

SERFF Tracking Number: AFDL-127094541 State: Arkansas
Filing Company: American Public Life Insurance Company State Tracking Number: 48336
Company Tracking Number: GDISC11APL
TOI: H11G Group Health - Disability Income Sub-TOI: H11G.002 Short Term
Product Name: GDISC11APL Group Disability Income Conversion Policy
Project Name/Number: APL Group Conversion Policy /GDISC11APL/C

Filing at a Glance

Company: American Public Life Insurance Company

Product Name: GDISC11APL Group Disability Income Conversion Policy SERFF Tr Num: AFDL-127094541 State: Arkansas

TOI: H11G Group Health - Disability Income SERFF Status: Closed-Approved-Closed State Tr Num: 48336

Sub-TOI: H11G.002 Short Term

Co Tr Num: GDISC11APL

State Status: Approved-Closed

Filing Type: Form

Reviewer(s): Rosalind Minor

Author: Joelle Harbour

Disposition Date: 03/29/2011

Date Submitted: 03/24/2011

Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: APL Group Conversion Policy

Status of Filing in Domicile: Authorized

Project Number: GDISC11APL/C

Date Approved in Domicile: 03/23/2011

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

Overall Rate Impact:

Filing Status Changed: 03/29/2011

State Status Changed: 03/29/2011

Deemer Date:

Created By: Joelle Harbour

Submitted By: Joelle Harbour

Corresponding Filing Tracking Number: GDISC11APL

Filing Description:

Based on the enclosed authorization, American Fidelity Assurance Company is submitting this form filing on behalf of American Public Life Insurance Company.

Submitted for review is group disability income conversion policy GDISC11APL and its corresponding certificate, GDISC11APLC. This form is new and does not replace any previously approved form.

The GDISC11APL provides disability income coverage for insured's who choose to exercise the conversion option provided under the GDIS11APL group disability income policy. The GDIS11APL has been filed under separate cover.

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Any combination of pages of the policy or certificate form will produce a minimum Flesch Score of 50, excluding defined terms.

Also submitted for review is M-3370, the enrollment form that will be used in conjunction with the GDISC11APL. The Flesch score is 48.

Domiciliary state approval was granted on March 23, 2011.

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

Thank you for your assistance in this matter. If you should have any questions or comments, or if you need any additional information, please feel free to contact me at 1-800-654-8489, ext 5997 or by e-mail at Joelle.Harbour@af-group.com.

Company and Contact

Filing Contact Information

Joelle Harbour, Compliance Analyst I joelle.harbour@af-group.com
2000 N Classen Blvd 405-523-5997 [Phone]
Oklahoma City, OK 73106

Filing Company Information

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

Filing Fees

Fee Required? Yes
Fee Amount: \$150.00
Retaliatory? No
Fee Explanation: Policy-\$50
Certificate-\$50

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Enrollment form-\$50
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
American Public Life Insurance Company	\$150.00	03/24/2011	45940655

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	03/29/2011	03/29/2011

SERFF Tracking Number: *AFDL-127094541* *State:* *Arkansas*
Filing Company: *American Public Life Insurance Company* *State Tracking Number:* *48336*
Company Tracking Number: *GDISC11APL*
TOI: *H11G Group Health - Disability Income* *Sub-TOI:* *H11G.002 Short Term*
Product Name: *GDISC11APL Group Disability Income Conversion Policy*
Project Name/Number: *APL Group Conversion Policy /GDISC11APL/C*

Disposition

Disposition Date: 03/29/2011

Implementation Date:

Status: Approved-Closed

Comment:

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	Letter of Authorization	Approved-Closed	Yes
Form	Group Conversion Policy	Approved-Closed	Yes
Form	Group Conversion Certificate	Approved-Closed	Yes
Form	Group Enrollment Form	Approved-Closed	Yes

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Form Schedule

Lead Form Number: GDISC11APL

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 03/29/2011	GDISC11A PL	Policy/Cont ract/Fratern al Certificate	Group Conversion Policy	Initial		50.000	GDISC11APL .pdf
Approved-Closed 03/29/2011	GDISC11A PLC	Certificate	Group Conversion Certificate	Initial		50.000	GDISC11APL C.pdf
Approved-Closed 03/29/2011	M-3370	Application/ Enrollment Form	Group Enrollment Form	Initial		48.000	M- 3370_Enrollm entForm.pdf



American Public Life Insurance Company

A member of the American Fidelity Group.

2305 Lakeland Drive, Flowood, Mississippi 39232

POLICYHOLDER: [ABC Conversion]
ADDRESS: [123 Main Street, Oklahoma City, Oklahoma, 73106]
EFFECTIVE DATE: [June 1, 2011]
DATE OF ISSUE: [June 1, 2011]
POLICY NUMBER: [GDISC-2T]
POLICY ANNIVERSARY DATE: [June 1]

In consideration of:

- (a) the application of the Policyholder, a copy of which is attached to and made a part of this Group Conversion Policy; and
- (b) the payment of the first premium,

the Company agrees to pay the benefits of this Group Conversion Policy subject to all of its terms.

This Group Conversion Policy is executed by American Public Life Insurance Company as of its Date of Issue. This Group Conversion Policy will take effect on the Effective Date.


 President


 Secretary

NON PARTICIPATING GROUP DISABILITY INCOME INSURANCE POLICY

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

TABLE OF CONTENTS

Schedule of Benefits

Section 1	.....	Definitions
Section 2	.....	Eligibility and Effective Date
Section 3	.....	Disability Benefits
Section 4	.....	Exclusions and Pre-Existing Limitations
Section 5	.....	Termination of Insurance
Section 6	.....	Premium Calculation and Payment
Section 7	.....	General Provisions

SCHEDULE OF BENEFITS

POLICYHOLDER: [ABC Conversion]

POLICY NUMBER: [G-DISC-2T]

POLICY EFFECTIVE DATE: [January 30, 2011]

ELIGIBILITY: [Any person who is working 25 hours or more per week on the Effective Date of coverage, excluding self-employment, and who meets the Eligibility requirements in Section 2.]

DISABILITY BENEFIT: The Insured's Monthly Disability Benefit under the Group Policy, not to exceed 70% of his or her current Monthly Compensation.

MINIMUM DISABILITY BENEFIT: \$100.00

MAXIMUM DISABILITY PERIOD: [6 months, 12 months] for Injury or Sickness

ELIMINATION PERIOD: 30 days for Injury or Sickness

SECTION 1 DEFINITIONS

ACTIVE EMPLOYMENT means that the Insured is:

- (a) doing in the usual manner all of the regular duties of his or her employment on a full-time basis on a scheduled work day; and
- (b) these duties are being done at one of the places of business where the Insured normally does such duties or at some location to which the Insured's employment sends him or her.

The Insured will be said to be on Active Employment on a day which is not a scheduled work day only if the Insured is not Disabled and would be able to perform in the usual manner all of the regular duties of his or her employment if it were a scheduled work day.

CERTIFICATE means the individual Certificate issued to the Insured. It describes the Insured's coverage under the Group Conversion Policy.

DISABILITY (or Disabled) means the Insured is unable to perform the material and substantial duties of his or her Regular Occupation.

DISABILITY PAYMENT means the Insured's Disability Benefit minus any Deductible Sources of Income as outlined in Section 3.

EFFECTIVE DATE means the date described in the Group Conversion Policy. The date shown in the Insured's individual Certificate or Policy will be the Effective Date of coverage for that Insured. The Effective Date will start at 12:01 a.m. at the main place of business of the Policyholder.

ELIMINATION PERIOD means that period of time, which starts after the Insured's Effective Date of coverage, during which:

- (a) the Insured is Disabled; and
- (b) no Disability Benefits are payable.

EMPLOYER means the individual, company, corporation, or governmental entity where the Insured is on Active Employment.

GROUP CONVERSION POLICY means the policy issued to the Policyholder which covers the Insureds.

GROUP POLICY means the group disability income policy issued by Us, from which conversion was made for coverage under the Group Conversion Policy.

INJURY means physical harm or damage to the body sustained by the Insured which:

- (a) results directly from an accidental bodily injury;
- (b) is independent of disease or bodily infirmity; and
- (c) takes place while the Insured's coverage is in force.

INSURED means a person whose coverage has been applied for and is in force under the terms of the Group Conversion Policy.

MONTHLY COMPENSATION means:

- (a) one-twelfth (1/12) of the Insured's annual salary through the Insured's Employer exclusive of overtime or bonus earnings; or
- (b) one-twelfth (1/12) of the preceding 12 months' salary through the Insured's Employer, if the Insured's salary is solely or partially based on commissioned sales, overtime, or bonus earnings.

PHYSICIAN means a medical practitioner of the healing art(s) which is recognized by applicable state law, who:

- (a) is practicing within the scope of his or her license;
- (b) is certified or credentialed by the appropriate medical or professional board that provides certification or credentials for practitioners who perform the type of treatment or service appropriate for the Insured's Sickness or Injury; and
- (c) possesses the necessary training and qualifications according to generally accepted medical standards, to evaluate and treat the Insured's condition.

The term Physician does not include the Insured, an employee of the Employer, anyone related to the Insured by blood or marriage, or anyone living in the Insured's household.

POLICYHOLDER means the trustee to whom the Group Conversion Policy has been issued.

REGULAR AND APPROPRIATE CARE means:

- (a) the Insured personally visits a Physician as frequently as medically required, according to standard medical practice, to effectively manage and treat the Insured's disabling condition(s); and
- (b) the Insured is receiving appropriate treatment and care for the Insured's disabling condition(s), which conforms with standard medical practice, by a Physician whose specialty or experience is the most appropriate for such disabling condition(s), according to standard medical practice.

REGULAR OCCUPATION means the occupation the Insured is routinely performing when the Insured's Disability begins. The Company will look at the Insured's occupation as it is normally performed in the national economy, rather than how the work tasks are performed for a specific Employer or at a specific location.

SCHEDULE OF BENEFITS (or Schedule) means the benefit schedule set forth in the Group Conversion Policy or Certificate.

SICKNESS means a disease or illness (including pregnancy). Disability must begin while this coverage is in force.

SECTION 2 ELIGIBILITY AND EFFECTIVE DATE

ELIGIBILITY

All persons who meet the terms described in the Schedule of Benefits and:

- (a) have been continuously covered under the Group Policy for at least 12 consecutive months prior to the date the Insured's employment terminated;
- (b) are not Disabled on the Effective Date of coverage under this Group Conversion Policy;
- (c) are not covered under any other group disability income plan;
- (d) are employed on the date the Insured's conversion coverage becomes effective;
- (e) are not on a leave of absence;
- (f) employment was not terminated due to retirement; and
- (g) are less than age 70.

are eligible for coverage under the Group Conversion Policy.

EFFECTIVE DATE

The Insured's coverage under the Group Conversion Policy will take effect on the first of the month after termination of the Insured's coverage under the Group Policy provided:

- (a) application for coverage is received within 30 days of the termination date of the Group Policy; and
- (b) premium has been paid; and
- (c) the Insured is on Active Employment on the Effective Date of this Coverage.

If the Insured is not on Active Employment coverage will not take effect.

SECTION 3 DISABILITY BENEFITS

Disability Payments will be provided if the Insured furnishes Proof of Loss that the Insured is Disabled and under the Regular and Appropriate Care of a Physician. Disability must:

- (a) be due to a covered Injury or Sickness; and
- (b) begin while the Insured's coverage is in force under the Group Conversion Policy.

Disability Payments will be provided for each period the Insured remains Disabled due to a covered Disability and under the Regular and Appropriate Care of a Physician which continues beyond the Elimination Period.

No Disability Payment will be provided for any period in which the Insured is not under the Regular and Appropriate Care of a Physician.

Disability Payments will be provided for only one Disability when:

- (a) more than one Disability exists at the same time; or
- (b) a Disability results from two or more causes.

If any Disability Payment is to be paid for less than a full month, the amount of benefit will be reduced pro rata on the basis that one day's benefit equals one-thirtieth (1/30) the Disability Benefit.

Disability will be considered to have begun on the date the Insured was seen and treated by a Physician following continuous cessation of work.

SUCCESSIVE DISABILITIES are those Disabilities which result from the same or related causes for which benefits are payable under the Group Conversion Policy and will be considered one period of Disability unless the Disabilities are separated by the Insured's return to Active Employment for at least 3 consecutive months. A Disability due to a different or unrelated cause will be considered a new period of Disability.

Any Disability which begins after termination of coverage:

- (a) will not be considered a Successive Disability; and
- (b) will not be covered under the Group Conversion Policy.

IF THE INSURED IS DISABLED DUE TO A COVERED DISABILITY AND NOT WORKING

The Insured's Disability Payment will be the Disability Benefit described in the Schedule less any Deductible Sources of Income the Insured receives or is entitled to receive.

DEDUCTIBLE SOURCES OF INCOME

Deductible Sources of Income will include all of the following:

- (a) Governmental or other retirement system, whether due to disability, normal retirement or voluntary election of retirement benefits.
- (b) United States Social Security Act or similar plan or act, including any amounts due the Insured's dependent(s) on account of the Insured's Disability.
- (c) State Disability.
- (d) Unemployment compensation.
- (e) Substitute differential.
- (f) Sick leave or other salary or wage continuance plans provided by the Employer.

In the case of other group disability insurance which provides for a reduction of benefits payable under the Group Conversion Policy, the Company's liability under the Group Conversion Policy shall equal its pro rata share of the Disability Payment. The pro rata share shall be determined by dividing the Disability Payment by the total of the monthly benefit payable under all group disability income policies under which the Insured is entitled to receive benefits and multiplying that result by the Disability Payment.

If the Company determines that the Insured may qualify for benefits under items (a), (b), or (d) listed above, the Company may estimate the amount of benefits the Insured may be entitled to receive.

The Insured's Disability Payment will not be reduced by the estimated amount if the Insured:

- (a) applies for benefits under items (a), (b), and/or (d) listed above and submits proof of application to the Company; and,
- (b) appeals any denial received to all administrative levels the Company feels are necessary; and,
- (c) signs the Reimbursement Agreement form, which states the Insured's promise to repay any overpayment caused by receipt of benefits from a Deductible Source of Income for a period previously paid by the Company at the time the benefits are received.

If the Insured's Disability Payment has been reduced by an estimated amount, the Company will adjust the Disability Payment when proof is received:

- (a) of the amount awarded; or
- (b) that benefits have been denied and all appeals the Company feels necessary have been completed.

REIMBURSEMENT OF OVERPAYMENT:

If the Insured receives a lump sum payment from a Deductible Source of Income for a period previously paid by the Company, any resulting overpayment made by the Company will be due to the Company on a lump sum basis.

LUMP SUM RETIREMENT WITHDRAWALS:

If the Insured has the option of taking retirement benefits on a monthly basis but chooses to receive retirement benefits on a lump sum basis or withdraw the Insured's retirement contributions, the Company will assume the Insured is receiving retirement benefits based upon the standard monthly retirement plan benefit available prior to lump sum withdrawal.

INCREASES OF INCOME DUE TO COST OF LIVING ADJUSTMENTS:

The Disability Payment will not be reduced due to a cost of living increase if the increase takes effect after the onset of Disability and while benefits are payable under the Group Conversion Policy.

MINIMUM DISABILITY BENEFIT:

The Disability Payment payable will be no less than the Minimum Disability Benefit amount indicated in the Schedule of Benefits.

TERMINATION OF BENEFITS

Disability Payments will end on the earliest of these dates:

- (a) the date the Insured is no longer Disabled;
- (b) the date the Insured dies;
- (c) the last day Disability Payments are made according to the Schedule of Benefits;
- (d) the date the Insured fails to provide the Company with written proof of the Insured's Disability, satisfactory to the Company;
- (e) the date the Insured ceases to be under the Regular and Appropriate Care of a Physician, refuses to undergo an examination by a Physician, or refuses vocational testing when the Company requires such examination or testing;
- (f) the date the Insured refuses to receive medical treatment that is generally acknowledged by Physicians to cure or improve the Insured's condition so as to reduce its disabling effect;
- (g) the date the Insured refuses to try or attempt to work with the assistance of:
 - (1) modifications made to the Insured's work environment, functional job elements or work schedule; or
 - (2) adaptive equipment or devices,

that a Physician has indicated will allow a return to the Insured's own occupation and which accommodations are approved by the Insured's Employer.

SECTION 4 EXCLUSIONS AND LIMITATIONS

ALCOHOLISM AND DRUG ADDICTION LIMITED BENEFIT

If the Insured is Disabled due to alcoholism or drug addiction, a limited benefit of up to 15 days for each Disability will be paid. In no event will benefits be paid beyond the Maximum Disability Period shown in the Schedule. If drug addiction is sustained at the hands of, or while under the Regular and Appropriate Care of a Physician in the course of treatment for Injury or Sickness, it will be covered the same as any other illness.

EXCLUSIONS

The Group Conversion Policy does not cover any loss, fatal or non-fatal, which results from any of the following:

- (a) Intentionally self-inflicted injury while sane or insane.
- (b) An act of war, declared or undeclared.
- (c) Injury sustained or Sickness contracted while in the service of the armed forces of any country.
- (d) Committing a felony.
- (e) Penal incarceration. We will not pay benefits for Disability or any other loss during any period for which the Insured is incarcerated in a penal or correctional institution for a period of 30 consecutive days or longer.
- (f) Injury or Sickness arising out of and in the course of any occupation for wage or profit or for which the Insured is entitled to Workers' Compensation. The term "entitled to Workers' Compensation" shall also include Workers' Compensation claim settlements which occur via compromise and release. Further, no benefits will be paid under this Group Conversion Policy for any period during which the Insured is entitled to Workers' Compensation benefits.

PRE-EXISTING CONDITION means a disease, Injury, Sickness, physical condition or mental illness for which the Insured has experienced any of the following:

- (a) treatment;
- (b) incurred expense;
- (c) took medication;
- (d) received care or services including diagnostic testing or related measures; or
- (e) received a diagnosis or advice from a Physician,

during the 12-month period immediately before the Effective Date of the Insured's coverage. The term Pre-Existing Condition will also include conditions which are related to such disease, Injury, Sickness, physical condition or mental illness.

PRE-EXISTING CONDITION LIMITATION

No Disability Benefit will be payable if Disability is caused by or resulting from a Pre-Existing Condition and begins before the Insured has been continuously covered under the Group Policy for 12 months.

This provision will not apply if the Insured has:

- (a) gone treatment-free;
- (b) incurred no expense;
- (c) taken no medication; and
- (d) received no diagnosis or advice from a Physician

for 12 consecutive months for such condition(s).

This limitation will not apply to a Disability resulting from a Pre-Existing Condition that begins after the Insured has been continuously covered under the Group Policy for 12 months.

SECTION 5 TERMINATION OF INSURANCE

The Insured's insurance coverage will end on the earliest of these dates:

- (a) the date the Insured becomes covered under another group disability income policy;
- (b) the date the Insured's employment terminates;
- (c) the end of the last period for which premium payment has been paid for coverage under the Group Conversion Policy;
- (d) the date the Group Conversion Policy is discontinued;
- (e) the date the Insured is no longer Actively Employed; or
- (f) the date the Insured no longer meets the Eligibility requirements stated in the Group Conversion Policy; or
- (g) the last day of the month ending five (5) years from the conversion Effective Date.

If:

- (a) the Insured's Active Employment terminates;
- (b) such termination is caused by an Injury or Sickness for which Disability Benefits would be payable; and
- (c) Disability is established prior to the termination of Active Employment,

then Disability Benefits will be paid as if such termination had not occurred.

Termination of the Group Conversion Policy will have no effect on Disability Payments which began before such termination.

The Company or the Policyholder, may end the Policy on any premium due date. Thirty-one days advance written notice of such termination must be given.

The Company may end the Insured's coverage if the Insured makes a fraudulent claim.

SECTION 6 PREMIUM CALCULATION AND PAYMENT

Premiums will be figured on the basis stated in the Policyholder's application.

The first premium is due on or before the Insured's Effective Date of coverage. Premiums after the first are due on or before the premium due date stated in the application. Premiums may be paid to the Company's Home Office.

The premium may be changed based on experience at the first anniversary date of the Group Conversion Policy or any premium due date after that. No such increase in rate will be made unless 31 days prior notice is given to the Policyholder and to the Insured.

LATE FEES

The Company may, at its discretion, accept premium beyond the Grace Period and agree to continuation of coverage. Any payments accepted by the Company beyond the Grace Period will be subject to a late fee of 1% of the total delinquent payment for each month due beyond the Grace Period.

SECTION 7 GENERAL PROVISIONS

ENTIRE CONTRACT-CHANGES: The entire contract shall include:

- (a) the Group Conversion Policy;
- (b) the application of the Policyholder;
- (c) the Insured's enrollment form attached to the Certificate; and
- (d) all endorsements and amendments.

Statements made by the Policyholder or the Insured are representations and not warranties, if fraud was not intended. No such statements will be used to avoid the insurance, reduce benefits, or defend a claim under the Group Conversion Policy unless:

- (a) the statement is in writing; and
- (b) a copy of that statement is given to the Insured.

The terms of the Group Conversion Policy can be changed only by endorsement or amendment signed by an executive officer of the Company. Any amendment that reduces or eliminates coverage must be requested in writing or signed by the Policyholder. No agent may change the Group Conversion Policy or waive its provisions.

TIME LIMIT ON CERTAIN DEFENSES: After 2 years from the Insured's Effective Date of coverage, no statements in the application, except fraudulent misstatements, can be used to:

- (a) avoid the coverage; or
- (b) deny a claim for loss incurred or Disability (as defined in the Group Conversion Policy) that starts after such 2-year period.

GRACE PERIOD: A grace period of 31 days will be allowed for each premium payment after the first premium. Coverage will stay in force during this time. The Insured's coverage under the Group Conversion Policy will terminate at the end of the grace period if the premium has not been paid. The Insured must still pay all unpaid premium. This includes the premium due for the grace period.

The Policyholder or the Insured may, by writing to the Company, cancel the coverage under the Group Conversion Policy:

- (a) on any future premium due date; or
- (b) on any date during the grace period.

If coverage is canceled on a premium due date, the grace period will not apply. If cancellation is during the grace period, the Insured will be liable for any unpaid premium including the pro rata premium for that part of the grace period while coverage was in force.

NOTICE OF CLAIM: Written Notice of Claim must be given to the Company at 2305 Lakeland Drive, Flowood, Mississippi 39232, or to the Company's agent. Such Notice should be made within 30 days after any loss covered by the Group Conversion Policy. If it is not reasonably possible to give Notice of Claim within that time, the claim may not be denied or reduced due to the delay.

PROOF OF LOSS: Proof of Loss must be given to the company within 90 days after the loss. Late proof may be accepted if:

- (a) it was not reasonably possible to give Proof in that time; and
- (b) the proof is given within one year from the date of loss. This 1-year limit will not apply in the absence of legal capacity.

Proof of Loss, provided at the Insured's expense, must show:

- (a) that the Insured is under the Regular and Appropriate Care of a Physician;
- (b) the date the Insured's Disability began;
- (c) the cause of the Insured's Disability;
- (d) the appropriate documentation of the Insured's Monthly Compensation;
- (e) the extent of the Insured's Disability, including restrictions and limitations preventing the Insured from performing the Insured's Regular Occupation; and
- (f) the name and address of any hospital or institution where the Insured received treatment, including all attending Physicians.

CLAIM FORMS: Claim forms should be used for filing Proof of Loss. They will be sent to the claimant within 15 days of receipt of Notice of Claim. If Claim Forms are not supplied within 15 days, a claimant can give proof as follows:

- (a) in writing;
- (b) containing the required information as indicated in the Proof of Loss Provision; and
- (c) within the time stated in the Proof of Loss Provision.

TIME OF PAYMENT OF CLAIMS: All accrued benefits for loss for which the Group Conversion Policy provides periodic payment will be paid each month, subject to written Proof of Loss. Any balance not paid when liability ends will be paid immediately upon receipt of written Proof. Benefits for any other covered loss will be paid as soon as the Company receives written proof of such Proof of Loss.

PAYMENT OF BENEFITS: All benefits will be paid to the Insured. Accrued benefits that are not paid at the Insured's death will be paid to the Insured's beneficiary or estate. If a benefit is to be paid to the Insured's estate, or to the Insured and the Insured is not competent to give a valid release, the Company may pay up to \$1,000 of such benefit to one of the Insured's relatives who are deemed by the Company to be justly entitled to it. Such payment, made in good faith, fully discharges the Company to the extent of the payment.

PHYSICAL EXAMINATION: While a claim is pending, the Company has the right to have the Insured:

- (a) examined as often as is reasonably necessary. The Company will pay for such examination; and/or
- (b) interviewed by an authorized Company representative to determine the extent of any Sickness or Injury for which the Insured has made a claim. This right may be used as often as reasonably required.

LEGAL ACTION: No legal action may be brought to recover under this Group Conversion Policy:

- (a) within 60 days after written Proof of Loss has been furnished as required; or
- (b) more than 3 years from the time written Proof of Loss is required to be furnished.

CERTIFICATES: An Individual Certificate will be issued to the Insured. The Certificate will describe:

- (a) the benefits under the Group Conversion Policy;
- (b) to whom benefits will be paid; and
- (c) the limitations and terms of the Group Conversion Policy.

If more than one Certificate is issued under the Group Conversion Policy to the Insured, only the last one issued will be in effect.

MISSTATEMENT OF FACTS: If relevant facts regarding the Insured are not accurate:

- (a) a fair adjustment of premium will be made; and
- (b) the true facts will decide if and in what amount of insurance coverage is valid.

CONFORMITY WITH STATE LAWS: A provision of the Group Conversion Policy that conflicts with a law of the state of issue is hereby changed to meet the minimum standards of that law.

CLAIM OVERPAYMENT: The Company has the right to recover from the Insured any amount that the Company determines to be an overpayment. The Insured has the obligation to refund to the Company any such amount. The Company's rights and the Insured's obligations in this regard may also be set forth in the reimbursement agreement the Insured may be required to sign when the Insured becomes eligible for benefits under this Group Conversion Policy.

If benefits are overpaid on any claim, the Insured must reimburse the Company within 30 days.

If reimbursement is not made in a timely manner, the Company has the right to:

- (a) recover such overpayments from:
 - (1) the Insured;
 - (2) any other person to or for whom payment was made;
 - (3) the Insured's estate;

- (4) the Insured's beneficiary;
- (5) any other organization; and
- (6) any other insurance company;
- (b) reduce or offset against any future benefits payable to the Insured, the Insured's Estate, the Insured's Survivors, or the Insured's Beneficiary, including the Minimum Monthly Benefit, until full reimbursement is made. Payments may continue when the overpayment has been recovered;
- (c) refer the Insured's unpaid balance to a collection agency; and
- (d) pursue and enforce all legal and equitable rights in court.



American Public Life Insurance Company

A member of the American Fidelity Group

2305 Lakeland Drive, Flowood, Mississippi 39232

GROUP DISABILITY INCOME CONVERSION CERTIFICATE

American Public Life Insurance Company (We, Us, Our) hereby certifies that it has issued and delivered to the Policyholder a Group Conversion Policy, described on the Schedule of Benefits page. The Group Conversion Policy covers certain eligible persons, as described in the Policy.

This Certificate describes the benefits and provisions of the Group Conversion Policy and becomes Your Certificate of insurance only if:

- (1) You are eligible for the insurance (see ELIGIBILITY on Schedule of Benefits);
- (2) You are on Active Employment on the date it is to take effect; and
- (3) You become insured and remain insured in accordance with all of the provisions of the Policy.

Further, the insurance is to be effective only if the required premium payments are made by You or on Your behalf to Us. (See Section 2, Eligibility and Effective Date.)

No agent may change the Policy or waive any of its provisions.

This Certificate takes the place of any other Certificate previously issued to You under the Group Conversion Policy. It should be kept in a safe place. This Certificate is not the insurance contract. The Group Conversion Policy is the only contract under which benefits are paid. You may examine it at the office of the Policyholder.

IN WITNESS WHEREOF, We cause this Certificate to take effect on the Effective Date.

Jim Pate
President

William F. Weems
Vice President and C.A.O

NON PARTICIPATING GROUP DISABILITY INCOME INSURANCE CERTIFICATE

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

TABLE OF CONTENTS

Schedule of Benefits

Section 1	.....	Definitions
Section 2	.....	Eligibility and Effective Date
Section 3	.....	Disability Benefits
Section 4	.....	Exclusions and Pre-Existing Limitations
Section 5	.....	Termination of Insurance
Section 6	.....	Premium Calculation and Payment
Section 7	.....	General Provisions

SCHEDULE OF BENEFITS

POLICYHOLDER: [ABC Conversion]

POLICY NUMBER: [GDISC-1T]

CERTIFICATE EFFECTIVE DATE: [June 1, 2011]

ELIGIBILITY: [Any person who is working 25 hours or more per week on the Effective Date of coverage, excluding self-employment, and who meets the Eligibility requirements in Section 2.]

DISABILITY BENEFIT: Your Monthly Disability Benefit under the Group Policy, not to exceed 70% of Your current Monthly Compensation.

MINIMUM DISABILITY BENEFIT: \$100.00

MAXIMUM DISABILITY PERIOD: [6 months, 12 months] for Injury or Sickness

ELIMINATION PERIOD: 30 days for Injury or Sickness

SECTION 1 DEFINITIONS

ACTIVE EMPLOYMENT means that You are:

- (a) doing in the usual manner all of the regular duties of Your employment on a full-time basis on a scheduled work day; and
- (b) these duties are being done at one of the places of business where You normally do such duties or at some location to which Your employment sends You.

You will be said to be on Active Employment on a day which is not a scheduled work day only if You are not Disabled and would be able to perform in the usual manner all of the regular duties of Your employment if it were a scheduled work day.

CERTIFICATE means the individual Certificate issued to You. It describes Your coverage under the Group Conversion Policy.

DISABILITY (or Disabled) means You are unable to perform the material and substantial duties of Your Regular Occupation.

DISABILITY PAYMENT means Your Disability Benefit minus any Deductible Sources of Income as outlined in Section 3.

EFFECTIVE DATE means the date described in the Policy. The date shown in Your individual Certificate or Policy will be Your Effective Date of coverage. The Effective Date will start at 12:01 a.m. at the main place of business of the Policyholder.

ELIMINATION PERIOD means that period of time, which starts after Your Effective Date of coverage, during which:

- (a) You are Disabled; and
- (b) no Disability Benefits are payable.

EMPLOYER means the individual, company, corporation, or governmental entity where You are on Active Employment.

GROUP CONVERSION POLICY means the policy issued to the Policyholder which covers the Insureds.

GROUP POLICY means the group disability income policy issued by Us, from which conversion was made for coverage under the Group Conversion Policy.

INJURY means physical harm or damage to the body sustained by You which:

- (a) results directly from an accidental bodily injury;
- (b) is independent of disease or bodily infirmity; and
- (c) takes place while Your coverage is in force.

INSURED means a person whose coverage has been applied for and is in force under the terms of the Group Conversion Policy.

MONTHLY COMPENSATION means:

- (a) one-twelfth (1/12) of Your annual salary through Your Employer exclusive of overtime or bonus earnings; or
- (b) one-twelfth (1/12) of the preceding 12 months' salary through Your Employer, if Your salary is solely or partially based on commissioned sales, overtime, or bonus earnings.

PHYSICIAN means a medical practitioner of the healing art(s) which is recognized by applicable state law, who:

- (a) is practicing within the scope of his or her license;
- (b) is certified or credentialed by the appropriate medical or professional board that provides certification or credentials for practitioners who perform the type of treatment or service appropriate for Your Sickness or Injury; and
- (c) possesses the necessary training and qualifications according to generally accepted medical standards, to evaluate and treat Your condition.

The term Physician does not include You, an employee of the Employer, anyone related to You by blood or marriage, or anyone living in Your household.

POLICYHOLDER means the trustee to whom the Group Conversion Policy has been issued.

REGULAR AND APPROPRIATE CARE means:

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

REGULAR OCCUPATION means the occupation You are routinely performing when Your Disability begins. We will look at Your occupation as it is normally performed in the national economy, rather than how the work tasks are performed for a specific Employer or at a specific location.

SCHEDULE OF BENEFITS (or Schedule) means the benefit schedule set forth in the Group Conversion Policy or Certificate.

SICKNESS means a disease or illness (including pregnancy). Disability must begin while this coverage is in force.

SECTION 2 ELIGIBILITY AND EFFECTIVE DATE

ELIGIBILITY

All persons who meet the terms described in the Schedule of Benefits and:

- (a) have been continuously covered under the Group Policy for at least 12 consecutive months prior to the date Your employment terminated;
- (b) are not Disabled on the Effective Date of coverage under this Policy;
- (c) are not covered under any other group disability income plan;
- (d) are employed on the date Your conversion coverage becomes effective;
- (e) are not on a leave of absence;
- (f) employment was not terminated due to retirement; and
- (g) are less than age 70.

are eligible for coverage under the Group Conversion Policy.

EFFECTIVE DATE

Your coverage under the Group Conversion Policy will take effect on the first of the month after termination of Your coverage under the Group Policy provided:

- (a) application for coverage is received within 30 days of the termination date of the Group Policy; and
- (b) premium has been paid; and
- (c) You are on Active Employment on the Effective Date of this Coverage.

If You are not on Active Employment coverage will not take effect.

SECTION 3 DISABILITY BENEFITS

Disability Payments will be provided if You furnish Proof of Loss that You are Disabled and under the Regular and Appropriate Care of a Physician. Disability must:

- (a) be due to a covered Injury or Sickness; and
- (b) begin while Your coverage is in force under the Group Conversion Policy.

Disability Payments will be provided for each period You remain Disabled due to a covered Disability and under the Regular and Appropriate Care of a Physician which continues beyond the Elimination Period.

No Disability Payment will be provided for any period in which You are not under the Regular and Appropriate Care of a Physician.

Disability Payments will be provided for only one Disability when:

- (a) more than one Disability exists at the same time; or
- (b) a Disability results from two or more causes.

If any Disability Payment is to be paid for less than a full month, the amount of benefit will be reduced pro rata on the basis that one day's benefit equals one-thirtieth (1/30) the Disability Benefit.

Disability will be considered to have begun on the date You were seen and treated by a Physician following continuous cessation of work.

SUCCESSIVE DISABILITIES are those Disabilities which result from the same or related causes for which benefits are payable under the Group Conversion Policy and will be considered one period of Disability unless the Disabilities are separated by Your return to Active Employment for at least 3 consecutive months. A Disability due to a different or unrelated cause will be considered a new period of Disability.

Any Disability which begins after termination of coverage:

- (a) will not be considered a Successive Disability; and
- (b) will not be covered under the Group Conversion Policy.

IF YOU ARE DISABLED DUE TO A COVERED DISABILITY AND NOT WORKING

Your Disability Payment will be the Disability Benefit described in the Schedule less any Deductible Sources of Income You receive or are entitled to receive.

DEDUCTIBLE SOURCES OF INCOME

Deductible Sources of Income will include all of the following:

- (a) Governmental or other retirement system, whether due to disability, normal retirement or voluntary election of retirement benefits.
- (b) United States Social Security Act or similar plan or act, including any amounts due Your dependent(s) on account of Your Disability.
- (c) State Disability.
- (d) Unemployment compensation.
- (e) Sick leave or other salary or wage continuance plans provided by the Employer.

In the case of other group disability insurance which provides for a reduction of benefits payable under the Group Conversion Policy, Our liability under the Group Conversion Policy shall equal its pro rata share of the Disability Payment. The pro rata share shall be determined by dividing the Disability Payment by the total of the monthly benefit payable under all group disability income policies under which You are entitled to receive benefits and multiplying that result by the Disability Payment.

If We determine that You may qualify for benefits under items (a), (b), or (d) listed above, We may estimate the

amount of benefits You may be entitled to receive.

Your Disability Payment will not be reduced by the estimated amount if You:

- (a) apply for benefits under items (a), (b), and/or (d) listed above and submit proof of application to Us; and,
- (b) appeal any denial received to all administrative levels We feel are necessary; and,
- (c) sign the Reimbursement Agreement form, which states You promise to repay any overpayment caused by receipt of benefits from a Deductible Source of Income for a period previously paid by Us at the time the benefits are received.

If Your Disability Payment has been reduced by an estimated amount, We will adjust the Disability Payment when proof is received:

- (a) of the amount awarded; or
- (b) that benefits have been denied and all appeals We feel necessary have been completed.

REIMBURSEMENT OF OVERPAYMENT:

If You receive a lump sum payment from a Deductible Source of Income for a period previously paid by Us, any resulting overpayment made by Us will be due to Us on a lump sum basis.

LUMP SUM RETIREMENT WITHDRAWALS:

If You have the option of taking retirement benefits on a monthly basis but choose to receive retirement benefits on a lump sum basis or withdraw Your retirement contributions, We will assume You are receiving retirement benefits based upon the standard monthly retirement plan benefit available prior to lump sum withdrawal.

INCREASES OF INCOME DUE TO COST OF LIVING ADJUSTMENTS:

The Disability Payment will not be reduced due to a cost of living increase if the increase takes effect after the onset of Disability and while benefits are payable under the Policy.

MINIMUM DISABILITY BENEFIT:

The Disability Payment payable will be no less than the Minimum Disability Benefit amount indicated in the Schedule of Benefits.

TERMINATION OF BENEFITS

Disability Payments will end on the earliest of these dates:

- (a) the date You are no longer Disabled;
- (b) the date You die;
- (c) the last day Disability Payments are made according to the Schedule of Benefits;
- (d) the date You fail to provide Us with written proof of Your Disability, satisfactory to Us;
- (e) the date You cease to be under the Regular and Appropriate Care of a Physician, refuse to undergo an examination by a Physician, or refuse vocational testing when We require such examination or testing;
- (f) the date You refuse to receive medical treatment that is generally acknowledged by Physicians to cure or improve Your condition so as to reduce its disabling effect;
- (g) the date You refuse to try or attempt to work with the assistance of:
 - (1) modifications made to Your work environment, functional job elements or work schedule; or
 - (2) adaptive equipment or devices,

that a Physician has indicated will allow a return to Your own occupation and which accommodations are approved by Your Employer.

SECTION 4 EXCLUSIONS AND LIMITATIONS

ALCOHOLISM AND DRUG ADDICTION LIMITED BENEFIT

If You are Disabled due to alcoholism or drug addiction, a limited benefit of up to 15 days for each Disability will be paid. In no event will benefits be paid beyond the Maximum Disability Period shown in the Schedule. If drug addiction is sustained at the hands of, or while under the Regular and Appropriate Care of a Physician in the course of treatment for Injury or Sickness, it will be covered the same as any other illness.

EXCLUSIONS

The Policy does not cover any loss, fatal or non-fatal, which results from any of the following:

- (a) Intentionally self-inflicted injury while sane or insane.
- (b) An act of war, declared or undeclared.
- (c) Injury sustained or Sickness contracted while in the service of the armed forces of any country.
- (d) Committing a felony.
- (e) Penal incarceration. We will not pay benefits for Disability or any other loss during any period for which You are incarcerated in a penal or correctional institution for a period of 30 consecutive days or longer.
- (f) Injury or Sickness arising out of and in the course of any occupation for wage or profit or for which You are entitled to Workers' Compensation. The term "entitled to Workers' Compensation" shall also include Workers' Compensation claim settlements which occur via compromise and release. Further, no benefits will be paid under this Policy for any period during which You are entitled to Workers' Compensation benefits.

PRE-EXISTING CONDITION means a disease, Injury, Sickness, physical condition or mental illness for which You have experienced any of the following:

- (a) treatment;
- (b) incurred expense;
- (c) took medication;
- (d) received care or services including diagnostic testing or related measures; or
- (e) received a diagnosis or advice from a Physician,

during the 12-month period immediately before the Effective Date of Your coverage. The term Pre-Existing Condition will also include conditions which are related to such disease, Injury, Sickness, physical condition or mental illness.

PRE-EXISTING CONDITION LIMITATION

No Disability Benefit will be payable if Disability is caused by or resulting from a Pre-Existing Condition and begins before You have been continuously covered under the Group Policy for 12 months.

This provision will not apply if You have:

- (a) gone treatment-free;
- (b) incurred no expense;
- (c) taken no medication; and
- (d) received no diagnosis or advice from a Physician

for 12 consecutive months for such condition(s).

This limitation will not apply to a Disability resulting from a Pre-Existing Condition that begins after You have been continuously covered under the Group Policy for 12 months.

SECTION 5 TERMINATION OF INSURANCE

Your insurance coverage will end on the earliest of these dates:

- (a) the date You become covered under another group disability income policy;
- (b) the date Your employment terminates;
- (c) the end of the last period for which premium payment has been paid for coverage under the Group Conversion Policy;
- (d) the date the Group Conversion Policy is discontinued;
- (e) the date You are no longer Actively Employed; or
- (f) the date You no longer meet the Eligibility requirements stated in the Policy; or
- (g) the last day of the month ending five (5) years from the conversion Effective Date.

If:

- (a) Your Active Employment terminates;
- (b) such termination is caused by an Injury or Sickness for which Disability Benefits would be payable; and
- (c) Disability is established prior to the termination of Active Employment,

then Disability Benefits will be paid as if such termination had not occurred.

Termination of the Group Conversion Policy will have no effect on Disability Payments which began before such termination.

We or the Policyholder, may end the Policy on any premium due date. Thirty-one days advance written notice of such termination must be given.

We may end Your coverage if You make a fraudulent claim.

SECTION 6 PREMIUM CALCULATION AND PAYMENT

Premiums will be figured on the basis stated in the Policyholder's application.

The first premium is due on or before Your Effective Date of coverage. Premiums after the first are due on or before the premium due date stated in the application. Premiums may be paid to Our Home Office.

The premium may be changed based on experience at the first anniversary date of the Policy or any premium due date after that. No such increase in rate will be made unless 31 days prior notice is given to the Policyholder and to You.

SECTION 7 GENERAL PROVISIONS

ENTIRE CONTRACT-CHANGES: The entire contract shall include:

- (a) the Group Conversion Policy;
- (b) the application of the Policyholder;
- (c) Your application, if any, attached to the Certificate; and
- (d) all endorsements and amendments.

Statements made by the Policyholder or You are representations and not warranties, if fraud was not intended. No such statements will be used to avoid the insurance, reduce benefits, or defend a claim under the Group Conversion Policy unless:

- (a) the statement is in writing; and
- (b) a copy of that statement is given to You.

The terms of the Policy can be changed only by endorsement or amendment signed by an executive officer of Ours. Any amendment that reduces or eliminates coverage must be requested in writing or signed by the Policyholder. No agent may change the Policy or waive its provisions.

TIME LIMIT ON CERTAIN DEFENSES: After 2 years from Your Effective Date of coverage, no statements in the application, except fraudulent misstatements, can be used to:

- (a) avoid the coverage; or
- (b) deny a claim for loss incurred or Disability (as defined in the Policy) that starts after such 2-year period.

GRACE PERIOD: A grace period of 31 days will be allowed for each premium payment after the first premium. Coverage will stay in force during this time. Your coverage under the Group Conversion Policy will terminate at the end of the grace period if the premium has not been paid. You must still pay all unpaid premium. This includes the premium due for the grace period.

The Policyholder or You may, by writing to Us, cancel the coverage under the Policy:

- (a) on any future premium due date; or
- (b) on any date during the grace period.

If coverage is canceled on a premium due date, the grace period will not apply. If cancellation is during the grace period, You will be liable for any unpaid premium including the pro rata premium for that part of the grace period while coverage was in force.

NOTICE OF CLAIM: Written Notice of Claim must be given to Us at 2305 Lakeland Drive, Flowood, Mississippi 39232, or to Our agent. Such Notice should be made within 30 days after any loss covered by the Policy. If it is not reasonably possible to give Notice of Claim within that time, the claim may not be denied or reduced due to the delay.

PROOF OF LOSS: Proof of Loss must be given to Us within 90 days after the loss. Late proof may be accepted if:

- (a) it was not reasonably possible to give Proof in that time; and
- (b) the proof is given within one year from the date of loss. This 1-year limit will not apply in the absence of legal capacity.

Proof of Loss, provided at Your expense, must show:

- (a) that You are under the Regular and Appropriate Care of a Physician;
- (b) the date Your Disability began;
- (c) the cause of Your Disability;
- (d) the appropriate documentation of Your Monthly Compensation;
- (e) the extent of Your Disability, including restrictions and limitations preventing You from performing Your Regular Occupation; and
- (f) the name and address of any hospital or institution where You received treatment, including all attending Physicians.

CLAIM FORMS: Claim forms should be used for filing Proof of Loss. They will be sent to the claimant within 15 days of receipt of Notice of Claim. If Claim Forms are not supplied within 15 days, a claimant can give proof as follows:

- (a) in writing;
- (b) containing the required information as indicated in the Proof of Loss Provision; and
- (c) within the time stated in the Proof of Loss Provision.

TIME OF PAYMENT OF CLAIMS: All accrued benefits for loss for which the Policy provides periodic payment will be paid each month, subject to written Proof of Loss. Any balance not paid when liability ends will be paid immediately upon receipt of written Proof. Benefits for any other covered loss will be paid as soon as We receive written proof of such Proof of Loss.

PAYMENT OF BENEFITS: All benefits will be paid to You. Accrued benefits that are not paid at Your death will be paid to Your beneficiary or estate. If a benefit is to be paid to Your estate, or to You and You are not competent to give a valid release, We may pay up to \$1,000 of such benefit to one of Your relatives who are deemed by Us to be justly entitled to it. Such payment, made in good faith, fully discharges Us to the extent of the payment.

PHYSICAL EXAMINATION: While a claim is pending, We have the right to have You:

- (a) examined as often as is reasonably necessary. We will pay for such examination; and/or
- (b) interviewed by an authorized Company representative to determine the extent of any Sickness or Injury for which You have made a claim. This right may be used as often as reasonably required.

LEGAL ACTION: No legal action may be brought to recover under the Policy:

- (a) within 60 days after written Proof of Loss has been furnished as required; or
- (b) more than 3 years from the time written Proof of Loss is required to be furnished.

CERTIFICATES: An Individual Certificate will be issued to You. The Certificate will describe:

- (a) the benefits under the Group Conversion Policy;
- (b) to whom benefits will be paid; and
- (c) the limitations and terms of the Group Conversion Policy.

If more than one Certificate is issued under the Group Conversion Policy to You, only the last one issued will be in effect.

MISSTATEMENT OF FACTS: If relevant facts regarding You are not accurate:

- (a) a fair adjustment of premium will be made; and
- (b) the true facts will decide if and in what amount of insurance coverage is valid.

CONFORMITY WITH STATE LAWS: A provision of the Policy that conflicts with a law of the state of issue is hereby changed to meet the minimum standards of that law.

CLAIM OVERPAYMENT: We have the right to recover from You any amount that We determine to be an overpayment. You have the obligation to refund to Us any such amount. Our rights and Your obligations in this regard may also be set forth in the reimbursement agreement You may be required to sign when You become eligible for benefits under this Policy.

If benefits are overpaid on any claim, You must reimburse Us within 30 days.

If reimbursement is not made in a timely manner, We have the right to:

- (a) recover such overpayments from:
 - (1) You;
 - (2) any other person to or for whom payment was made;
 - (3) Your estate;
 - (4) Your beneficiary;
 - (5) any other organization; and
 - (6) any other insurance company;
- (b) reduce or offset against any future benefits payable to You, Your Estate, Your Survivors, or Your Beneficiary, including the Minimum Monthly Benefit, until full reimbursement is made. Payments may continue when the overpayment has been recovered;
- (c) refer Your unpaid balance to a collection agency; and
- (d) pursue and enforce all legal and equitable rights in court.



American Public Life Insurance Company

A member of the American Fidelity Group

GROUP DISABILITY INCOME CONVERSION ENROLLMENT FORM	2305 Lakeland Drive, Flowood, Mississippi 39232								
---	---	--	--	--	--	--	--	--	--

Last Name:		First Name:		Full Middle Name:		Suffix:	
------------	--	-------------	--	-------------------	--	---------	--

Age:	Date of Birth:	Gender: F <input type="checkbox"/> M <input type="checkbox"/>	Social Security Number:	Country of Citizenship:	
------	----------------	--	-------------------------	-------------------------	--

Residence Address (Not a PO Box):			Home Phone Number: ()	Work Phone Number: ()
-----------------------------------	--	--	---------------------------	---------------------------

City:			State:	Zip Code:
-------	--	--	--------	-----------

Mailing Address (if different from residence):		City:	State:	Zip Code:
--	--	-------	--------	-----------

E-mail Address:				
-----------------	--	--	--	--

Date of Termination:	Reason For Termination:	Former Employer:		
----------------------	-------------------------	------------------	--	--

Current Employer: Name, Address and Phone Number:		Current Monthly Salary (on Effective Date): \$	Current Employment Hire Date:
---	--	--	-------------------------------

Are you currently enrolled in any other Group Disability Income Plan? Yes No

Are you currently able to perform the duties of your occupation? Yes No

(You are not eligible for conversion coverage if you have other group disability income insurance or if you are currently Disabled.)

Conversion Coverage Effective Date:	Monthly Disability Benefit: \$
-------------------------------------	--------------------------------

(Coverage will be effective the first of the month following your date of termination)

Premium: \$	Payment Mode: <input type="checkbox"/> Annual Payment <input type="checkbox"/> Monthly Bank Draft (Please complete and return the enclosed EFT form.)
----------------	--

Elimination Period: <input checked="" type="checkbox"/> 30 days	Benefit Period: <input type="checkbox"/> 6 months <input type="checkbox"/> 12 months
---	--

Beneficiary: First Name	Middle Name	Last Name	Relationship	Country of Citizenship
-------------------------	-------------	-----------	--------------	------------------------

I understand that my Disability Income Conversion amount is equal to the Monthly Disability Benefit for which I was covered under the Group Policy as of the last day of coverage under the Group Policy. My Monthly Disability Benefit may be adjusted so as not to exceed 70% of my new salary.

Brochure # _____ has been explained to me and I have received a copy. (Please Initial)

FRAUD NOTICE: Any person, who knowingly and with intent to injure or deceive any insurer, files a statement of claim or application containing any false, incomplete, or misleading information may be guilty of insurance fraud. (In CT, insurance fraud is determined by a court of competent jurisdiction; in IN, KY, and OK, insurance fraud is a felony; in NV, insurance fraud is a Category D Felony). In AR, DC, LA, NJ, NM, PA, TN, and VA: Any person who knowingly presents false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. (In DC, TN, and VA, also denial of insurance benefits; in NJ, NM, and PA, civil fines and criminal penalties.)

Signature	Date
-----------	------

M-3370

PLEASE RETURN THIS FORM ALONG WITH YOUR PREMIUM PAYMENT WITHIN 30 DAYS AFTER THE DATE YOUR EMPLOYMENT ENDS.

For Home Office Use Only:

Group #: _____
Effective Date: _____

SERFF Tracking Number: AFDL-127094541 State: Arkansas
 Filing Company: American Public Life Insurance Company State Tracking Number: 48336
 Company Tracking Number: GDISC11APL
 TOI: H11G Group Health - Disability Income Sub-TOI: H11G.002 Short Term
 Product Name: GDISC11APL Group Disability Income Conversion Policy
 Project Name/Number: APL Group Conversion Policy /GDISC11APL/C

Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification Comments: Attachment: AR_Compliance_Certification.pdf	Approved-Closed	03/29/2011

	Item Status:	Status Date:
Satisfied - Item: Application Comments: Attachments: A1269.pdf AGM107.pdf	Approved-Closed	03/29/2011

	Item Status:	Status Date:
Satisfied - Item: Letter of Authorization Comments: Attachment: APL_Authorization11.pdf	Approved-Closed	03/29/2011



2000 N. Classen Boulevard, Oklahoma City, Oklahoma 73125

COMPLIANCE CERTIFICATION

ARKANSAS

This is to certify that the attached forms comply with the requirements of:

Arkansas Rule & Regulation 19

Arkansas Rule & Regulation 49

ACA 23-80-206

ACA-23-79-138


Signature

John Lanier, Vice President
Name and Title

3/23/2011
Date



A member of the American Fidelity Group.

2305 Lakeland Drive Flowood, MS 39232
Phone: (800) 256-8606 FAX: (877) 807-0911

FOR AGENT USE ONLY:

Requested Effective Date: _____

Bill Location: _____

GROUP DISABILITY INCOME APPLICATION

1. PROPOSED INSURED INFORMATION
Last Name First Name Full Middle Name Suffix
Age Date of Birth Sex Soc Sec Number Date of Employment
Residence Address: Number & Street (Not a P.O. Box) City State Zip
Home Phone # Work Phone # Country of Citizenship
Mailing Address (if different than Residence) City State Zip
Employer Name Salary: \$ Occupation
Are you currently able to perform the duties of your occupation? Yes No

Applicant's E-mail Address

2. BENEFITS APPLIED FOR

Table with 8 columns: Product, New, Change, Benefit Amount, Employee, Employer, Frequency, Total. Rows include [STD], [Rider], and a TOTAL row.

3. BENEFICIARY

First Name Middle Name Last Name Relationship to Insured Country of Citizenship

4. ELECTION I hereby enroll, add or change, as checked above, group insurance coverage(s) for which I am eligible. I authorize my employer to deduct my premiums, if any, from my pay.

5. ACKNOWLEDGMENT I understand and agree that:

- The information in this application will be used to determine my eligibility for insurance; the statements and answers shown in this application (first page and, if applicable, the second page) are true and complete; the Company may rely upon such answers as the basis of my contract; and no coverage will take effect until the application is approved by the Company, the first premium is received, and a Certificate is issued.
If applying for disability income coverage, OTHER INCOME I AM ENTITLED TO RECEIVE WILL, IF APPLICABLE, REDUCE MY MONTHLY BENEFIT. I SHOULD READ MY CERTIFICATE FOR MORE DETAILED INFORMATION REGARDING HOW OTHER INCOME WILL REDUCE MY BENEFIT.
"Pre-Existing Conditions" may not be covered; and I should read my Certificate for a more detailed explanation of the Pre-Existing Condition exclusion, if any.

BROCHURE(S) # HAS/HAVE BEEN EXPLAINED TO ME, AND I HAVE RECEIVED A COPY/COPIES; OR, I HAVE HAD ACCESS TO AND THE OPPORTUNITY TO PRINT THE BROCHURE(S). (Applicant Initials):

6. FRAUD NOTICE Any person, who knowingly and with intent to injure or deceive any insurer, files a statement of claim or application containing any false, incomplete, or misleading information may be guilty of insurance fraud. (In CT, insurance fraud is determined by a court of competent jurisdiction; in IN, KY, and OK, insurance fraud is a felony; in NV, insurance fraud is a Category D Felony). In AR, DC, LA, NJ, NM, PA, TN, and VA: Any person who knowingly presents false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. (In DC, TN, and VA, also denial of insurance benefits; in NJ, NM, and PA, civil fines and criminal penalties.)

APPLICANT SIGNATURE _____ Date _____

AGENT SIGNATURE (where required by law) _____ Agent # _____

AMERICAN PUBLIC LIFE INSURANCE COMPANY

2305 Lakeland Drive, Flowood, MS 39232

GROUP DISABILITY INCOME APPLICATION

PROPOSED INSURED'S NAME _____

HEALTH HISTORY

7. Within the **past 5 years**, have you received a diagnosis, taken medication and/or had treatment by a member of the medical profession for any of the following:

Cancer (other than basal or squamous cell skin cancer), heart and/or circulatory disorder, peripheral vascular disease (PVD), stroke or transient ischemic attack, liver or kidney disorder/disease (excluding stones), pulmonary disease, diabetes requiring insulin, rheumatoid arthritis, epilepsy, ulcerative colitis, Crohn's disease, organ transplant, systemic lupus erythematosus, disorder of blood cells or blood clotting disorder, seizures, Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), or Human Immunodeficiency Virus (HIV), Chronic Fatigue Syndrome (CFS), fibromyalgia, alcohol or drug addiction or abuse, or neurological disorder (excluding headaches or migraines).

Yes No

8. Within the **past 12 months**, have you:

Received advice from a medical provider, taken medication, incurred an expense, undergone tests, or received treatment (including, but not limited to, spinal manipulation, physical therapy, or counseling) for a condition related to: (a) your back, neck or spine; (b) a mental or nervous condition; or (c) had surgery recommended that has not yet been performed or received a referral for surgery consultation?

Yes No

9. Are you currently pregnant?

Yes No

10. I hereby certify that I have read the above statements and all of the medical conditions or they have been read to me. I also understand that additional investigation could occur at time of claim and any misrepresentation contained herein relied on by the Company may be used to reduce or deny a claim and/or void the coverage if such misrepresentation materially affects the acceptance of the risk.

Applicant's Initials: _____ Date: _____

 **American Public Life Insurance Company**

A member of the American Fidelity Group

Contract Number: _____

2305 Lakeland Drive • Flowood, MS • 39232 • Phone: (800) 256-8606 • Fax: (877) 807-0911

Application for **Group Disability Income Insurance** is hereby made to American Public Life Insurance Company based on the following:

- 1. Full Legal Name of Policyholder: _____
- 2. Mailing Address: _____
- 3. Physical Address (if different): _____
- 4. Group Type: Association Corporation Sole Proprietorship or Partnership Education Other
- 5. Nature of Organization: _____ Tax ID Number: _____
- 6. Designation of Class or Classes Eligible for Coverage (attach an additional page if necessary): _____

- 7. Current employees are eligible: Immediately After _____ days employment As determined by each firm
- 8. New employees are eligible after _____ days employment.
- 9. Minimum Standards: Before this Policy or the insurance of additional persons or a change in class takes effect, the following applicable minimum standards must be met. Where the Policyholder is a/an: Employer Trust Association, the participation requirements are as follows: _____

If these standards are not met, it is agreed that the Company may:

- (1) ask for satisfactory evidence of insurability before an eligible person's coverage takes effect; or
- (2) terminate the Policy or Subscribing Unit.

To issue coverage and maintain eligibility:

- 10. Initial Premium rate is as follows: _____
The premium is due on the _____ of each month.
- 11. Effective Date: _____ Original Policy Effective Date: _____ Policy Amended Effective: _____
If this application is approved by the Company, it is desired that the Policy takes effect at 12:01 AM at the place where the Policy is delivered. It is agreed that the coverage of an eligible person will not take effect until the first premium has been paid for or by such person.
- 12. The Policyholder declares that to the best of his knowledge and belief the statements and answers shown above are true and complete. The Policyholder understands and agrees that: (a) the application will form a part of any policy issued; (b) no information given to, or acquired by, any representative of the Company will bind the Company unless it appears in writing on this application; (c) no waiver or modification will bind the Company unless it is in writing and is signed by an Executive Officer of the Company; and (d) only those persons eligible under the terms of the policy or policies issued will be covered.
- 13. I hereby request American Public Life Insurance Company to issue and deliver the Group Certificates of Insurance for the coverage applied. I agree to make payroll deductions for the Employee portion of any premium.
- 14. Non-ERISA Group
 ERISA Acknowledgment: The Employer named below acknowledges that the Employee Retirement Income Security Act of 1974 (ERISA), as amended or other laws, if applicable, may require that the Employer be responsible for certain duties or obligations with respect to the Employer or Employer's Employees and dependents under any certificate under such group policy or policies.

Dated at _____ on the _____ day of _____ 20_____

Authorized Signature: _____ Official Position: _____

Agent: _____ Agent Number: _____

FRAUD WARNING: Any person, who knowingly and with intent to injure or deceive any insurer, files a statement of claim or application containing any false, incomplete, or misleading information may be guilty of insurance fraud. (In CT, insurance fraud is determined by a court of competent jurisdiction; in IN, KY, and OK, insurance fraud is a felony; in NV, insurance fraud is a Category D Felony). In AR, DC, LA, NJ, NM, PA, TN, and VA: Any person who knowingly presents false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. (In DC, TN, and VA, also denial of insurance benefits; in NJ, NM, and PA, civil fines and criminal penalties.)



American Public Life Insurance Company

A member of the American Fidelity Group.

January 2, 2011

NAIC Number: 60801
FEIN Number: 64-0349942

To Whom It May Concern:

American Fidelity Assurance Company, located at 2000 N. Classen Boulevard, Oklahoma City, Oklahoma, 73125, is hereby authorized to submit forms for approval to the Department of Insurance on behalf of American Public Life Insurance Company. Changes to the forms, as may be necessary to gain approval, are included in this authorization.

Sincerely,

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