

SERFF Tracking Number: ALST-127320817 State: Arkansas
Filing Company: American Heritage Life Insurance Company State Tracking Number: 49302
Company Tracking Number: ABJ4580AR
TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other
Product Name: Multiple
Project Name/Number: EOI Form/

Filing at a Glance

Company: American Heritage Life Insurance Company

Product Name: Multiple

SERFF Tr Num: ALST-127320817 State: Arkansas

TOI: H21 Health - Other

SERFF Status: Closed-Approved-
Closed State Tr Num: 49302

Sub-TOI: H21.000 Health - Other

Co Tr Num: ABJ4580AR

State Status: Approved-Closed

Filing Type: Form

Reviewer(s): Rosalind Minor

Authors: Jennifer Aiello, Lynn

Disposition Date: 07/15/2011

Bautista, Patti Hicks, Sara Welch,
Josefin Sison

Date Submitted: 07/14/2011

Disposition Status: Approved-
Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: EOI Form

Status of Filing in Domicile: Not Filed

Project Number:

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Group

Submission Type: New Submission

Group Market Size: Small and Large

Group Market Type: Employer

Overall Rate Impact:

Filing Status Changed: 07/15/2011

State Status Changed: 07/15/2011

Deemer Date:

Created By: Patti Hicks

Submitted By: Patti Hicks

Corresponding Filing Tracking Number:

PPACA: Not PPACA-Related

PPACA Notes: null

Filing Description:

Re: Filing for American Heritage Life Insurance Company

NAIC No. 60534

Form ABJ4580AR

To Whom It May Concern:

SERFF Tracking Number: ALST-127320817 State: Arkansas
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The above form is being submitted for your approval. ABJ4580AR is new and does not replace any form. This form will be used to enroll in and/or provide evidence of insurability for group products already approved by your department. The current products are as follows:

Marketing name Form Number Approval date Filing Number
Accident GVAP1(AR) 04-22-02 N/A
Cancer/Specified Disease GVCP2 08-01-00 N/A
Cancer/Specified Disease GVCP3AR 05-15-09 ALST-126130853 / 42305
Critical Illness GVCIP1AR 05-04-06 N/A
Critical Illness GVCIP2AR 03-29-10 ALST-126529305 / 45128
Dental G-DEN(AR)-P 04-05-01 N/A
Short Term Disability GVDIP 02-02-2011 ALST-126989580/47778
Hospital Indemnity GVSP1AR 10-18-04 N/A
Universal Life GUL22P 08-05-08 VFPC-125737190

The logo, address and phone number on this form will be the current logo, address and phone number of American Heritage Life Insurance Company. The bracketing on this form will allow us the ability to customize the form for particular groups by removing products the employer has chosen to not offer to their employees. In certain circumstances, we may not require full underwriting with our life and/or disability products; thus some of the medical questions will be deleted and the remaining ones re-numbered. This will result in a more streamlined and less confusing form for the employees to complete. Additional bracketing includes the following: the marketing names of these products will also be updated to match the marketing names used in the brochures the employees will be referencing when they enroll; and the Electronic Delivery of Certificates language is bracketed to allow for changes to the system requirements needed to receive certificates of insurance electronically. Additional explanation for bracketed information is further explained in the Statement of Variability. The language in the medical questions used on the forms will not be altered except as may be noted on the Statement of Variability.

If you have any questions regarding this filing, feel free to contact me at patti.hicks@allstate.com, or (904) 992-3424.

Sincerely,

Patti Hicks
Senior Compliance Analyst
Compliance Department

Company and Contact

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Filing Contact Information

Patti Hicks, Senior Filing Analyst patti.hicks@allstate.com
 1776 American Heritage Life Drive 904-992-3424 [Phone]
 Jacksonville, FL 32224-6687 904-992-2975 [FAX]

Filing Company Information

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

Filing Fees

Fee Required? Yes
 Fee Amount: \$50.00
 Retaliatory? No
 Fee Explanation: \$50.00 x 1 Application/Enrollment Form = \$50.00
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
American Heritage Life Insurance Company	\$50.00	07/14/2011	49799440

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	07/15/2011	07/15/2011

SERFF Tracking Number: ALST-127320817 *State:* Arkansas
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Disposition

Disposition Date: 07/15/2011

Implementation Date:

Status: Approved-Closed

HHS Status: HHS Approved

State Review: Reviewed-No Actuary

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: ALST-127320817 State: Arkansas
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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	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	PPACA Uniform Compliance Summary	Approved-Closed	Yes
Supporting Document	Coverletter	Approved-Closed	Yes
Supporting Document	Variables	Approved-Closed	Yes
Form	Evidence of Insurability and Enrollment Form	Approved-Closed	Yes

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Form Schedule

Lead Form Number: ABJ4580AR

Schedule Item	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 07/15/2011	ABJ4580A R	Application/Evidence of Enrollment Insurability and Form Enrollment Form	Initial		51.400	ABJ4580AR.pdf



**[AMERICAN HERITAGE LIFE INSURANCE COMPANY (AHL)
1776 AMERICAN HERITAGE LIFE DRIVE
JACKSONVILLE, FLORIDA 32224]**

[PRODUCT] ENROLLMENT [AND] [EVIDENCE OF INSURABILITY] FORM

New Certificate Change/Increase Certificate # _____

Remarks:	This box for AHL Home Office use only
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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
RESIDENCE ADDRESS (Street or P.O. Box)	CITY	STATE	ZIP	
BIRTHDATE (MM/DD/YEAR)	[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		

[DEPENDENT COVERAGE SECTION

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

Abbreviations: Acc-Accident Can-Cancer CI-Critical Illness Den-Dental Hosp-Hospital LIR-Riders available with UL

Choose Plan(s):	Dependent's Name	Relationship	Sex	Date of Birth	Social Security Number
Acc Can CI Den Hosp LIR	(Last, First, M.I.)			(MM/DD/YEAR)	

[Are you changing any existing coverage due to a qualifying event such as marriage, birth, or adoption?

Accident	<input type="checkbox"/> Yes <input type="checkbox"/> No	Short-Term Disability	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer/Specified Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hospital Indemnity	<input type="checkbox"/> Yes <input type="checkbox"/> No
Critical Illness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Universal Life	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dental	<input type="checkbox"/> Yes <input type="checkbox"/> No		

If "Yes", please complete the following: Qualifying Event _____
 Date of Qualifying Event _____ Current Certificate Number _____

Do you currently have any of the following individual products with American Heritage Life Insurance Company (AHL)?
 Accident Yes No Cancer Yes No Critical Illness Yes No Disability Yes No Hospital Indemnity Yes No

If you answered "Yes" to any of the products, please enter the Policy Number _____

Do you wish to terminate this coverage? Yes No If "Yes", please enter effective date of termination _____]

[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		

ENROLLMENT [AND] [EVIDENCE OF INSURABILITY] FORM SELECTION OF COVERAGE SECTION

(Answer Yes or No and complete for each coverage selected)

[Accident] <input type="checkbox"/> Yes <input type="checkbox"/> No	Base Units _____	<input type="checkbox"/> Benefit Enhancement Rider Units: _____	<input type="checkbox"/> Employee Only <input type="checkbox"/> Employee+Spouse <input type="checkbox"/> Employee+Child(ren) <input type="checkbox"/> Family	Section 125 <input type="checkbox"/> Yes <input type="checkbox"/> No	Total Mode Premium \$ _____
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Optional Disability Riders for Employee <input type="checkbox"/> Off the Job Accident <input type="checkbox"/> Off the Job Accident and Sickness <input type="checkbox"/> On and Off the Job Accident <input type="checkbox"/> On and Off the Job Accident and Sickness				Employee Monthly Salary \$ _____	Rider Units _____
--	--	--	--	-------------------------------------	----------------------

Optional Disability Riders for Spouse <input type="checkbox"/> On and Off the Job Accident for Insured Spouse* <input type="checkbox"/> On and Off the Job Accident and Sickness for Insured Spouse* *Available only when Employee + Spouse or Family coverage is selected and the insured spouse has worked 25 hours per week for 3 or more consecutive months.				Spouse Monthly Salary \$ _____	Rider Units _____
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Strike/Layoff Riders: (Only one Rider may be selected.)
 Continuation During Strike or Layoff Rider Premium Refund Upon Layoff Rider **(Not available on Section 125 plans)**]

[Cancer/Specified Disease (GVCP2)] <input type="checkbox"/> Yes <input type="checkbox"/> No	Plan _____	<input type="checkbox"/> Employee Only <input type="checkbox"/> Family	Section 125 <input type="checkbox"/> Yes <input type="checkbox"/> No	Total Mode Premium \$ _____
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Benefits	Hospital	Radiation / Chemotherapy	Surgery Related	Misc.	Cancer Initial Diagnosis Option <input type="checkbox"/>	Intensive Care Option <input type="checkbox"/>	Cancer Screening Option <input type="checkbox"/>
Units				1]

[Cancer/Specified Disease (GVCP3)] <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Employee Only <input type="checkbox"/> Employee+Spouse <input type="checkbox"/> Employee+Child(ren) <input type="checkbox"/> Family	Section 125 <input type="checkbox"/> Yes <input type="checkbox"/> No	Total Mode Premium \$ _____
---	---	---	--------------------------------

Benefits	Hospital	Radiation / Chemotherapy	Surgery Related	Misc.	Cancer Initial Diagnosis Option <input type="checkbox"/>	Intensive Care Option <input type="checkbox"/>	Wellness Option <input type="checkbox"/>
Units				1			

Strike/Layoff Riders: (Only one Rider may be selected.)
 Continuation During Strike or Layoff Rider Premium Refund Upon Layoff Rider **(Not available on Section 125 plans)**]

[Critical Illness (GVCIP1)] (My Lifeline) <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Employee Only <input type="checkbox"/> Employee+Spouse <input type="checkbox"/> Employee+Child(ren) <input type="checkbox"/> Family	Section 125 <input type="checkbox"/> Yes <input type="checkbox"/> No	Total Mode Premium \$ _____
---	---	---	--------------------------------

Basic Benefit Amount \$ _____ If covered, Basic Benefit amount for spouse or other dependents is 50% of the employee's.	Critical Illness Cancer Option <input type="checkbox"/>	Recurrence Option <input type="checkbox"/>	Wellness Option <input type="checkbox"/> Units: _____]
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[Critical Illness (GVCIP2)] <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Employee Only <input type="checkbox"/> Employee+Spouse <input type="checkbox"/> Employee+Child(ren) <input type="checkbox"/> Family	Section 125 <input type="checkbox"/> Yes <input type="checkbox"/> No	Basic Benefit Amount \$ _____ If covered, Basic Benefit amount for spouse or other dependents is 50% of the employee's.	Total Mode Premium \$ _____
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Cancer CI Option <input type="checkbox"/>	2 nd Event Cancer CI Option <input type="checkbox"/>	2 nd Event CI Option <input type="checkbox"/>	Supp. CI Option I (HIV) <input type="checkbox"/>	Supp. CI Option II <input type="checkbox"/>	Inc. CI Benefit <input type="checkbox"/> Units: _____	Wellness Option <input type="checkbox"/> Units: _____
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Strike/Layoff Riders: (Only one Rider may be selected.)
 Continuation During Strike or Layoff Rider Premium Refund Upon Layoff Rider **(Not available on Section 125 plans)**]

ENROLLMENT [AND] [EVIDENCE OF INSURABILITY] FORM

SELECTION OF COVERAGE SECTION

(Answer Yes or No and complete for each coverage selected)

[Heritage Choice Dental] <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Plan 1 <input type="checkbox"/> Plan 4 <input type="checkbox"/> Plan 2 <input type="checkbox"/> Plan 5 <input type="checkbox"/> Plan 3	<input type="checkbox"/> Employee Only <input type="checkbox"/> Employee+One <input type="checkbox"/> Family	Section 125 <input type="checkbox"/> Yes <input type="checkbox"/> No	Total Mode Premium \$ _____
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Were you covered under your Employer's prior Dental Plan? Yes No
 If "Yes", please enter the date that coverage was effective _____]

[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 \$ _____
	Monthly Benefit \$ _____	Benefit Period _____ Months		

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: _____]

[Hospital Indemnity] <input type="checkbox"/> Yes <input type="checkbox"/> No	Plan _____	<input type="checkbox"/> Employee Only <input type="checkbox"/> Employee+Spouse <input type="checkbox"/> Employee+Child(ren) <input type="checkbox"/> Family	Section 125 <input type="checkbox"/> Yes <input type="checkbox"/> No	Total Mode Premium \$ _____
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Benefits	Hospital Related	Surgery / Inpatient Physician	Outpatient Related	Diagnostic / Wellness Option <input type="checkbox"/>	Prescription Drug Option <input type="checkbox"/>	Disability Rider <input type="checkbox"/>	Life Rider <input type="checkbox"/>
Units						1	

Strike/Layoff Riders: (Only one Rider may be selected.)
 Continuation During Strike or Layoff Rider Premium Refund Upon Layoff Rider **(Not available on Section 125 plans)**]

ENROLLMENT [AND] [EVIDENCE OF INSURABILITY] FORM

SELECTION OF COVERAGE SECTION

(Answer Yes or No and complete for each coverage selected)

[Universal Life]		<input type="checkbox"/> CGI <input type="checkbox"/> GI (Employee only) <input type="checkbox"/> SI			Death Benefit Option		Face Amount		Total Mode Premium			
<input type="checkbox"/> Yes <input type="checkbox"/> No					<input type="checkbox"/> 1 <input type="checkbox"/> 2		\$ _____		\$ _____			
Life Riders	Rider	Rider	Rider	Rider	Rider	Rider	Rider	Rider	Rider	Rider		
Units/Amt												
If this coverage is for your spouse, your child or grandchild, complete this section.												
NAME (Last, First, M.I.)				<input type="checkbox"/> Spouse <input type="checkbox"/> Child		<input type="checkbox"/> M		SOCIAL SECURITY NUMBER		BIRTHDATE (MM/DD/YYYY)		
				<input type="checkbox"/> Grandchild		<input type="checkbox"/> F						
RESIDENCE ADDRESS					CITY			STATE		ZIP		
OCCUPATION			EMPLOYER			ANNUAL SALARY			PHONE NUMBER			
						\$ _____						
OWNER'S NAME AND RESIDENCE ADDRESS						CITY			STATE		ZIP	
PRIMARY BENEFICIARY FULL NAME		AGE		RELATIONSHIP		CONTINGENT BENEFICIARY FULL NAME		AGE		RELATIONSHIP		
[Replacement and Existing Insurance Section (Must Answer)												
1a. Replacement. Proposed Insured. Is this insurance to replace or change any existing life coverage? If yes, indicate product being replaced or changed and complete replacement form provided by your producer, if required by your state.										<input type="checkbox"/> Yes <input type="checkbox"/> No		
_____ _____												
1b. Producer. To your knowledge, is change or replacement involved?										<input type="checkbox"/> Yes <input type="checkbox"/> No		
2a. Existing Insurance. Proposed Insured. Is there any other life insurance in force or applied for on the proposed insured? If yes, list company name, policy number, year issued, type of coverage, and amount of benefit.										<input type="checkbox"/> Yes <input type="checkbox"/> No		
_____ _____												
2b. Producer. To your knowledge, does the proposed insured have existing coverage in force?										<input type="checkbox"/> Yes <input type="checkbox"/> No		
Illustration Regulation Certification (Must Answer)												
3a. Illustration Certification. Proposed Insured. The Certificateholder/Insured certifies that no illustration conforming to the coverage applied for was provided, but that an illustration conforming to the coverage issued will be provided upon delivery of the certificate. If no, complete the applicable illustration certification form provided, if required in your state.										<input type="checkbox"/> Yes <input type="checkbox"/> No		
3b. Producer. The Producer certifies that no illustration conforming to the coverage applied for was provided, but that an illustration conforming to the coverage issued will be provided upon delivery of the certificate. If no, complete the applicable illustration certification form provided, if required in your state.										<input type="checkbox"/> Yes <input type="checkbox"/> No		

ENROLLMENT [AND] [EVIDENCE OF INSURABILITY] FORM

EVIDENCE OF INSURABILITY SECTION

(Please complete each question applicable to coverages selected. [Does not apply to Dental.])

Abbreviations: EE - Employee [SP - Spouse] [CH - Child(ren)]

Non-Medical Questions		EE	SP	CH
[Cancer, Disability, Critical Illness, Hospital Indemnity, Life & Accident with Sickness Disability Rider	1. Is any person to be insured (employee and the employee's spouse if applying for life and/or accident disability rider) actively at work, for wage or profit, now and has he/she worked at least 20 hours each week performing all duties of his/her regular occupation at his/her regular place of employment for at least 3 months except for minor illness or injury of 1 week or less, or normal pregnancy?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	N/A
Critical Illness & Life	2. Has any person to be insured (employee or spouse), in the last 12 months, used tobacco in any form?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	N/A
[If any of the questions below are answered "yes", please list the required health history on page [7].]				
Medical Questions		EE	SP	CH
Cancer, Critical Illness, Disability, Hospital Indemnity, Life & Accident with Sickness Disability Rider	3. Is any person to be insured, now being treated, or in the last 10 years, been treated or diagnosed by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC), or tested positive for antigens or antibodies to an AIDS virus?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
CGI Life	4. Has any person to be insured, in the last 6 months, been disabled or hospitalized for anything other than normal pregnancy, lacerations or broken bones not related to a health condition?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
SI Life	5. Has any person to be insured had any of the following? •Anemia (other than iron deficiency) •Anxiety, depression or other mental or nervous illness (other than moderate severity controlled with medication, with no suicide attempts or hospitalizations) •Asthma (other than taking non-steroidal medication as needed with no hospitalizations), or any other lung disorder •Cancer, except basal cell carcinoma •Diabetes •Epilepsy with a seizure within the last 2 years •Gastric bypass within the last 2 years •Heart attack, cardiomyopathy, congestive heart failure, heart murmur (unless not taking any medications), angioplasty, coronary artery bypass surgery, coronary artery disease, stent, pacemaker, heart valve replacement or any other heart disorder •Hemophilia •Hepatitis •Kidney Disease involving dialysis or chronic renal failure •Liver Disease •Lou Gehrig's Disease (ALS) •Lupus •Multiple Sclerosis •Muscular Dystrophy •Parkinson's Disease, scleroderma, polymyositis, or fibromyalgia •Stroke including aneurysm, transient ischemic attack (TIA), arteriovenous malformation •Transplant of any organ •Been counseled for, or excessively used, alcohol or any type of drugs	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Critical Illness, Disability, Hospital Indemnity, Intensive Care, Life & Accident with Sickness Disability Rider	6. Has any person to be insured, in the last 5 years, been diagnosed by a licensed health practitioner with a systolic blood pressure reading higher than 150 more than once or a diastolic blood pressure reading higher than 100 more than once?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Disability, SI Life & Accident with Sickness Disability Riders	7. Has any person to be insured, in the last 3 years, had his/her driver's license suspended or revoked or been convicted of reckless or drunken driving and/or been involved in 3 or more motor vehicle accidents?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer, Critical Illness Cancer Rider, Disability, Hospital Indemnity & Accident with Sickness Disability Rider	8a. Has any person to be insured ever been diagnosed or treated for any type of cancer, other than basal cell carcinoma?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	8b. [If the answer to [8a.] is yes,] has any person to be insured ever been diagnosed with, or treated for, Leukemia, Hodgkin's Disease, Lymphoma, or Cancer with any lymph node involvement or more than one metastasis?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	8c. [If the answer to [8a.] is yes,] has any person to be insured, in the last 5 years, been diagnosed with or received treatment for any other type of cancer (other than those listed in [8b.] and/or basal cell carcinoma)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

**ENROLLMENT [AND] [EVIDENCE OF INSURABILITY] FORM
EVIDENCE OF INSURABILITY SECTION**

(Please complete each question applicable to coverages selected. [Does not apply to Dental.])

Abbreviations: EE - Employee [SP - Spouse] [CH - Child(ren)]

If any of the questions below are answered "yes", please list the required health history on page [7].

Medical Questions (Continued)		EE	SP	CH								
[Critical Illness, Disability, Hospital Indemnity & Accident with Sickness Disability Rider	9. Has any person to be insured, in the last 2 years, had any disease, impairment of, or treatment (other than minor illness) for any of the following? <ul style="list-style-type: none"> •Asthma •Central nervous system (to include Multiple Sclerosis or Muscular Dystrophy) •Chronic fatigue syndrome •Diabetes •Emphysema •Epilepsy •Fibromyalgia •Heart •Kidneys •Liver •Lungs •Lupus •Mental or nervous condition •Parkinson's Disease •Pancreas •Paralysis •Rheumatoid arthritis •Been counseled for alcohol or drug abuse 	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No								
Disability & Accident with Sickness Disability Rider	10. Has any person to be insured, in the last 2 years, had or been treated by a licensed health care practitioner for any disorder of the back or neck?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No								
Cancer with Intensive Care Benefit	11. Has any person to be insured, in the last 5 years, been treated for a stroke or transient ischemic attack (TIA), a heart attack, a heart condition, heart trouble, any abnormality of the heart, or any artery disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No								
Critical Illness, Disability, Hospital Indemnity, Life & Accident with Sickness Disability Rider	12. Has any person to be insured, in the last 5 years, had any medical or surgical procedures (including organ transplant) advised or recommended by a physician but not done at this time?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No								
Critical Illness Supplemental Benefit Options	13a. Has any person to be insured, in the last 10 years, received any advice, treatment, or consultation for Alzheimer's Disease, dementia, senility or organic brain syndrome?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No								
	13b. Has any person to be insured, in the last 10 years, been diagnosed with or received treatment for macular degeneration, glaucoma, optic neuritis, or cataracts?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No								
	13c. Has any person to be insured, in the last 10 years, had an average hearing threshold sensitivity for air conduction of 40 decibels or greater?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No								
Critical Illness (over \$50,000) Life (over \$150,000)	14. Please indicate the names and addresses of all physicians for each person to be insured; use the required health history section, on page [7] for additional explanations.	N/A	N/A	N/A								
Cancer	15. Has any person to be insured ever been diagnosed with or treated by a licensed health care practitioner for any of the following? <ul style="list-style-type: none"> •Addison's Disease •Brucellosis •Cerebrospinal meningitis •Cystic Fibrosis •Encephalitis •Hansen's Disease •Hepatitis (Chronic B or Chronic C with liver failure or hepatoma) •Legionnaire's Disease •Lou Gehrig's Disease (ALS) •Lyme Disease •Muscular Dystrophy •Multiple Sclerosis •Myasthenia Gravis •Osteomyelitis •Primary Biliary Cirrhosis •Primary Sclerosing Cholangitis •Reye's Syndrome •Rocky Mountain Spotted Fever •Sickle Cell Anemia •Systemic Lupus Erythematosus •Tetanus •Tuberculosis •Thalassemia •Tularemia •Typhoid Fever 	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No								
Life, Critical Illness, Disability, Cancer with Intensive Care Benefit, Hospital Indemnity & Accident with Sickness Disability Rider	16. Indicate Height and Weight: <table border="0" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%;">Employee:</td> <td style="width: 33%;">Spouse:</td> <td style="width: 33%;">Child:</td> <td></td> </tr> <tr> <td>Height:</td> <td>Weight:</td> <td>Height:</td> <td>Weight:</td> </tr> </table>				Employee:	Spouse:	Child:		Height:	Weight:	Height:	Weight:
Employee:	Spouse:	Child:										
Height:	Weight:	Height:	Weight:									

ENROLLMENT [AND] [EVIDENCE OF INSURABILITY] FORM

[REQUIRED HEALTH HISTORY

List physician's name, address and telephone number

Name of Proposed Insured	Nature of Illness/Injury or Medical Attention/Reason Last Consulted	Date and/or Duration	Name, Address and Telephone Number of Physician or Hospital/Clinic

Use this space for any additional explanation of questions on previous pages. Indicate the applicable question number and person to whom it applies. 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 remain covered. 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.]

REPRESENTATION, [UNDERSTANDING] [AND] [AUTHORIZATIONS]

[REPRESENTATION. I REPRESENT that the statements and answers provided are true, complete and correctly recorded and I understand that any misstatement or misrepresentation may result in loss of coverage. • **UNDERSTANDING. I [UNDERSTAND** that the "effective date" of my coverage for health insurance coverages will be the effective date of the coverage, not the date I enroll. I also] understand that my deductions for the coverage(s) may begin before the effective date of my coverage(s) and that this does not change the effective date of coverage. If the coverage(s) is (are) not issued, AHL will refund any deductions it receives. I also understand that no producer (agent) has authority to waive any answer or otherwise modify this enrollment. 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.

[• PREMIUM DEDUCTION AUTHORIZATION. I AUTHORIZE my employer to deduct from my salary or wages, if applicable, the necessary premium for the coverages requested.] • **AUTHORIZATION TO OBTAIN AND DISCLOSE CERTAIN DATA (FOR SI LIFE AND CRITICAL ILLNESS). I AUTHORIZE** any physician, medical practitioner, hospital, clinic or other medical facility, Pharmacy Benefit Managers, insurance company, the Medical Information Bureau (MIB, Inc.) or other organization, institution or person, that has records or knowledge of me or my health including my prescription medication history to give to AHL, its subsidiaries or its reinsurers any information. I understand that AHL or its reinsurers make a brief report about me to MIB, Inc. I acknowledge receipt of the Important Notice About Privacy and MIB Notice form. A copy of this authorization is as valid as the original. This authorization applies to any dependent on whom insurance is requested. This authorization is valid for 24 months from the date signed. I understand that I may revoke this authorization at any time by notifying AHL in writing of my desire to do so.

FRAUD NOTICE: Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent act, which is a crime and subjects such person to criminal and civil penalties.]

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

[Spouse's Signature _____ Signed at _____ Date Signed _____ **]**
(If applying for life) (City and State)

[Producer's Statement. I certify that to the best of my knowledge and belief the information on this form is complete, accurate and correctly recorded.

Signature of Producer: _____ Print Producer's Name: _____ **]**

IMPORTANT NOTICE ABOUT PRIVACY:

In processing your application, an investigative report may be made. Information is obtained through interviews with third parties, such as family members, business associates, financial sources, friends, neighbors, or others with whom you are acquainted. This inquiry includes information as to your character, general information and personal characteristics. In certain limited circumstances, we are allowed by law to disclose necessary items of personal information to third parties without your specific authorization. You have the right to make a written request within a reasonable period of time for a complete and accurate disclosure of additional information concerning the nature and scope of the investigation. No information obtained from the Medical Information Bureau pertaining to Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS) will affect the issuance or the underwriting of this coverage except, upon written consent, to be medically tested for HIV or AIDS and the results of such testing prove positive.

GIN/MIB**(08/11)****MIB NOTICE:**

Information regarding your insurability will be treated as confidential. We or our reinsurers may, however, make a brief report to the Medical Information Bureau (Bureau), a non-profit organization of life insurance companies, which operates an information exchange for its members. If you apply to another Bureau member company for life or health insurance coverage or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information in its file. Upon receipt of a request from you, the Bureau arranges disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, contact the Bureau and seek a correction in accordance with the procedure set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734, PH. 866-692-6901 (TTY 866-346-3642 for hearing impaired). American Heritage Life Insurance Company or its reinsurers may release information in its file to other insurance companies that you apply to for life or health insurance, or submit a claim to for benefits. However, no specific information pertaining to Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS) will be disclosed to anyone outside the company or its employees, insurance affiliates, agents or reinsurers, except to a physician designated by the applicant, in writing, or in the absence of such designation, to the State Department of Health.

GIN/MIB**(03/08)**

SERFF Tracking Number: ALST-127320817 State: Arkansas
 Filing Company: American Heritage Life Insurance Company State Tracking Number: 49302
 Company Tracking Number: ABJ4580AR
 TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other
 Product Name: Multiple
 Project Name/Number: EOI Form/

Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification Comments: Attachment: Readability Certification AR.pdf	Approved-Closed	07/15/2011
Bypassed - Item: Application Bypass Reason: N/A- This is an application/enrollment form filing. Comments:	Approved-Closed	07/15/2011
Bypassed - Item: Health - Actuarial Justification Bypass Reason: N/A- This is an application/enrollment form filing. Comments:	Approved-Closed	07/15/2011
Bypassed - Item: Outline of Coverage Bypass Reason: N/A- This is an application/enrollment form filing. Comments:	Approved-Closed	07/15/2011
Bypassed - Item: PPACA Uniform Compliance Summary Bypass Reason: N/A- This is an application/enrollment form filing. Comments:	Approved-Closed	07/15/2011

SERFF Tracking Number: ALST-127320817 State: Arkansas
Filing Company: American Heritage Life Insurance Company State Tracking Number: 49302
Company Tracking Number: ABJ4580AR
TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other
Product Name: Multiple
Project Name/Number: EOI Form/

Item Status: Approved-Closed
Status Date: 07/15/2011
Satisfied - Item: Coverletter
Comments:
Attachment:
Coverletter AR.pdf

Item Status: Approved-Closed
Status Date: 07/15/2011
Satisfied - Item: Variables
Comments:
Attachment:
ABJ4580 Variables.pdf

AMERICAN HERITAGE LIFE INSURANCE COMPANY

Jacksonville, Florida 32224-6687

To the Forms 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>
ABJ4580AR	51.4

Date: July 14, 2011



Diane Ierna
Assistant Vice President, Compliance Department



Patti Hicks
Senior Compliance Analyst
Group Products
Compliance Department

July 14, 2011

Life & Health Division
Arkansas Insurance Department
1200 West Third Street
Little Rock, AR 72201

Re: Filing for American Heritage Life Insurance Company
NAIC No. 60534
Form ABJ4580AR

To Whom It May Concern:

The above form is being submitted for your approval. ABJ4580AR is new and does not replace any form. This form will be used to enroll in and/or provide evidence of insurability for group products already approved by your department. The current products are as follows:

Marketing name	Form Number	Approval date	Filing Number
Accident	GVAP1(AR)	04-22-02	N/A
Cancer/Specified Disease	GVCP2	08-01-00	N/A
Cancer/Specified Disease	GVCP3AR	05-15-09	ALST-126130853 / 42305
Critical Illness	GVCIP1AR	05-04-06	N/A
Critical Illness	GVCIP2AR	03-29-10	ALST-126529305 / 45128
Dental	G-DEN(AR)-P	04-05-01	N/A
Short Term Disability	GVDIP	02-02-2011	ALST-126989580/47778
Hospital Indemnity	GVSP1AR	10-18-04	N/A
Universal Life	GUL22P	08-05-08	VFCP-125737190

The logo, address and phone number on this form will be the current logo, address and phone number of American Heritage Life Insurance Company. The bracketing on this form will allow us the ability to customize the form for particular groups by removing products the employer has chosen to not offer to their employees. In certain circumstances, we may not require full underwriting with our life and/or disability products; thus some of the medical questions will be deleted and the remaining ones re-numbered. This will result in a more streamlined and less confusing form for the employees to complete. Additional bracketing includes the following: the marketing names of these products will also be updated to match the marketing names used in the brochures the employees will be referencing when they enroll; and the Electronic Delivery of Certificates language is bracketed to allow for changes to the system requirements needed to receive certificates of insurance electronically. Additional explanation for bracketed information is further explained in the Statement of Variability. The language in the medical questions used on the forms will not be altered except as may be noted on the Statement of Variability.

If you have any questions regarding this filing, feel free to contact me at patti.hicks@allstate.com, or (904) 992-3424.

Sincerely,

A handwritten signature in black ink that reads "Patti Hicks".

Patti Hicks
Senior Compliance Analyst
Compliance Department

American Heritage Life Insurance Company

1776 American Heritage Life Drive Jacksonville, FL 32224 Phone 904.992.3424 Fax 904.992.2975 E-mail: patti.hicks@allstate.com

American Heritage Life Insurance Company (AHL) Variables for Enrollment and Evidence of Insurability Form (ABJ4580)

This form will be used by employees and members to enroll in coverage and to provide medical information to be used for underwriting purposes. No medical questions will be asked for Dental, this product is included on this form for enrollment only so that applicants who are being offered multiple products and need to answer medical questions may do so on one form. The following explains the variables included in the form.

1. The address and logo will be the current address and logo of American Heritage Life Insurance Company. In the title, "Evidence of Insurability" will be deleted for guaranteed issue groups. Also, the products that the employer will be offering will be listed in the title.
2. The page numbers at the bottom of each page will be adjusted as text is removed for customized forms.
3. If agreed to by the employer and us, some items in the "General Information Section" will be deleted. This includes Marital Status, Phone Number, and Plant or Division.
4. If an employer is not offering coverage for dependents, the entire "Dependent Coverage Section" will be deleted. If this form is customized for a specific group, any coverage(s) not being offered by the employer will be deleted from the "Dependent Coverage Section".
5. If this form is customized for a specific group, any coverage(s) not being offered by the employer will be deleted from the box that asks whether the applicant is changing any coverage.
6. The Premium/Billing Mode box is for our home office use only and may be adjusted to allow us to capture applicant information in our systems.
7. The "Accident" box may be deleted in its entirety if the form is customized for a specific group and the employer has chosen not to offer this coverage to their employees. The marketing name of this product may also be updated to match the marketing name used in the brochure the employees will be referencing when they enroll. We may also remove reference to dependent coverage if dependent coverage will not be offered by the employer. Any riders not being offered by the employer may also be deleted.
8. The "Cancer (GVCP2)" box may be deleted in its entirety if the form is customized for a specific group and the employer has chosen not to offer this coverage to their employees. The marketing name of this product may also be updated to match the marketing name used in the brochure the employees will be referencing when they enroll. We may also remove reference to family coverage if family coverage will not be offered by the employer.
9. The "Cancer (GVCP3)" box may be deleted in its entirety if the form is customized for a specific group and the employer has chosen not to offer this coverage to their employees. The marketing name of this product may also be updated to match the marketing name used in the brochure the employees will be referencing when they enroll. We may also remove reference to dependent coverage if dependent coverage will not be offered by the employer. Any riders not being offered by the employer may also be deleted.
10. The "Critical Illness (GVCIP1)" box may be deleted in its entirety if the form is customized for a specific group and the employer has chosen not to offer this coverage to their employees. The marketing name of this product may also be updated to match the marketing name used in the brochure the employees will be referencing when they enroll. We may also remove reference to dependent coverage if dependent coverage will not be offered by the employer.
11. The "Critical Illness (GVCIP2)" box may be deleted in its entirety if the form is customized for a specific group and the employer has chosen not to offer this coverage to their employees. The marketing name of this product may also be updated to match the marketing name used in the

brochure the employees will be referencing when they enroll. We may also remove reference to dependent coverage if dependent coverage will not be offered by the employer. Any riders not being offered by the employer may also be deleted.

12. The “Heritage Choice Dental” box may be deleted in its entirety if the form is customized for a specific group and the employer has chosen not to offer this coverage to their employees. The marketing name of this product may also be updated to match the marketing name used in the brochure the employees will be referencing when they enroll. We may also remove reference to dependent coverage if dependent coverage will not be offered by the employer.
13. The “Short-Term Disability” box may be deleted in its entirety if the form is customized for a specific group and the employer has chosen not to offer this coverage to their employees. The marketing name of this product may also be updated to match the marketing name used in the brochure the employees will be referencing when they enroll.
14. The “Hospital Indemnity” box may be deleted in its entirety if the form is customized for a specific group and the employer has chosen not to offer this coverage to their employees. The marketing name of this product may also be updated to match the marketing name used in the brochure the employees will be referencing when they enroll. We may also remove reference to dependent coverage if dependent coverage will not be offered by the employer. Any riders not being offered by the employer may also be deleted.
15. The “Universal Life” box may be deleted in its entirety if the form is customized for a specific group and the employer has chosen not to offer this coverage to their employees. It may further be customized depending on what riders are offered and whether a producer is involved in the completion of the enrollment. The marketing name of this product may also be updated to match the marketing name used in the brochure the employees will be referencing when they enroll. We may also remove reference to dependent coverage if dependent coverage will not be offered by the employer.
16. If this form is customized for a specific group and Dental is not being offered to the group’s employees, the statement “Does not apply to Dental” in the “Evidence of Insurability Section” will be revised to remove the product.
17. We may remove reference to spouse or child(ren) if dependent coverage will not be offered by the employer. This also includes the columns for dependent answers (“yes”/“no” columns).
18. In certain circumstances, we may not require full underwriting with our Group products; thus some of the medical questions will be deleted and the remaining ones re-numbered to make customized forms for specific groups more stream-lined and easier for the applicant to complete. The language within any of the medical questions will not be altered. Any alteration of the actual question language will be filed with your department before use.
19. The “Required Health History Section” will be deleted for Guaranteed Issue groups.
20. The “Electronic Acceptance” section is bracketed to allow for changes to the system requirements needed to receive certificates of insurance electronically. We may also remove this section entirely if this form is customized for a particular group and the employer has chosen not to allow electronic delivery of certificates to their employees.
21. The “Representation” section is bracketed to allow for changes if this form is customized for a particular group and the employer chooses not to offer Life, Critical Illness, or Health coverages. The “Premium Deduction Authorization” section may be removed if the employer chooses to obtain this Authorization by another method.
22. The “Spouse’s Signature” section will be removed if the form is customized for a particular group and the employer has chosen not to offer spouse/dependent coverage to their employees.
23. The “Producer’s Statement” section will be removed if there is no producer involved in the enrollment.