLICY

The remainder of this group policy consists of the provisions that will appear in the group certificate, including any optional riders or endorsements or amendments. The group certificate describes the insurance made available under this group policy to insured employees or members.

(This space intentionally left blank.)



AMERICAN HERITAGE LIFE INSURANCE COMPANY

HOME OFFICE:
1776 AMERICAN HERITAGE LIFE DRIVE
JACKSONVILLE, FLORIDA 32224-6687
(904) 992-1776

A Stock Company

**THIS IS A GROUP DISABILITY ONLY POLICY WHICH PROVIDES
BENEFITS FOR DISABILITIES AS STATED WITHIN THIS POLICY**

1



AMERICAN HERITAGE LIFE INSURANCE COMPANY

HOME OFFICE:
 1776 AMERICAN HERITAGE LIFE DRIVE
 JACKSONVILLE, FLORIDA 32224-6687
 (904) 992-1776

A Stock Company

CERTIFICATE OF INSURANCE

This certificate of insurance ("certificate") describes your insurance coverage under the policy.

2

In this certificate, the words:

"You" and "your" mean the named insured employee or member shown [in this certificate] [on the Certificate Specifications page] [on page 3] [in your benefit statement] who is a member of an eligible class as described in the policy and for whom premiums are remitted.

"We", "us" and "our" mean American Heritage Life Insurance Company.

"The policy" means the policy of insurance issued by us to the policyholder.

The policy alone makes up the agreement under which insurance coverage is provided and benefits are determined. If the terms of your certificate and the policy differ, the policy will govern. The policy may be inspected at the office of the policyholder during normal business hours.

Coverage under the policy is issued in consideration of your enrollment or other form of application and the payment of the first premium.

We certify that coverage under the policy is in effect for persons who have satisfied all eligibility requirements and for whom the required premium has been paid when due.

The policy is delivered in and is governed by the laws of the governing jurisdiction and, to the extent applicable, by the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments.

The policy and this certificate may be changed in whole or in part or cancelled by agreement between us and the policyholder. Such an action may be taken without the consent or notice to you or anyone covered under the policy. Only an authorized officer at our home office can approve a change. The approval must be in writing and endorsed on or attached to the policy. No other person, including an agent, may change the policy or certificate or waive any of its provisions. Premiums are subject to periodic changes.

This certificate supersedes and replaces any certificate previously issued to you under the policy.

3

A handwritten signature in black ink that reads "Gary Stewart". The signature is enclosed in large, bold square brackets.

Secretary

A handwritten signature in black ink that reads "David A. Beard". The signature is enclosed in large, bold square brackets.

President

**THIS IS GROUP DISABILITY ONLY COVERAGE WHICH PROVIDES
 BENEFITS FOR DISABILITIES AS STATED WITHIN THIS CERTIFICATE**

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GENERAL PROVISIONS [4]

LIMITATIONS AND EXCLUSIONS..... [x]

BENEFIT INFORMATION [x]

[PORTABILITYx]

CLAIM INFORMATION [x]

GLOSSARY [x]

GENERAL PROVISIONS

EFFECTIVE DATE OF COVERAGE

6 Your coverage will be effective at 12:01 a.m. on the effective date shown [in this certificate] [on the Certificate Specifications page] [on page 3] [in your benefit statement] provided you are an active employee on that date.

If you are not an active employee on that date due to disability, injury, sickness, temporary layoff, leave of absence or Family and Medical Leave of Absence, coverage begins on the date you return to active employment. This applies to your initial coverage, as well as any increase or addition to coverage that occurs after your initial coverage is effective.

For any change in coverage [that is subject to evidence of insurability,] the change in coverage is effective on the date we approve such change.

[For any change in coverage that is not subject to evidence of insurability, the change in coverage is effective on the date we receive such request for change.]

Any decrease in coverage will take effect on the [first day of the calendar month that next follows the] date you apply for the decrease, but will not affect a payable claim that occurs prior to the effective date of the decrease.

CERTIFICATE OF INSURANCE

This certificate of insurance provides a description of the insurance provided by the policy issued to the policyholder. It describes the essential features of the insurance coverage and to whom benefits are payable.

If there is any discrepancy between the provisions of this certificate and the provisions of the policy, the provisions of the policy govern.

WHEN YOU CAN ENROLL, CHANGE OR DISCONTINUE COVERAGE

1. You may apply for coverage during:
 - a. the initial enrollment period; or
 - b. [a re-enrollment period.] [at any time, subject to evidence of insurability.]
2. You may increase coverage [at any time] [at the next re-enrollment period] [, subject to evidence of insurability].
3. You may decrease coverage [at any time] [at the next re-enrollment period].
4. You may discontinue coverage [at any time] [at the next re-enrollment period].

8 [WHEN EVIDENCE OF INSURABILITY IS REQUIRED

Evidence of insurability is required if you[:

- 1.] voluntarily canceled coverage and are reapplying[; or
2. are applying for an amount of coverage over the Guaranteed Issue Limit; or]
- [3. are applying for coverage, or for an increase in the amount of coverage, during the re-enrollment period]; or
- [4. are applying for the coverage at any time after the initial enrollment period.]]

9 TERMINATION OF COVERAGE

Your coverage under the policy ends on the earliest of:

1. the date the policy is canceled; or
2. the last day of the period for which any required premium payment was made; or
3. the last day you are an active employee with your employer and/or a member in good standing in the labor union, association or other entity that is the policyholder [or the employer participating under the Trust], except as provided under the TEMPORARY LAYOFF, LEAVE OF ABSENCE OR FAMILY AND MEDICAL LEAVE OF ABSENCE provision; or
4. the date you are no longer in an eligible class; or
5. the date your class is no longer eligible; or
6. upon our discovery of fraud or material misrepresentation in the presentation of a claim under this certificate.

GENERAL PROVISIONS (Continued)

9 TERMINATION OF COVERAGE (Continued)

If we accept a premium for coverage extending beyond the date, age or event specified for termination, such premium will be refunded, coverage will terminate and claims will not be paid. We will provide coverage for a payable claim which occurs while you are covered under the policy.

Coverage may be eligible for continuation as outlined in the [IF REHIRED BY YOUR EMPLOYER WITHIN 12 MONTHS FOLLOWING THE DATE EMPLOYMENT TERMINATED provision or the] [WHEN YOUR COVERAGE CAN BE CONTINUED] [PORTABILITY PRIVILEGE] provision.

10 TEMPORARY LAYOFF, LEAVE OF ABSENCE OR FAMILY AND MEDICAL LEAVE OF ABSENCE

[If you cease active employment with your current employer due to a temporary layoff or leave of absence, and if premiums are paid, coverage will be continued for [one month] following the [date] [last day of the month in which] active employment ceased.]

[We will continue your coverage in accordance with your employer's written human resource policy on temporary layoff, leave of absence or family and medical leave of absence, if premium payments continue and the employer approved your leave in writing, for the following periods:

1. If you are on temporary layoff or leave of absence, coverage will be continued for [one month] following the [date] [last day of the month in which] you ceased active employment.
2. If you are on a Family and Medical Leave of Absence as defined by the Federal Family and Medical Leave Act of 1993, and any amendments, coverage will continue as though you are in active employment. Coverage will continue up to the greater of the leave period required under the:
 - a. Federal Family and Medical Leave Act of 1993, and any amendments; or
 - b. applicable state law.]

If your employer's human resource written policy does not provide for continuation of coverage during a family and medical leave of absence, coverage will be reinstated when you return to active employment.

We will not[:

- 1.] apply a new eligibility waiting period[; or
2. apply a new pre-existing condition exclusion] [; or
3. require evidence of insurability].

11 [IF REHIRED BY YOUR EMPLOYER WITHIN 12 MONTHS FOLLOWING THE DATE EMPLOYMENT TERMINATED

If you are rehired by your employer within 12 months following the date that employment terminated and request coverage under the policy by applying for the coverage and authorizing payroll deduction, if applicable, you:

1. will be insured for the same coverage that was in effect on the date your employment terminated; and
2. may not change coverage until the next re-enrollment period.

The monthly benefit will be [the lesser of:

- 1.] the amount received at the time employment terminated[; or
2. [60%] of the amount of monthly earnings upon re-hire].

You may not change coverage until the next re-enrollment period.]

12 [WHEN YOUR COVERAGE CAN BE CONTINUED

Your coverage may be continued for up to [12 months] if employment with the policyholder [or an employer participating under the Trust] ends. However, to be eligible to continue the insurance, the following requirements must have been met on the date employment ends:

1. you must have been continuously covered under the policy for at least [12] consecutive months just before employment ends; and
2. you are not disabled; and
3. you are not on a leave of absence; and
4. you are not retired; and
5. you are not covered under any other group disability plan.]

GENERAL PROVISIONS (Continued)

12 [WHEN YOUR COVERAGE CAN BE CONTINUED (Continued)]

You must apply in writing and pay the first premium to us within [31] days after the date employment ends. The coverage that may be continued is the same coverage in effect on the last day of employment and will be based on monthly earnings at that time.

Coverage that is continued under this provision will end the earlier of [12 months] or:

1. the date the policy is canceled; or
2. the last day any required premium payments are made; or
3. the day there is coverage under any other group disability policy.]

13 [DISCRETIONARY AUTHORITY, IF GOVERNED BY ERISA]

The following applies only when the administration of the policy is governed by the Employee Retirement Income Security Act (ERISA), 29 U.S.C. 1001 et seq.:

We have the discretion and authority to construe disputed or seemingly inconsistent provisions of the policy and to make all decisions regarding eligibility and/or entitlement to coverage or benefits. Whenever we make reasonable determinations which are not arbitrary or capricious in the administration of the policy, such determinations shall be final and conclusive.]

LEGAL ACTION

No legal action may be brought to obtain benefits under the policy:

1. for at least 60 days after proof of loss has been furnished; or
2. after the expiration of 3 years from the time written proof of loss is required to have been furnished.

INCONTESTABILITY

After 2 years from the effective date of your coverage, no misstatement, made in writing, can be used to void coverage or deny a claim for a disability incurred.

14 CLERICAL ERROR

Clerical error on the part of the policyholder[, by any employer] or us will not invalidate insurance otherwise in force nor continue insurance otherwise terminated. Upon discovery of any error, an adjustment will be made in the premiums and/or benefits available. Complete proof must be supplied by us or the policyholder [or any employer] documenting any clerical errors.

WORKERS' COMPENSATION OR STATE DISABILITY INSURANCE

This certificate does not replace or affect the requirements for coverage by any workers' compensation or state disability insurance.

AGENCY

For purposes of the policy, the policyholder acts on its own behalf or as your agent. Under no circumstances will the policyholder be deemed the agent of American Heritage Life Insurance Company.

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[PRE-EXISTING CONDITION LIMITATION

15

We will not pay for disabilities during the first [12] months of coverage due to a pre-existing condition.

You have a pre-existing condition if:

1. your disability begins in the first [12] months after your effective date of coverage; and
2. you received medical treatment, consultation, care or services, including diagnostic measures, took or were prescribed drugs or medicines, took over the counter medications or followed treatment recommendations in the [12] months just prior to your effective date of coverage or the date an increase in benefits would otherwise be effective; or
3. you had symptoms in the [12] months just prior to your effective date of coverage or the date an increase in benefits would otherwise be effective.]

16

[WAIVER OF PRE-EXISTING CONDITION LIMITATION FOR PRIOR [AMERICAN HERITAGE LIFE] GROUP INSURANCE

We will waive the pre-existing condition limitation for a claim made by you not to exceed the amount you were insured under a prior group policy [issued by us] if:

1. the claim would have satisfied the pre-existing condition limitation of the prior group policy; and
2. you:
 - a. were in active employment on the policy date of this policy; and
 - b. had been continuously insured under this policy since the policy date; and
 - c. were insured under the prior group policy when it terminated; and
3. the prior group policy:
 - a. [was issued by us; and]
 - b. had the same policyholder as this policy; and
 - c. provided coverage substantially similar to this policy; and
 - d. was issued before the policy date of this policy; and
 - e. terminated within 60 days of the policy date of this policy.]

17

[WAIVER OF PRE-EXISTING CONDITION LIMITATION FOR PRIOR [AMERICAN HERITAGE LIFE] INDIVIDUAL INSURANCE

We will waive the pre-existing condition limitation for a claim made by you not to exceed the amount you were insured under a prior individual policy [issued by us] if:

1. the claim would have satisfied the pre-existing condition limitation of the prior individual policy; and
2. you:
 - a. were in active employment on the policy date of this policy; and
 - b. had been continuously insured under this policy since the policy date; and
 - c. were insured under the prior individual policy when it terminated; and
3. the prior individual policy:
 - a. [was issued by us; and]
 - b. provided coverage substantially similar to this policy; and
 - c. was issued before the policy date of this policy; and
 - d. terminated within 60 days of the policy date of this policy.]

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EXCLUSIONS

We will not pay benefits for any disabilities that are caused by, contributed to by or result from:

1. [Bipolar affective disorder (manic depressive syndrome), delusional (paranoid) disorders, psychotic disorders, somatoform disorders (psychosomatic illness), eating disorders, schizophrenia, anxiety disorders, depression or mental illness. We will pay, however, for covered disabilities resulting from Alzheimer's disease or similar forms of senility or senile dementia first manifested while coverage is in force.]
- [2.] War, declared or undeclared, participation in a riot, insurrection or rebellion.
- [3.] Illegal activities or participation in an illegal occupation.
- [4.] Intentionally self-inflicted injury or action.
- [5.] Substance abuse, to include abuse of alcohol, alcoholism, drug addiction or dependence upon any controlled substance.
- [6.] Participation in any form of aeronautics except as a fare paying passenger in a licensed aircraft provided by a common carrier and operating between definitely established airports.
- [7.] Voluntary inhalation of fumes or gases.
- [8.] Cosmetic surgery (except complications from such surgery will be covered).
- [9.] Pre-existing conditions during the first 12 months of coverage.]
- [10.] Occupational sickness or injury, unless covered by an on-the-job disability rider.]

18

We will not pay a benefit for any period of disability during which you are incarcerated.

[As used in this provision, mental illness means a psychiatric or psychological condition regardless of cause such as schizophrenia, depression, manic depressive or bipolar illness, anxiety, post traumatic stress disorder, personality disorders and/or adjustment disorders or other conditions. These conditions are usually treated by a mental health provider or other qualified provider using psychotherapy, psychotropic drugs, or other similar methods of treatment.]

As used in this provision, substance abuse means the consuming of alcohol or taking of other drugs at dosages that place your psychological and physical welfare in danger or which habitual influence of such substance (except as prescribed and directed by a doctor) endangers public health, safety or welfare.

[As used in this provision, occupational sickness or injury means a sickness or injury that was caused by, contributed to by or aggravated by any employment for pay or profit.]

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BENEFIT INFORMATION

GENERAL

19 The following are shown [on the Certificate Specifications page] [on page 3] [in your benefit statement]:

1. the elimination period(s); and
2. the monthly benefit amount.

You must be an active employee on the date your disability occurs for disability benefits to be payable.

We may require an exam by a doctor, other medical practitioner, or vocational expert of our choice. We will pay for this examination. We can require an examination as often as it is reasonable to do so. We may also require an interview by our authorized representative.

The loss of a professional or occupational license or certification does not, in itself, constitute a disability.

A. Elimination Period

You must be totally disabled continuously throughout the elimination period.

20 If your covered disability is the result of an injury or sickness that occurs while covered under the policy, [the elimination period is the time period stated [on the Certificate Specifications page] [on page 3] [in your benefit statement]] [benefits begin immediately].

[If, because of your covered disability, you are hospital confined, benefits begin on the first day of hospital confinement, if this is earlier than the end of the elimination period.]

B. Monthly Benefit Amount

21 We pay the monthly benefit amount (or part of the monthly benefit amount, if less than a full month) for a covered disability at the end of the month for which it is due. You will receive benefits as long as you remain totally disabled, except [:

1.] we pay only up to the maximum benefit period for any one total disability. [; and
2. any monthly benefit we pay is subject to the DEDUCTIBLE SOURCES OF INCOME provision].

If a monthly benefit is payable for any period less than a full month, we pay 1/30th of the applicable monthly benefit for each day.

When a benefit is due for a payable claim, we will send you a payment each month up to the maximum benefit period. The maximum benefit period during a continuous period of disability is shown [on the Certificate Specifications page] [on page 3] [in your benefit statement].

We will stop sending payments and your claim will end on the earliest of the following:

1. when you are able to return to work in your own occupation on a part-time or full-time basis but choose not to do so; or
2. the end of the maximum benefit period; or
3. the date you are no longer disabled under the terms of the policy; or
4. the date proof of your continuing disability is not submitted; or
5. the date of your death.

[We will continue to pay you a disability benefit after benefits have been received under the policy according to the IF YOU ARE DISABLED AND WORKING (PROPORTIONATE LOSS) provision.]

C. Amount of Payment

When you are totally disabled and not working we will follow the process described below to determine your amount of payment:

- 22
1. Multiply your monthly earnings by [60%].
 2. Subtract any deductible sources of income from item 1.
 3. Determine the lesser of the amount listed [on the Certificate Specifications page] [on page 3] [in your benefit statement] and the result of item 2.
 4. Compare item 3 with the [\$100] minimum monthly payment and we will pay the greater of the two.

The amount calculated in item 4 is your monthly payment.

After the elimination period, if you continue to be disabled for less than 1 month, we will send 1/30th of your payment for each day of disability.

[We may apply this amount toward an outstanding overpayment.]

BENEFIT INFORMATION (Continued)

GENERAL (Continued)

23

[D. Deductible Sources of Income

Deductible sources of income include:

- [1.] The amount that you receive, or are eligible to receive, as disability income payments under any:
 - a. [state compulsory benefit act or law; or
 - b.] individual disability income policies [which are paid for by your employer]; or
 - [c.] other group insurance coverage; or
 - [d.] automobile liability insurance policy.
- [2.] The amount you receive:
 - a. under Title 46, United States Code Section 688 (the Jones Act); or
 - b. from a third party (after subtracting attorney's fees) by judgment, settlement or otherwise; not to exceed 50% of the net settlement; or
 - c. under the mandatory portion of any "no fault" motor vehicle policy; or
 - d. under a salary continuation or accumulated sick leave plan.
3. The amount you:
 - a. receive as disability payments under your employer's retirement plan; or
 - b. voluntarily elect to receive as retirement payments under your employer's retirement plan; or
 - c. are eligible to receive as retirement payments when you reach the later of age 62 or normal retirement age, as defined in your employer's retirement plan.
4. The amount you receive under:
 - a. the United States Social Security Act; and/or
 - b. Railroad Retirement disability; or
 - c. other federal disability benefits while entitled to a disability benefit under the policy.]
- [5.] The amount you receive or are entitled to receive under:
 - a. a workers' compensation law; or
 - b. an occupational disease law; or
 - c. any other act or law with similar intent.]
- [6.] The amount you, your spouse and your children receive or are entitled to receive as disability payments because of a disability under:
 - a. the Canada Pension Plan; or
 - b. the Quebec Pension Plan; or
 - c. any similar plan or act.]

[Disability payments under a retirement plan are those benefits which are paid due to disability and do not reduce the retirement benefit which would have been paid if the disability had not occurred.

Retirement payments are those benefits which are paid based on your employer's contribution to the retirement plan. Disability benefits which reduce the retirement benefit under the policy will also be considered as a retirement benefit. Regardless of how the retirement funds from the retirement plan are distributed, we will consider the contributions of both you and your employer to be distributed simultaneously throughout your lifetime.

Amounts received do not include amounts rolled over or transferred to any eligible retirement plan. We will use the definition of eligible retirement plan as defined in Section 402 of the Internal Revenue Code including any future amendments which affect the definition.

We will subtract only deductible sources of income which are payable as a result of the same disability.]

Other than for increases in any income you earn from any form of employment, once we have subtracted any deductible source of income from your gross monthly disability payment, we will not further reduce your payment due to a cost of living increase from that source.]

BENEFIT INFORMATION (Continued)

GENERAL (Continued)

[E. Non-Deductible Sources of Income

24 Non-deductible sources of income include, but are not limited to, income received from the following:

1. 401(k) plans; or
2. [salary continuation (both formal and informal) except as indicated below; or]
3. [accumulated sick leave plans except as indicated below; or]
- [4.] profit sharing plans; or
- [5.] thrift plans; or
- [6.] tax sheltered annuities; or
- [7.] stock ownership plans; or
- [8.] non-qualified plans of deferred compensation; or
- [9.] pension plans for partners; or
- [10.] military pension and disability income plans; or
- [11.] credit disability insurance; or
- [12.] franchise disability income plans; or
- [13.] no-fault automobile insurance plans; or]
- [14.] individual disability plans paid by you; or
- [15.] a retirement plan from another employer; or
- [16.] individual retirement accounts (IRA's).

If salary continuation or accumulated sick leave plan payments plus the sum of the gross disability benefit and disability earnings exceed [100%] of your monthly earnings, we will subtract the amount in excess of [100%] from your benefit.]

[F. You May Qualify For Deductible Income Benefits

25 When we determine that you may qualify for benefits under items 1, [5,] [and 6] in the DEDUCTIBLE SOURCES OF INCOME provision, we will estimate your entitlement to these benefits. We can reduce your payment by the estimated amounts if such benefits:

1. have not been awarded; and
2. have not been denied; or
3. have been denied and the denial is being appealed.

Your monthly payment will NOT be reduced by the estimated amount if you:

1. apply for the disability payments under items 1, [5,] [and 6] in the DEDUCTIBLE SOURCES OF INCOME provision and appeal your denial to all administrative levels we feel are necessary; and
2. sign our payment option form. This form states that you promise to pay us any overpayment caused by an award.

If your payment has been reduced by an estimated amount, the payment will be adjusted when we receive proof:

1. of the amount awarded; or
2. that benefits have been denied and all appeals we feel are necessary have been completed. In this case, a lump sum payment of the estimated amount will be made to you.

If you receive a lump sum payment from any deductible source of income, the lump sum will be pro-rated on a monthly basis over the time period for which the sum was given. If no time period is stated, the sum will be pro-rated on a monthly basis to the end of the maximum benefit period.]

BENEFIT INFORMATION (Continued)

DISABILITY BENEFITS

A. Total Disability Benefit

We pay the monthly benefit amount after the elimination period if we receive sufficient proof that you are totally disabled.

Benefits will not continue beyond the maximum benefit period for total disability.

You are totally disabled when we determine that due to a sickness or injury you are:

1. unable to perform the material and substantial duties of your own occupation; and
2. under the regular care of a doctor; and
3. not working in any job for wage or profit.

26 [B. Partial Disability Benefit

We pay 50% of the monthly benefit if we receive sufficient proof that you are partially disabled, subject to the following:

1. the total disability benefit must have been payable for at least one full month immediately prior to being partially disabled; and
2. the maximum benefit period for a partial disability is 3 months; and
3. for a given period of disability, you may receive either a partial disability benefit, or a total disability benefit, but not both.

Benefits paid under this benefit count towards your maximum benefit period.

You are partially disabled when we determine that due to a sickness or injury you are:

1. unable to perform the material and substantial duties of your own occupation on a full-time basis, but you are able to work on a part-time basis; and
2. under the regular care of a doctor.]

27 [B. If You Are Disabled and Working (Proportionate Loss)

We will send you the monthly payment if disabled and the monthly disability earnings, if any, are less than 20% of your monthly earnings, due to the same sickness or injury.

If disabled and the monthly disability earnings are from 20% to 80% of your monthly earnings, we will make payments based on the percentage of income lost due to the disability. We will use the following process to calculate your payment:

1. Subtract any disability earnings from your monthly earnings.
2. Divide the answer in item 1 by your monthly earnings. This is the percentage of lost earnings.
3. Multiply the monthly payment by the answer in item 2.

This is the amount we will pay you each month.

Your loss of earnings must be as a result of or due to the same sickness or injury which caused the disability.

If you are disabled and working, and the monthly disability earnings are more than 80% of your monthly earnings, then no payment will be made.

We may require that you send proof of any disability earnings each month. We will adjust your payment based on any disability earnings. As part of the proof of disability earnings, we can require that you send us appropriate financial records which we believe are necessary to substantiate your income.]

[If your disability earnings fluctuate from month to month, we may average the disability earnings over the most recent 3 months to determine if your claim should continue. If we average the disability earnings, we will not terminate your claim unless the average of your disability earnings from the last 3 months exceeds 80% of monthly earnings.]

C. Concurrent Disability

During any period in which you are disabled due to more than one cause, benefits will be paid as if you are disabled due to only one cause. In no event will being disabled due to more than one cause extend the time for which benefits will be paid under the maximum benefit period.

BENEFIT INFORMATION (Continued)

DISABILITY BENEFITS (Continued)

28

D. Recurrent Disability

If you have a recurrent disability, we will treat the disability as part of the prior claim and another elimination period will not have to be completed if you were continuously insured under the policy for the period between the prior claim and the recurrent disability and:

1. your recurrent disability occurs within [6 months] of the end of your prior claim; or
2. you fully performed any occupation for your employer on a full-time basis for less than [30 full days] and your current disability is unrelated to your prior disability for which we made a payment.

Your recurrent disability will be subject to the same terms as your prior claim.

Any disability which occurs after [6 months] from the date your prior claim ended will be treated as a new claim. Your new claim will be subject to all of the policy provisions.

If you become entitled to payments under any other group disability policy, you will not be eligible for payments under our policy.

As used in this provision, recurrent disability means a disability which is:

1. caused by a worsening in condition; or
2. due to the same cause(s) or related cause(s) as the prior disability for which we made a payment.

As used in the provision, any occupation means any gainful occupation for which you are suited by education, training or experience.

E. Pregnancy Benefit

Pregnancy or childbirth will be covered the same as any covered sickness if you meet the definition of total disability, as outlined in the TOTAL DISABILITY BENEFIT provision, provided that your coverage has been in effect for a period of 9 months or more from your effective date of coverage.

F. Organ Donor Benefit

If your disability is the result of your serving as an organ donor in an organ transplant procedure performed while covered under the policy, we will pay the monthly benefit you would receive if you are totally or partially disabled. Sufficient proof that you are totally or partially disabled must be received by us.

As used in this provision, organ transplant means the surgical transplantation of a:

1. kidney; or
2. lung; or
3. portion of the liver, pancreas, or intestines; or
4. bone marrow.

A procedure to have bone marrow removed and stored for your own future use is not considered organ donation.

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G. Waiver of Premium

After you have been totally or [partially disabled] [disabled and working] as the result of a covered sickness or injury for [30] or more consecutive days while covered under the policy, or after the elimination period shown [on the Certificate Specifications page] [on page 3] [in your benefit statement], whichever is greater, we will waive the premium for this coverage and any attached rider(s) for as long as you remain disabled. The waiver of the premium will not exceed the maximum benefit period shown [on the Certificate Specifications page] [on page 3] [in your benefit statement]. You must pay all premiums to keep your coverage and any attached rider(s) in force until you have qualified for waiver of premium as described in this provision.

You must send us written notice as soon as you are no longer disabled. We will assume that you are no longer disabled if you:

1. do not send us satisfactory proof of loss when we request it; or
2. notify us that you are no longer disabled.

You must pay all premiums to keep your coverage and any attached rider(s) in force beginning with the first premium due after you are no longer disabled.

Waiver of premium does not apply to any period that you are totally or partially disabled as a result of sickness or injury which is excluded by name or specific description under the policy.

There is no limit to the number of times that you can receive a waiver of premium.]

[PORTABILITY PRIVILEGE

30

We will provide portability coverage, subject to these provisions.

Such coverage will be available if:

1. coverage under the policy terminates under the TERMINATION OF COVERAGE provision; and
2. we receive a written request and payment of the first premiums for the portability coverage not later than 30 days after such termination; and
3. the request is made for that purpose; and
4. any required information is sent to us.

No portability coverage will be provided if your insurance under the policy terminated due to the discovery of fraud or material misrepresentation or due to your failure to make required premium payments.

PORTABILITY COVERAGE

The benefits, terms and conditions of the portability coverage will be the same as those provided under the policy when the insurance terminated. Changes made to the policy after portability coverage begins will not apply to you unless it is required by law.

Portability coverage will be effective on the day after insurance under the policy terminates.

PORTABILITY PREMIUMS

Premiums for portability coverage are due and payable in advance to us at our home office. Premium due dates are the first day of each calendar month. The portability premium rate may differ from the premium rate in effect for insured employees or members and may change on any premium due date. If you are on portability coverage, we will give you written notice at least [60] days before a change is to take effect.

GRACE PERIOD

The grace period, as defined, will apply to each certificate holder of portability coverage as if such insured employee or member is the policyholder.

TERMINATION OF INSURANCE

Portability coverage will automatically end on the earliest of the following dates:

1. the date you again become eligible for insurance under the policy; or
2. the last day for which premiums have been paid, if you fail to pay premiums when due, subject to the grace period; or
the date you request to discontinue coverage in writing.

TERMINATION OF THE POLICY

If the policy terminates, you will be eligible to exercise the portability privilege on the termination date of the policy. Portability coverage may continue beyond the termination date of the policy, subject to the timely payment of premiums. Benefits for portability coverage will be determined as if the policy had remained in full force and effect.

CLAIM INFORMATION

NOTICE OF A CLAIM

31

We encourage you to notify us of a claim as soon as possible so that a claim decision can be made in a timely manner. Written notice of a claim should be sent within 30 days after the date your disability begins. However, written proof of your claim must be sent to us no later than 90 days after the elimination period. If it is not possible to give proof within 90 days, it must be given no later than 1 year after the time proof is otherwise required except in the absence of legal capacity. Notice given to us by, or on behalf of, you or the beneficiary at [1776 American Heritage Life Drive, Jacksonville, Florida 32224-6687], or to any authorized agent of ours, with your name and certificate number, is notice to us.

The claim form can be requested from us. If the claim form is not received within 15 days of the request, written proof of your claim may be sent to us without waiting for the form.

We must be notified immediately when you return to work in any capacity.

FILING A CLAIM

You and the policyholder must complete your own sections of the claim form and then give it to the attending doctor. The doctor should complete the attending physician statement on the form and send it directly to us. The form will include an additional section for completion by your employer, if different from the policyholder. In this event, the claim form should be forwarded to your employer before it is given to the doctor for completion.

PROOF OF CLAIM

Proof of claim, provided at your expense, must show:

1. proof that you are under the regular care of a doctor whose specialty or expertise is the most appropriate for treating the disabling condition(s) according to generally accepted medical practice;
2. the date your disability began;
3. the cause of your disability;
4. the extent of your disability, including restrictions and limitations preventing you from performing your own occupation;
5. the prognosis of your disability;
6. the name and address of any hospital or institution where treatment was received, including all attending doctors;
7. objective medical findings which support your disability. Objective medical findings include but are not limited to tests, procedures, or clinical examinations accepted as standard in the practice of medicine, for the disabling condition(s); and
8. the appropriate documentation of monthly earnings; and
9. proof of active employment on the date your disability began.

We may request that proof of continuing disability be sent to us indicating that you are under the regular care of a doctor. This proof, provided at your expense, must be received within 30 days of a request by us.

In some cases, you will be required to give us authorization to obtain additional medical information, and to provide non-medical information as part of the proof of claim, or proof of continuing disability. We will deny a claim, or stop sending payments, if any appropriate information is not submitted.

As used in this provision, generally accepted medical practice means care and treatment which is consistent with relevant guidelines of national medical, research and health care coverage organizations and governmental agencies.

CLAIM INFORMATION (Continued)

PAYMENT OF CLAIMS

32

After receiving written proof of claim, we will pay all benefits then due under this certificate and we will make payments to you. Any amounts unpaid at your death may, at our option, be paid either to the named beneficiary or to your estate.

If benefits are payable to your estate or a beneficiary who cannot execute a valid release, we can pay benefits up to [\$1,000], to someone related to you or your beneficiary by blood or marriage whom we consider to be entitled to the benefits. We will be discharged to the extent of any such payment made in good faith.

OVERPAID CLAIM

We have the right to recover any overpayments due to:

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1. fraud; or
2. any error we make in processing a claim[; or
3. your receipt of deductible sources of income].

You must reimburse us in full. We will work with you to develop a reasonable method of repayment if you are financially unable to repay us in a lump sum.

We will not recover more money than the amount we overpaid.

UNPAID PREMIUM

Any unpaid premium that is due from you may be deducted from the payment of your claim.

CLAIM REVIEW

If your claim is denied, we will provide written notice of:

1. the reason for denial; and
2. the policy provision that relates to the denial; and
3. the right to ask for a review of your claim; and
4. the right to submit any additional information that might allow us to change our decision.

You may, upon written request, read any reports that are not confidential. For a small fee, we will make copies of those reports.

APPEALS PROCEDURE

Prior to filing any lawsuit and within 60 days after denial of a claim, you or your beneficiary must appeal any denial of benefits under the policy by making a written request for review of the denial.

(This space is intentionally left blank.)

GLOSSARY

Active Employment means you are working for your employer for earnings that are paid regularly and that you are performing the material and substantial duties of your own occupation. For the purposes of this coverage:

1. you must be working at least the minimum number of hours as described under Eligible Class(es); and
2. you will be deemed to be in active employment on a day which is not your employer's scheduled work days only if you were an active employee on the preceding scheduled work day.

Your work site must be:

1. your employer's usual place of business; or
2. an alternative work site at the direction of your employer; or
3. a location to which your job requires you to travel.

34 Normal vacation is considered active employment. However, if vacation days are used to cover disability, sickness or injury, those days are not considered active employment. [Temporary and seasonal workers are excluded from coverage.]

35 **[Deductible Sources of Income]** means income from deductible sources listed in this certificate which you receive while disabled. This income will be subtracted from the gross monthly disability payment.]

36 **[Disability Earnings]** means the earnings which you receive while disabled and working, plus the earnings you could receive if working to maximum capacity. It will always be considered to be 1/12th of the basic annual wage payable by your employer at the start of the term of continuous disability. Regardless of your timing of payment from your employer, it will be considered to be received over a 12 month period.]

Doctor means:

1. a person performing tasks that are within the limits of his or her medical license; and
2. a person who is licensed to practice medicine and prescribe and administer drugs or to perform surgery; or
3. a person with a doctoral degree in Psychology (Ph.D. or Psy.D.) whose primary practice is treating patients; or
4. a person who is a legally qualified medical practitioner according to the laws and regulations of the governing jurisdiction.

We will not recognize you, your spouse, children, parents or siblings as a doctor for a claim that is sent to us.

Eligibility Waiting Period means the continuous period of time that you must be in active employment in an eligible class before eligible for coverage under the policy.

Elimination Period means a period of continuous total disability which must be satisfied before you are eligible to receive benefits from us.

Employee means a person who is a citizen or resident of the United States or Canada in active employment with his or her employer.

37 **Employer** means [the individual, company or corporation under which you are in active employment, and includes any division, subsidiary, or affiliated company of such employer] [an organization participating in the Trust that we have issued coverage under the policy to and are providing coverage to its eligible employees or members according to the terms of the Participation Agreement].

38 **[Evidence of Insurability]** means a statement of your medical history which we will use to determine if you are approved for coverage. Evidence of insurability will be provided at your expense.]

39 **Full-Time Basis** means a job at which you have worked [25] or more hours a week for pay or profit.

40 **Gainful Occupation** means an occupation that is or can be expected to provide you with an income of the lesser of the gross monthly disability payment or [\$6,000] per month within 12 months of your return to work.

41 **Grace Period** means the [31] day period of time following the premium due date during which premium payment may be made.

42 **[Gross Monthly Disability Payment]** means the monthly benefit amount before we subtract deductible sources of income [and disability earnings].]

GLOSSARY (Continued)

Hospital or Institution means an accredited facility licensed to provide care and treatment for the condition causing your disability.

Initial Enrollment Period means one of the following periods during which you may first apply in writing for coverage under the policy:

1. if eligible for coverage on the policy effective date, a period before the policy effective date as set by us and the policyholder; or
2. if you become eligible for coverage after the policy effective date, the period ending [31] days after the date first eligible to apply for coverage.

Injury means a bodily injury that is the direct result of an accident and not related to any other cause. Injury which occurs before you are insured under the policy will be treated as a sickness. Disability must begin while you are insured under the policy.

Insured Employee or Member means the employee or member covered under the policy.

Material and Substantial Duties means duties that:

1. are normally required for the performance of your own occupation; and
2. cannot be reasonably omitted or modified, except if required to work on average in excess of 40 hours per week, we will consider you able to perform that requirement if working or having the capacity to work 40 hours per week.

- 44 **[Maximum Capacity**, based on your restrictions and limitations, means the greatest extent of work you are able to do in your own occupation, but choose not to do.]

Maximum Benefit Period means the longest period of time we will make payments to you for any one period of disability.

- 45 **Member** means a member in good standing in the labor union or association named as the policyholder and who is [:(a)] a citizen or resident of the United States; and [(b) is (i) engaged in, or (ii) able to engage in and currently seeking, active employment].

- 46 **Monthly Benefit Amount** means the total benefit amount [listed [on the Certificate Specifications page] [on page 3] [in your benefit statement]]for which you are insured under the policy subject to the maximum benefit period.

- 47 **Monthly Earnings** means your gross monthly income from your employer in effect just prior to the date of disability. Gross monthly income is the total income before taxes and any pre-tax deductions made under a qualified deferred compensation plan recognized by the Internal Revenue Service. [It will always be considered to be 1/12th of the basic annual wage payable by your employer at the start of the term of continuous disability. Regardless of your timing of payment from your employer, it will be considered to be received over a 12 month period.] [It does not include income received from commissions, bonuses, overtime pay, or other extra compensation.] [It does include commissions, and bonuses, which will be averaged for the 12 month period just prior to the date of disability.] It does not include income received from sources other than your employer.

[If you become disabled while on a covered layoff or leave of absence, we will use your gross monthly income from your employer in effect just prior to the date the absence began.]

- 48 **Monthly Payment** means [your payment after any deductible sources of income [and disability earnings] have been subtracted from the gross monthly disability payment].

Own Occupation means the occupation you are performing when a period of disability begins. It refers to the occupation as performed in the national economy, rather than for a specific employer in a specific location.

Part-Time Basis means the ability to work and earn between 20% and 80% of your monthly earnings.

Payable Claim means a claim for which we are liable under the terms of the policy.

Policy means the policy of insurance issued by us to the policyholder.

Policy Date means the effective date of the policy.

GLOSSARY (Continued)

49 **Policyholder** means the [legal entity] [Trust] to whom the policy is issued.

50 **[Re-enrollment Period]** means a period of time as set by the policyholder and us during which you may apply, in writing, for coverage under the policy, or change coverage under the policy if currently enrolled.]

Regular Care means that you:

1. personally visit a doctor as frequently as is medically required, according to standard medical practice, to effectively manage and treat a disabling condition(s); and
2. are receiving appropriate treatment and care of a disabling condition(s), which conforms with standard medical practice, by a doctor whose specialty or experience is the most appropriate for the disabling condition(s), according to standard medical practice.

51 **[Retirement Plan]** means a defined contribution plan or defined benefit plan. These are plans which provide retirement benefits to insureds and are not funded entirely by contributions of the insured employee or member.]

52 **[Salary Continuation or Accumulated Sick Leave]** means continued payments to you by your employer of all or part of your monthly earnings, after becoming disabled as defined. This continued payment must be part of an established plan maintained by your employer for the benefit of all persons covered under the policy. This includes, but is not limited to: paid time off, vacation time, annual leave, or floating holiday pay. [Salary continuation or accumulated sick leave does not include compensation paid to you by your employer for work actually performed after the disability begins. Such compensation is considered disability earnings, and would be taken into account in calculating the monthly payment.]]

Sickness means an illness or disease. Disability must begin while you are insured under the policy.

Temporary Layoff or Leave of Absence or Family and Medical Leave of Absence means you are absent from active employment for a period of time that has been agreed to in advance in writing by your employer.

Normal vacation time or any period of disability is not considered a temporary layoff or leave of absence.

We, Us, and Our means American Heritage Life Insurance Company.

53 **You and Your** mean the named insured employee or member shown [in this certificate] [on the Certificate Specifications page] [on page 3] [in your benefit statement] who is a member of an eligible class as described in the policy and for whom premiums are remitted.

(This space is intentionally left blank.)



AMERICAN HERITAGE LIFE INSURANCE COMPANY

HOME OFFICE:
1776 AMERICAN HERITAGE LIFE DRIVE
JACKSONVILLE, FLORIDA 32224-6687
(904) 992-1776

A Stock Company

**THIS IS GROUP DISABILITY ONLY COVERAGE WHICH PROVIDES
BENEFITS FOR DISABILITIES AS STATED WITHIN THIS CERTIFICATE**

AMERICAN HERITAGE LIFE INSURANCE COMPANY

Jacksonville, Florida
(the "Company")

Amendment No. ____ to Group Policy No. ____
issued to

(the "Policyholder")

It is hereby agreed that, effective _____, the Group Policy is amended as follows:

I.

-

-

-

-

-

-

This Amendment will be attached to and form a part of the Group Policy, and will not be held to alter or affect any of the terms of such Policy other than as specifically stated, but not unless both the Company and the Policyholder have executed this Amendment.

Signed on _____
(Date)

Signed on _____
(Date)

**AMERICAN HERITAGE
LIFE INSURANCE COMPANY**
(the "Company")

(XYZ COMPANY, INC.)
(the "Policyholder")

by _____
(Signature of Officer) (Title)

by _____
(Authorized Representative) (Title)



AMERICAN HERITAGE LIFE INSURANCE COMPANY (AHL)

1776 AMERICAN HERITAGE LIFE DRIVE
JACKSONVILLE, FLORIDA 32224

[For AHL Home Office use only]

Group No.	Account	Location
Dep Code E S C F	Smoker EE Y or N SP Y or N	Issue State
EFFECTIVE DATE]		

EVIDENCE OF INSURABILITY AND ENROLLMENT FORM Group Voluntary Disability

New Certificate Change/Increase Certificate # _____

Remarks:	This box for AHL Home Office use only
----------	---------------------------------------

[GENERAL INFORMATION SECTION (Please complete entire section)]

Please print with black ink

EMPLOYEE'S NAME Last (Sr, Jr, etc.)	First	M.I.	<input type="checkbox"/> M <input type="checkbox"/> F	SOCIAL SECURITY NUMBER	<input type="checkbox"/> Married <input type="checkbox"/> Single
RESIDENT ADDRESS (Street or P.O. Box)			CITY	STATE	ZIP
BIRTHDATE (MM/DD/YEAR)	RESIDENT PHONE NUMBER	EMPLOYER/ASSOCIATION/UNION		DATE HIRED (MM/DD/YEAR)	
OCCUPATION			PLANT OR DIVISION		
EMPLOYEE'S EMAIL	BENEFICIARY'S NAME (Last, First, M.I.)			RELATIONSHIP	
Are you actively at work now and have you worked at least [20] hours each week performing all duties at your regular occupation at your 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 not, why? _____]					

[DEPENDENT COVERAGE SECTION

(Please complete if dependent coverage elected. Use additional paper if needed.)

Dependent's Name (Last, First, M.I.)	Relationship	Sex	Date of Birth (MM/DD/YEAR)	Social Security Number

[Short-Term Disability] <input type="checkbox"/> Yes <input type="checkbox"/> No	Monthly Salary \$ _____	Elimination Period ____ Days Acc. ____ Days Sick	Section 125 <input type="checkbox"/> Yes <input type="checkbox"/> No	Total Mode Premium \$ _____	Home Office Use Only SET ID/PLAN ID ACTIV/STD _____ and/or EMPLR/STD _____ and/or (other) _____		
	Monthly Benefit \$ _____	Benefit Period ____ Months			Rider	Rider	Rider
Rider	Rider	Rider	Rider	Rider	Rider	Rider	Rider
Rider Units]

A. [Is this insurance to replace any existing disability coverage? Yes No
If yes, provide the Company Name: _____

B. Is there any other disability insurance in force or applied for that will continue after the effective date of this coverage? Yes No
If yes, complete the following:
Company Name: _____ Year Issued: _____
Monthly Benefit: _____ Elimination Period: _____ Benefit Period: _____]

[Premium/Billing Mode] <input type="checkbox"/> Monthly <input type="checkbox"/> Semi-monthly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Weekly <input type="checkbox"/> Other Date of First Deduction _____ Requested Issue Date _____	Case Number	Producer/ Agent Number	Percentage Credit
	Employee ID		
	Situs State		

EVIDENCE OF INSURABILITY AND ENROLLMENT FORM

[EVIDENCE OF INSURABILITY SECTION

If questions 1-3 are answered "Yes", please list the required health history in question 5.
Use the additional space below for further explanation.

1. Are you 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 have you ever tested positive for antigens or antibodies to an AIDS virus?	<input type="checkbox"/> Yes <input type="checkbox"/> No			
2a. Have you in the last 2 years, had, been treated for, or been told by a member of the medical profession that you have: diabetes, emphysema, epilepsy, hepatitis, 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, or pancreas; paralysis; cancer (except basal cell skin cancer), malignant tumor, leukemia, Hodgkin's Disease; or stroke?	<input type="checkbox"/> Yes <input type="checkbox"/> No			
2b. Have you in the last 2 years, had, or been treated for asthma, a mental or nervous illness, or any disorder of the back or neck?	<input type="checkbox"/> Yes <input type="checkbox"/> No			
2c. Have you in the last year had either: (1) a systolic blood pressure reading higher than 150 more than once; or (2) a diastolic blood pressure reading higher than 100 more than once?	<input type="checkbox"/> Yes <input type="checkbox"/> No			
2d. Have you in the last 2 years been treated for or counseled for alcohol or drug abuse?	<input type="checkbox"/> Yes <input type="checkbox"/> No			
2e. Have you had any medical or surgical procedures (including organ transplant) advised or recommended by a doctor but not done at this time?	<input type="checkbox"/> Yes <input type="checkbox"/> No			
3. Have you, in the last 3 years, had your 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No			
4. Please indicate height and weight	<table style="width: 100%; border: none;"> <tr> <td style="width: 30%; border: none;">Employee</td> <td style="width: 35%; border: none;">Height:</td> <td style="width: 35%; border: none;">Weight:</td> </tr> </table>	Employee	Height:	Weight:
Employee	Height:	Weight:		
5. Nature of Illness/Injury or Medical Attention/ Reason Last Consulted	Date and/or Duration	Name and Address of Physician or Hospital/Clinic		
<div style="text-align: right; border: 1px solid black; padding: 2px;">]</div>				

Use this space for any additional explanation of questions 1-[3] above. Indicate the applicable question number.
Use additional paper if needed.

[ELECTRONIC ACCEPTANCE (Please check YES or NO)

By checking the "Yes" box below, I agree to electronic delivery of my certificate of insurance, describing my coverage under the group policy ("my Certificate"), and all future correspondence regarding my Certificate, to include claim correspondence, explanations of benefit, periodic notices (such as privacy notices) and certificate administration correspondence. If electronically delivered, I will be provided instructions on how to receive my Certificate and correspondence regarding my Certificate via the following address: [www.allstateatwork.com/mybenefits].

My consent is valid while I am covered under the group policy. At any time, I may withdraw my consent for any reason and receive future correspondence in paper to include a paper copy of my Certificate, free of charge, by calling, toll-free: [1-800-521-3535]; or by writing to: [Customer Care Center, American Heritage Life Insurance Company, 1776 American Heritage Life Drive, Jacksonville, Florida, 32224].

- YES, I agree to receive my Certificate and all correspondence regarding my Certificate electronically via the internet.
 NO, I prefer to receive paper copies of my Certificate and all correspondence regarding my Certificate.

CERTIFICATION, UNDERSTANDING AND AUTHORIZATIONS

I CERTIFY that the statements and answers provided are made by me, are complete and true, are correctly and fully recorded and that no important circumstance or information has been withheld or omitted. These statements and answers are offered to AHL as an inducement to grant insurance, and I understand that AHL may use misstatements or misrepresentations to contest the validity of any coverage provided on the basis of this evidence of insurability. · I UNDERSTAND that the "effective date" of my elected coverages will be the effective date recorded on the Certificate, not the date this form is signed. · I AUTHORIZE my employer to deduct from my salary or wages, if applicable, the necessary premium for the coverages requested. I understand that if I refuse any coverage for which I am eligible, satisfactory proof of insurability may be required, at my own expense, should I desire to apply for it at a later date. Any such application may be declined on the basis of such proof.

FRAUD NOTICE: Any person who knowingly presents a false or fraudulent claim for 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.

Employee's Signature _____ Signed at _____ Date Signed _____
(City and State)

AMERICAN HERITAGE LIFE INSURANCE COMPANY

1776 American Heritage Life Drive, Jacksonville, Florida 32224

PARTICIPATION AGREEMENT

For participation under Group Policy Number [G-12345]
Issued to the Trustee of the [ABC] Trust

Please complete this form to apply for participation in the Trust named above and to select benefits that will be made available to your employees [and their eligible dependent(s)].

Name of employer requesting participation (hereinafter called "Applicant"):

[ABC Company]

Address (street, city, state and zip):

[Any City, Any State]

Type of coverage(s) applied for:

[Group Disability Insurance]

Note: Coverage applied for may be issued under one or more policies.

Requested Effective Date:

[January 1, 2011]

I hereby agree to and understand the following will apply if my company is accepted by American Heritage Life Insurance Company (hereinafter called AHL) as a participating employer under the Trust:

- A. My company will be responsible for:
 1. Making premium payment to AHL for the insurance in force on employees covered under the Policy.
 2. Performing other duties as directed by AHL under the terms of the Policy.
- B. AHL has the right to bring action against my company for non-payment of premiums or non-performance of other duties for which it is responsible.
- C. My company's participation and coverage for my insured employees will terminate on the first of the following:
 1. The date I state in a written notice to AHL that premium payments for the coverage will cease. However, if notice is given after the date to which premiums are paid in full, participation will cease on the later of:
 - (a) the date I have requested in my written notice; or
 - (b) the date the notice is received by AHL.
 2. The last day of the grace period, as defined in the policy, if the premium due on that date remains unpaid.
 3. The date shown in a written notice sent by AHL to my company.
- D. In the event of termination, my company: (a) has no further right to, or interest in, the Trust; and (b) is liable to AHL for all unpaid premiums for the period my company participated in the Trust.

If this application is approved by AHL, group insurance will take effect: (a) on the Requested Effective Date; or (b) on the date AHL approves issuance of the group coverage, whichever is later. If this application is not approved, no insurance will take effect, and any premium submitted by the Applicant will be refunded.

SERFF Tracking Number: ALST-126989580 State: Arkansas
 Filing Company: American Heritage Life Insurance Company State Tracking Number: 47778
 Company Tracking Number: GVDIP
 TOI: H11G Group Health - Disability Income Sub-TOI: H11G.002 Short Term
 Product Name: Group Disability Insurance
 Project Name/Number: /

Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification	Approved-Closed	02/02/2011
Comments:		
Attachment: AR Readability Certification.pdf		

	Item Status:	Status Date:
Satisfied - Item: Application	Approved-Closed	02/02/2011
Comments: Multi-Product Employer Application ERAPPAR, approved on 3/29/10 under filing #45128: attached hereto Employer Application GVDIAPPAR: attached in Form Schedule Evidence of Insurability and Enrollment: ABJ4520AR: attached in Form Schedule		
Attachment: ERAPPAR.pdf		

	Item Status:	Status Date:
Satisfied - Item: Statement of Variability	Approved-Closed	02/02/2011
Comments:		
Attachment: GVDIP Statement of Variability.pdf		

	Item Status:	Status Date:
Satisfied - Item: List of Forms	Approved-Closed	02/02/2011
Comments:		
Attachment: Forms List AR.pdf		

AMERICAN HERITAGE LIFE INSURANCE COMPANY

Jacksonville, Florida 32224-6688

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>
GVDIP	57.7
GVDIC	53.6

Date: January 20, 2011



Diane Ierna
Assistant Vice President, Compliance Department

AMERICAN HERITAGE LIFE INSURANCE COMPANY

1776 American Heritage Life Drive, Jacksonville, Florida 32224

APPLICATION FOR GROUP INSURANCE

Applicant/Policyholder
[ABC Company]

Address (street, city, state and zip)
[Any City, Any State]

Type of group: Employer Association Union Other

Type of coverage(s) applied for:

Note: Coverage applied for may be issued under one or more policies.

Requested Effective Date:
[January 1, 2009]

If this application is approved by the Company, group insurance will take effect: (a) on the Requested Effective Date; or (b) on the date the Company approves issuance of the group coverage, whichever is later. If this application is not approved, no insurance will take effect, and any premium submitted by the Applicant will be refunded.

As the applicant, I declare to the best of my knowledge and belief, that the statements and answers shown above are true and complete. I understand and agree that: (a) this application will form a part of any policy that is issued; (b) no information given to, or acquired by, any representative of the Company will bind the Company, unless it is in writing on this application; (c) no waiver or modification will bind the Company, unless it is in writing and signed by an executive officer of the applicant; and (d) only those persons eligible under the terms of the policy or policies will be covered.

Fraud Notice: Any person who knowingly presents a false or fraudulent claim for 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.

[ABC COMPANY, INC.]

(Full or Corporate Name of Applicant)

Dated at [Any City, Any State]
(City and State)

By [/s/ James Brown, President]
(Authorized Signature and Title)

On [January 1, 2009]
(Date)

Witness [/s/ Joe Smith]

 [123456]
*(Agent's License Number)**

Witness [Joe Smith]
(Print Agent's Name as Shown on License)*

*Where required by law.

American Heritage Life Insurance Company (AHL)

Explanation of Variable Language for Group Policy Form GVDIP, et al

Policy Variables

This group policy will be available to issue to employer groups, labor union groups, associations and Trusts. The following explains the variables included in the policy form. The numbers correspond to the number within the boxes in the left margin of the text. When deleted text creates blank spaces, the following text may be moved to another page with the same form number.

1. The current logo and address will be on all policies issued.
2. The signatures of the current Secretary and President will be on all policies issued.
3. The Table of Contents may be changed to reflect the actual page numbers in the policy as issued.
4. Information about each specific policyholder will be inserted into the policy as it is issued. This includes the complete corporate name of the policyholder; a unique number assigned by us to each Group Policy; and the effective date requested by the policyholder, and agreed to by us.

The first policy anniversary will usually be one year from the Policy Effective Date. However, exceptions to this will occur. For example, if our policy is replacing an existing policy on a date other than the beginning of the Plan Year under ERISA, the employer may wish to retain the existing plan year. In such an instance, our policy might be effective December 1, 2010, but since their existing ERISA Plan Year is from January 1, to January 1, the first anniversary of our policy would be January 1, 2012. Another example would occur when we are asked to make our policy effective other than the first of the month. Since we prefer first of the month premium due dates and renewals, a policy might have an effective date of June 15, 2010 with a first anniversary of July 1, 2011.

The jurisdiction in which the policy will be delivered will be inserted.

5. The classes of employees or members who are eligible to enroll will be described here. The number of hours may vary, and other categories of employees or members may be included, such as: salaried, exempt or contract employees.
6. The eligibility waiting period will be described here. It may be different by category of employees or members as in the second example, or different by type of coverage, as in the third example. The fourth statement may be included if the policy is issued with a reinstatement provision. If a policyholder chooses to make a re-hired employee complete their eligibility waiting period again, the fourth statement will be deleted.
7. The monthly benefit may be an amount elected by the insured, a percentage of their monthly earnings or a flat benefit amount. The minimum amount will never be lower than \$400 and the maximum amount will never be higher than \$6,000, but when the policy is issued to a specific policyholder, the minimum may be raised or the maximum may be lowered based on participation, the risks associated with the group, or whether the situs state of the policyholder sponsors a state disability plan.
8. Any optional riders that would be issued with this policy would be listed here. At present, we have no riders to attach to this policy. Any new riders we may wish to attach to this policy will be filed with the Department of Insurance for approval.
9. The Guarantee Issue limit can range from \$1,000 to \$5,000, depending on participation or the risks associated with the policyholder. This section may be deleted if the policy is issued to a group to which all benefit amounts are guaranteed issued and evidence of insurability will never be required.
10. The elimination period may be 0, 7 days, 14 days, 30 days, 90 days or 180 days depending on the underwriting of the group. The statement waiving the elimination period if hospital-confined may be deleted.
11. The maximum period of payment may be 3 months, 6 months, 12 months or 24 months.
12. The Waiver of Premium provision may be deleted. If this provision is included, the number of days listed can vary from 30 to 180 days.
13. The Initial Rate may be per insured, a percentage of total covered payrolls, or per \$100 of monthly benefit as shown. If per \$100 of monthly benefit, the rate may vary for the insured's age as shown. The premium may be

paid annually, semi-annually, quarterly, monthly, semi-monthly, bi-weekly or weekly. Rates may be based on attained age or issue age.

14. The rate may be guaranteed for any period of 12 months or longer, as agreed to by us and the policyholder.
15. The first premium due date is the effective date of the policy. The day of the month may vary, and "calendar month" may be changed to "calendar quarter" or "third month".
16. Only one of these statements will be shown here, indicating whether or not the policyholder shares in the cost of the coverage. The other non-applicable statements will be deleted. Unless issued to a Trust, the reference to employers participating under the Trust will be deleted.
17. If issued to a Trust, this section will not apply and will be removed in its entirety. Any of the policyholder's divisions, subsidiaries or affiliated companies whose employees or members are to be eligible for coverage under the policy when issued will be named here.
18. If issued to a Trust, item 2 will be deleted and the following items renumbered.

If issued to a Trust, the term policyholder will be replaced with the term employer.

The time period for notice of change in premium rate will not be less than 31 days, but may be longer if agreed to by us and the policyholder.
20. The Waiver of Premium provision may be deleted. The timeframe listed will match the number in item 12.
21. Unless issued to a Trust, the bracketed text may be deleted.
22. A policy may provide that an employee or member who does not enroll during his initial enrollment period may later enroll only during a re-enrollment period, or at any time, with or without evidence of insurability. This will be determined when underwriting the group. Any language not applicable to a policyholder when this policy is issued may be deleted.
23. Unless issued to a Trust, the bracketed text may be deleted.
24. Unless issued to a Trust, the bracketed text may be deleted.
25. The time for us to give notice of cancellation or offer to modify may be any period of 31 days or longer. The participation percentage and number of insureds may be changed to any reasonable amounts taken into consideration when underwriting the group.

Unless issued to a Trust, the bracketed text referencing an employer participating under the Trust may be deleted.

The time period may be 31 days or more and may be changed to match the time period in #18.
26. Evidence of Insurability may be deleted if not applicable to the policyholder when this policy is issued.

Unless issued to a Trust, all the bracketed text referencing an employer participating under the Trust may be deleted.
27. Unless issued to a Trust, the bracketed text referencing an employer participating under the Trust may be deleted.

Certificate Variables

The following explains the variables included in the certificate form. The numbers correspond to the number within the boxes in the left margin of the text. When deleted text creates blank spaces, the following text may be moved to another page with the same form number.

1. The current logo and address will be on all certificates issued.
2. Depending on how the certificate is delivered to the insured employee or member, their benefit amounts may be listed on a Certificate Specifications page (page 3) or a benefit statement.

3. The signatures of the current Secretary and President will be on all certificates issued.
4. The Table of Contents may be changed to reflect the actual page numbers in the certificate as issued.
5. Depending on how the certificate is delivered to the insured employee or member, their benefit amounts may be listed on a Certificate Specifications page or a benefit statement. If included, the Certificate Specifications page will be customized for each insured employee or member to show their specific benefit amounts, optional benefits and/or riders, as well as premiums and any additional information that pertains to their coverage. This page may be deleted if a benefit statement is provided.
6. Depending on how the certificate is delivered to the insured employee or member, their effective date may be listed on a Certificate Specifications page (page 3) or a benefit statement.

If Evidence of Insurability is not applicable to a group, all reference to such will be deleted.

The effective date for decreases can be the first day of the month that next follows the date the insured employee or member applies. If the decrease takes effect immediately, the bracketed phrase will be deleted.

7. An insured can enroll, change or discontinue coverage at any time or during the group's annual re-enrollment period. Only one of these periods will appear when the certificate is issued. Late enrollments or increases may be subject to Evidence of Insurability. If Evidence of Insurability is not applicable to a group, all reference to such will be deleted.
8. The entire provision entitled "When Evidence of Insurability Is Required" may be deleted entirely if not applicable to a group when issued, or modified by deleting any or all of the language marked as variable.
9. Unless issued to a Trust, the bracketed text referencing an employer participating under the Trust may be deleted.

Coverage can be continued by one or two of the ways listed, as agreed to by us and the policyholder. Any provisions that are not applicable to a group when issued will be deleted from the certificate.

10. Any provisions that are not applicable to a group when issued will be deleted from the certificate.
The phrases "one month" and "last day of the month in which" may be deleted, making the coverage effective immediately.
If Evidence of Insurability is not applicable to a group, all reference to such will be deleted.
11. The entire provision "If Rehired By Your Employer Within 12 Months Following The Date Employment Terminated" may be deleted entirely.

If the provision is included the reinstated coverage may be reduced to 60% of the insured employee or member's earnings at the time of reinstatement. This percentage will usually be 60%, but may be less if agreed to by us and the policyholder.

12. The entire provision "When Your Coverage Can Be Continued" may be deleted entirely if another continuation provision is included.
If this provision is included, continuation will be extended for 12 months, but this time frame can range from 1 month to 24 months.
Unless issued to a Trust, the bracketed text referencing an employer participating under the Trust may be deleted.

Application and payment of first premium will be required within 31 days of termination, but this timeframe may be longer, up to 90 days, if agreed to by us and the policyholder.

13. The entire provision "Discretionary Authority, If Governed by ERISA" may be deleted if not allowed in the jurisdiction where the certificate will be delivered.
14. Unless issued to a Trust, the bracketed text referencing an employer participating under the Trust may be deleted.
15. The entire provision "Pre-Existing Condition Limitation" may be deleted if agreed to by us and the policyholder. If included, the timeframes listed will never be more than 12 months, but may be less if agreed to by us and the policyholder.
16. We may provide a waiver of pre-existing condition limitation if the policyholder sponsored previous group insurance. If the previous group insurance was not issued by us, we will delete the bracketed language

referencing our coverage. If the policyholder did not sponsor any previous group coverage, this entire provision may be deleted.

17. We may provide a waiver of pre-existing condition limitation if the policyholder had previous individual insurance. If the previous individual insurance was not issued by us, we will delete the bracketed language referencing our coverage. If the policyholder did not have any previous individual coverage, this entire provision may be deleted.
18. If the Pre-Existing Condition Limitation is deleted, then reference to such will be removed from this provision.
If the policy will be issued to cover mental illnesses, then the variable language to exclude such illnesses will be deleted and the remaining items will be renumbered.
If the policy will be issued to cover occupational sickness or injury, then the variable language to exclude such coverage will be deleted.
The definition of mental illness will always comply with the state or federal statutes regulating such definition.
19. Depending on how the certificate is delivered to the insured employee or member, their elimination periods and benefit amounts may be listed on a Certificate Specifications page (page 3) or a benefit statement.
20. The elimination period may be displayed on a Certificate Specifications page (page 3) or a benefit statement.
The statement regarding hospital confinement may be deleted.
21. The Deductible Sources of Income provision may be deleted from the certificate. If it is deleted, then all other references to such provision will be removed as well.
Depending on how the certificate is delivered to the insured employee or member, their maximum benefit period may be listed on a Certificate Specifications page (page 3) or a benefit statement.
The If You Are Disabled and Working (Proportionate Loss) provision may be deleted from the certificate. If it is deleted, then all other references to such provision will be removed as well.
22. The maximum percentage of monthly earnings will be 60%, but may be less if agreed to by us and the policyholder.
Depending on how the certificate is delivered to the insured employee or member, their benefit amounts may be listed on a Certificate Specifications page (page 3) or a benefit statement.
The minimum monthly payment will usually be \$100, but may be more if agreed to by us and the policyholder.
If requested by a policyholder, the statement that payments may be applied to outstanding overpayments may be deleted.
23. The Deductible Sources of Income provision may be deleted in its entirety. If included, some of the items within the provision may be deleted and the others renumbered.
If reference to retirement plans are deleted from the list of deductible sources of income, then the paragraphs regarding such payments will be removed from this provision.
24. The Non-Deductible Sources of Income provision may be deleted. If included, some of the items within the provision may be deleted and the others renumbered.
25. The You May Qualify For Deductible Income Benefits provision may be deleted. If items in the Deductible Sources of Income provision are renumbered, references to those items will be renumbered as well.
26. The Partial Disability Benefit provision may be deleted. If this provision is included, the If You Are Disabled And Working (Proportionate Loss) provision will be deleted instead. Only one of these provisions will appear as agreed to by us and the policyholder.
27. The If You Are Disabled And Working (Proportionate Loss) provision may be deleted. If this provision is included, the Partial Disability Benefit provision will be deleted instead. Only one of these provisions will appear as agreed to by us and the policyholder.
28. The timeframe indicated for recurrent disabilities will usually be 6 months, but may be between 3 to 12 months as agreed to by us and the policyholder. Performance of an occupation will usually be limited to 30 days, but may be between 1 to 90 days if agreed to by us and the policyholder.
29. The Waiver of Premium provision may be deleted in its entirety.

If this provision is included, "partially disabled" or "disabled and working" will be used, depending on whether the Partial Disability Benefit provision or the If You Are Disabled And Working (Proportionate Loss) provision is included. Only one of these terms will appear.

The number of days listed can vary from 30 to 180 days.

Depending on how the certificate is delivered to the insured employee or member, their maximum benefit amounts may be listed on a Certificate Specifications page (page 3) or a benefit statement.

30. The Portability provision may be deleted if another continuation provision is included in the certificate.
The timeframe for providing notice of a change in premium rates will never be less than 60 days, but may be longer if agreed to by us and the policyholder.
31. The claims address will be the current address of our company.
32. The maximum amount that can be paid to an insured's relative will usually be \$1,000, but may be more if allowed by law.
33. If the Deductible Sources of Income provision is deleted, all references to such provision will be deleted as well.
34. The exclusion of temporary and seasonal workers may be deleted if requested by a policyholder and agreed to by us.
35. If the Deductible Sources of Income provision is deleted, the definition of such will be deleted as well.
36. The definition of Disability Earnings may be deleted in its entirety.
37. Only one of these phrases will appear, depending on whether the policy is issued to an employer group or a Trust.
38. If the Evidence of Insurability provision is deleted, the definition of such will be deleted as well.
39. For the definition of Full-Time Basis, the timeframe listed will usually be 25 hours, but can be any number from 20 to 30 hours as agreed to by us and the policyholder.
40. The maximum gross monthly disability benefit payment will usually be \$6,000, but may be less if agreed to by us and the policyholder.
41. The grace period will usually be 31 days, but may be longer if agreed to by us and the policyholder. It may also be increased to comply with state regulations.
42. If the Deductible Sources of Income provision is deleted, the definition of Gross Monthly Disability Payment will be deleted as well. If the definition of Disability Earnings is deleted, reference to the term will be deleted from this definition.
43. The timeframe listed for the Initial Enrollment Period definition will usually be 31 days, but may be longer if agreed to by us and the policyholder.
44. The definition of Maximum Capacity may be modified to be consistent with the Proportionate Loss provision.
45. When issued to an employer group, the term employee will be used throughout the certificate and the term member may be deleted.
46. Depending on how the certificate is delivered to the insured employee or member, their monthly benefit amounts may be listed on a Certificate Specifications page (page 3) or a benefit statement.
47. The definition of monthly earnings may be revised to be consistent with the definition of Disability Earnings.
Only one of the statements regarding commissions, bonuses, etc... will appear in this definition when the certificate is issued. If extra compensation is to be excluded from monthly earnings, the first statement will appear and the second statement will be deleted. If extra compensation is to be included in monthly earnings, then the first statement will be deleted and the second statement will appear.
48. If the Deductible Sources of Income provision is deleted, the reference to such will be deleted from the definition of Monthly Payment.
49. Only one of these phrases will appear, depending on whether the policy is issued to an employer group or a Trust.

50. The definition of Re-Enrollment Period can be deleted if not applicable to the policyholder when the certificate is issued.
51. The definition of Retirement Plan will be deleted if the Deductible Sources of Income provision is deleted.
52. The definition of Salary Continuation or Accumulated Sick Leave will be deleted if the Deductible Sources of Income provision is deleted. If included, the exclusion of compensation after being disabled may be deleted.
53. Depending on how the certificate is delivered to the insured employee or member, their monthly benefit amounts may be listed on a Certificate Specifications page (page 3) or a benefit statement.

AMERICAN HERITAGE LIFE INSURANCE COMPANY

Jacksonville, Florida 32224-6688

Forms list for filing dated January 20, 2011

<u>Form</u>	<u>Description</u>
GVDIP	Group Disability Insurance Policy
GVDIC	Group Disability Certificate of Insurance
GVDIAPPAR	Employer Application
GVDIP-AMD	Policy Amendment
GT-PA1AR	Participation Agreement
ABJ4520AR	Evidence of Insurability and Enrollment Form