

State: Arkansas **Filing Company:** American Public Life Insurance Company
TOI/Sub-TOI: H07G Group Health - Specified Disease - Limited Benefit/H07G.001 Critical Illness
Product Name: GCRIT11APLA.R912
Project Name/Number: GCRIT11APLA.R912/GCRIT11APLA.R912

Filing at a Glance

Company: American Public Life Insurance Company
Product Name: GCRIT11APLA.R912
State: Arkansas
TOI: H07G Group Health - Specified Disease - Limited Benefit
Sub-TOI: H07G.001 Critical Illness
Filing Type: Form
Date Submitted: 09/27/2012
SERFF Tr Num: AFDL-128705211
SERFF Status: Closed-Approved-Closed
State Tr Num:
State Status: Approved-Closed
Co Tr Num: GCRIT11APLA.R912

Implementation: On Approval
Date Requested:
Author(s): Shari Vick, Melissa Mahanes, Ashlie Snyder, Ann Hobson
Reviewer(s): Rosalind Minor (primary)
Disposition Date: 10/01/2012
Disposition Status: Approved-Closed
Implementation Date:

State Filing Description:

State: Arkansas **Filing Company:** American Public Life Insurance Company
TOI/Sub-TOI: H07G Group Health - Specified Disease - Limited Benefit/H07G.001 Critical Illness
Product Name: GCRIT11APLA.R912
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General Information

Project Name: GCRIT11APLA.R912 Status of Filing in Domicile: Pending
 Project Number: GCRIT11APLA.R912 Date Approved in Domicile:
 Requested Filing Mode: Informational 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 Overall Rate Impact:
 Filing Status Changed: 10/01/2012
 State Status Changed: 10/01/2012 Deemer Date:
 Created By: Melissa Mahanes Submitted By: Melissa Mahanes
 Corresponding Filing Tracking Number:

Filing Description:

American Fidelity Assurance Company is filing the above listed forms for approval with your Department on behalf of American Public Life Insurance Company. A letter of authorization is enclosed.

Enclosed for informational purposes is the above-mentioned application. This is a revised form and will replace the GCRIT11APLA previously approved by your department on 12/20/11 (Serff Tracking Number AFDL-127817728).

We inadvertently placed the Actively at Work question with the Simplified Issue Underwriting Medical questions on page 3. At this time, we are moving this question from page 3 to page 1 of the application. This is the only change being made at this time. We did not change any words on the page. We have not yet issued any Certificates of Insurance at this time; therefore, the enclosed application will be substituted for the GCRIT11APLA previously approved by your department. A changes highlighted document is enclosed for your convenience.

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

Thank you for your assistance with this matter. If you have any questions, please feel free to call me at contact information shown on the Companies and Contacts tab.

Company and Contact

Filing Contact Information

Melissa Mahanes, Compliance Analyst II melissa.mahanes@af-group.com
 2000 Classen Blvd 800-654-8489 [Phone] 2035 [Ext]
 Oklahoma City, OK 73106 405-523-5793 [FAX]

Filing Company Information

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

State: Arkansas **Filing Company:** American Public Life Insurance Company
TOI/Sub-TOI: H07G Group Health - Specified Disease - Limited Benefit/H07G.001 Critical Illness
Product Name: GCRIT11APLA.R912
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Filing Fees

Fee Required? Yes
Fee Amount: \$50.00
Retaliatory? No
Fee Explanation: \$50.00 /Form
Per Company: No

Company	Amount	Date Processed	Transaction #
American Public Life Insurance Company	\$50.00	09/27/2012	63166899

SERFF Tracking #: AFDL-128705211

State Tracking #:

Company Tracking #:

GCRIT11APLA.R912

State: Arkansas

Filing Company:

American Public Life Insurance Company

TOI/Sub-TOI: H07G Group Health - Specified Disease - Limited Benefit/H07G.001 Critical Illness

Product Name: GCRIT11APLA.R912

Project Name/Number: GCRIT11APLA.R912/GCRIT11APLA.R912

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	10/01/2012	10/01/2012

SERFF Tracking #:

AFDL-128705211

State Tracking #:

Company Tracking #:

GCRIT11APLA.R912

State:

Arkansas

Filing Company:

American Public Life Insurance Company

TOI/Sub-TOI:

H07G Group Health - Specified Disease - Limited Benefit/H07G.001 Critical Illness

Product Name:

GCRIT11APLA.R912

Project Name/Number:

GCRIT11APLA.R912/GCRIT11APLA.R912

Disposition

Disposition Date: 10/01/2012

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	GCRIT11APLA.R912 Changes Highlighted	Approved-Closed	Yes
Form	Group Critical Illness Certificate Application	Approved-Closed	Yes

State: Arkansas **Filing Company:** American Public Life Insurance Company
TOI/Sub-TOI: H07G Group Health - Specified Disease - Limited Benefit/H07G.001 Critical Illness
Product Name: GCRIT11APLA.R912
Project Name/Number: GCRIT11APLA.R912/GCRIT11APLA.R912

Form Schedule

Lead Form Number: GCRIT11APLA.R912

Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments
1	Approved-Closed 10/01/2012	GCRIT11APLA. R912	AEF	Group Critical Illness Certificate Application	Initial:	52.000	GCRIT11APLA.R912.pdf

Form Type Legend:

ADV	Advertising	AEF	Application/Enrollment Form
CER	Certificate	CERA	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	FND	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	NOC	Notice of Coverage
OTH	Other	OUT	Outline of Coverage
PJK	Policy Jacket	POL	Policy/Contract/Fraternal Certificate
POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	SCH	Schedule Pages

FOR AGENT USE ONLY:

Requested Effective Date:

- New Enrollment
- Family Status Change
- Benefit Change



American Public Life Insurance Company

A member of the American Fidelity Group®

2305 Lakeland Drive • Flowood, Mississippi 39232
Phone: (601) 936-6600 or (800) 256-8606
Fax: (877) 807-0911

FOR HOME OFFICE USE ONLY:

Effective Date: _____

PRD #: _____

Group #: _____

Revised: _____

Group Products • Application for Critical Illness Insurance • Payroll Market

PROPOSED INSURED'S INFORMATION

Last Name	First Name	MI	Sex	Birthdate Mo/Day/Yr	Age	Height Feet/Inches	Weight Lbs.	Social Security #
Applicant			<input type="checkbox"/> M <input type="checkbox"/> F					
Spouse (must reside w/ applicant)			<input type="checkbox"/> M <input type="checkbox"/> F					
Child 1			<input type="checkbox"/> M <input type="checkbox"/> F					
Child 2			<input type="checkbox"/> M <input type="checkbox"/> F					
Child 3			<input type="checkbox"/> M <input type="checkbox"/> F					
Child 4			<input type="checkbox"/> M <input type="checkbox"/> F					

Resident Address: Number & Street City State Zip Home Phone

Mailing Address: (if different) Number & Street City State Zip

Email Address:

APPLICANT

EMPLOYER

Full Time? Yes No Hours Per Week: _____
 Salary: \$ _____ Hourly Weekly Monthly Annually
 Occupation: _____ Hire Date: _____

Payroll Deduction Frequency: 12 13 24 26 52
 Skip Mode: 8 9 10 11 Indicate Months: _____

Name: _____
 City: _____ State: _____
 Work Phone: _____
 Master Policyholder Name: _____

BENEFICIARY INFORMATION

APPLICANT: Primary _____ Relationship _____
 Contingent _____ Relationship _____

CITIZENSHIP INFORMATION

Is/Are the person(s) to be insured and the beneficiary(ies) a citizen of the United States? Yes No (If No, give details.)

Full Name _____ Country of Citizenship _____
 Full Name _____ Country of Citizenship _____

CRITICAL ILLNESS PRODUCT SELECTION

Critical Illness Plan Selected Applicant Only Applicant and Spouse Applicant & Child(ren) Applicant & Family
 Has any form of nicotine been used in the last 12 months? Applicant: Yes No [Spouse: Yes No]
 [[BASIC] [ENHANCED] [ENHANCED PLUS]]

TOTAL AMOUNT OF COVERAGE:
 Critical Illness Benefit Amount (For Applicant's age 18-69): [\$5,000 \$10,000 \$15,000 \$20,000 \$25,000] ... \$
 Critical Illness Benefit Amount (For Applicant's age 70+): [\$2,500 \$5,000 \$7,500 \$10,000 \$12,500] \$
 [ADDITIONAL BENEFIT RIDERS:
 Cancer Critical Illness Rider \$]
Total Premium \$

Are you actively at work on a full time basis as defined by your employer for the last 60 days, except for normal pregnancy, minor illnesses or injury lasting 5 consecutive days or less?
 Applicant Yes No Spouse Yes No Child(ren) (NAME, if Yes)

SIMPLIFIED ISSUE UNDERWRITING AND MEDICAL QUESTIONS

Any person answering YES to the following questions is not eligible for coverage. If multiple children are to be covered, please list the first name of any child answering Yes on the line provided in that area.

	Applicant	Spouse	Child(ren) (NAME, if Yes)
[BASIC] [ENHANCED] [ENHANCED PLUS]		<input type="checkbox"/> Yes <input type="checkbox"/> No	
If applying for spouse coverage, is the spouse currently disabled?			
[ENHANCED PLUS]			<input type="checkbox"/> Yes <input type="checkbox"/> No
If applying for child coverage, is any child currently disabled?			
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is any person to be covered currently covered by Medicaid?			
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has any person to be insured had any positive test results indicating Human Immunodeficiency Virus (HIV), or been diagnosed as having Acquired Immunodeficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?			
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Within the last 10 years, has any person to be insured received medical advice, sought treatment (including medication), or been treated or diagnosed by a member of the medical profession for: heart attack (acute myocardial infarction), coronary artery disease (including coronary angioplasty or bypass surgery), disease of the heart or circulatory system, any abnormality of the heart, transient ischemic attack (TIA), stroke, 3 or more prescriptions taken for the control of high blood pressure, emphysema, chronic obstructive pulmonary disorder (COPD), organ failure or transplant, hepatitis B, C, or D, chronic pancreatitis, liver disease, diabetes, kidney disease (except kidney stones), systemic lupus?			
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Within the last 12 months, has any person to be insured received medical advice by a member of the medical profession to have any diagnostic tests, examinations, or consultations to determine the existence of any heart or circulatory condition or stroke; that have not been completed; or that results have not been received; or results were abnormal and no follow-up or resolution has occurred?			
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
[ENHANCED PLUS]			<input type="checkbox"/> Yes <input type="checkbox"/> No
Within the last 10 years, has any person to be insured received medical advice, sought treatment (including medication), or been treated or diagnosed by a member of the medical profession 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
Within the last 10 years, has any person to be insured received medical advice, sought treatment (including medication), or been treated or diagnosed by a member of the medical profession for: macular degeneration, glaucoma, optic neuritis, or cataracts which have not been corrected?			
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Within the last 10 years, has any person to be insured had an average hearing threshold sensitivity test for air conduction of 50 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
CANCER RIDER			<input type="checkbox"/> Yes <input type="checkbox"/> No
Within the last 10 years, has any person to be insured received medical advice, sought treatment (including medication), or been treated or diagnosed by a member of the medical profession for: cancer, carcinoma, sarcoma, leukemia, lymphoma, Hodgkin's Disease, melanoma, or a malignant tumor in any form?			
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
In the last 3 years has any person to be insured received medical advice, sought treatment (including medication), or been treated or diagnosed by a member of the medical profession for: skin cancer, including but not limited to basal cell carcinoma, squamous cell carcinoma, and carcinoma in-situ?			
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has any person to be insured ever received medical advice by a member of the medical profession to have any diagnostic tests, examinations, or consultations to determine the existence of cancer or skin cancer: that have not been completed; or that results have not been received; or results were abnormal and no follow-up or resolution has occurred?			
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Print Applicant's Name _____	Applicant's Initials _____	Date _____
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SERFF Tracking #:

AFDL-128705211

State Tracking #:**Company Tracking #:**

GCRIT11APLA.R912

State:

Arkansas

Filing Company:

American Public Life Insurance Company

TOI/Sub-TOI:

H07G Group Health - Specified Disease - Limited Benefit/H07G.001 Critical Illness

Product Name:

GCRIT11APLA.R912

Project Name/Number:

GCRIT11APLA.R912/GCRIT11APLA.R912

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	10/01/2012
Comments:			
Attachment(s):			
FleschCert.pdf			

		Item Status:	Status Date:
Satisfied - Item:	Application	Approved-Closed	10/01/2012
Comments:			
Attachment(s):			
GCRIT11APLA.R912.pdf			

		Item Status:	Status Date:
Satisfied - Item:	GCRIT11APLA.R912 Changes Highlighted	Approved-Closed	10/01/2012
Comments:			
Attachment(s):			
GCRIT11APLA.R912_RL.pdf			



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READABILITY CERTIFICATION

I hereby certify that policy forms enclosed on the Forms filing tab meet the minimum reading ease score required by the Insurance Code in your state.

The Flesch Score for each form, excluding defined terms and state mandated language, is:

Form Number	Description	Flesch Score	Word Count (For AR, VA)	Sentence Count (For VA)
GCRITEP11APL	Critical Illness Policy – Employer Paid	54	5120	318
GCRITEP11APLC	Critical Illness Certificate – Employer Paid	53	4899	220
GCRITV11APL	Critical Illness Policy – Voluntary	51	5567	343
GCRITV11APLC	Critical Illness Certificate – Voluntary	50	5634	337
DN87APL	Disclosure Notice	50	94	6
GCRIT11APLMA	Master Application	53	462	39
AMD1317APL	Cancer Critical Illness Rider	50	933	51
AMD1318APL	Health Screening Test Rider	64	358	17
AMD1319APL	Accident Critical Illness Rider	54	1094	72
AMD1320APL	Additional Critical Illness Rider	52	1138	67
AMD1321APL	Recurrence Rider	70	436	31
AMD1326APL	Waiver of Premium Rider	65	945	62
AMD1329APL	Amendment Rider	73	115	7
AMD1334APL	COBRA Election Amendment Rider	62	228	14
GCRIT11APLOC	Outline of Coverage (if applicable)	50	2016	118

The Flesch Score for each form, excluding defined terms, medical terminology and state mandated language, is:

GCRIT11APLA	Certificate Application	52	662	41
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Our Company uses Microsoft Word to calculate the Flesch Score. Microsoft Word does not provide a syllable count.

Alex Bagby, ASA, MAAA
Vice President and Chief Risk Officer

November 8, 2011
Date

FOR AGENT USE ONLY:

Requested Effective Date:

- New Enrollment
- Family Status Change
- Benefit Change



American Public Life Insurance Company

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 2305 Lakeland Drive • Flowood, Mississippi 39232
 Phone: (601) 936-6600 or (800) 256-8606
 Fax: (877) 807-0911

FOR HOME OFFICE USE ONLY:

Effective Date: _____

PRD #: _____

Group #: _____

Revised: _____

Group Products • Application for Critical Illness Insurance • Payroll Market

PROPOSED INSURED'S INFORMATION

Last Name	First Name	MI	Sex	Birthdate Mo/Day/Yr	Age	Height Feet/Inches	Weight Lbs.	Social Security #
Applicant			<input type="checkbox"/> M <input type="checkbox"/> F					
Spouse (must reside w/ applicant)			<input type="checkbox"/> M <input type="checkbox"/> F					
Child 1			<input type="checkbox"/> M <input type="checkbox"/> F					
Child 2			<input type="checkbox"/> M <input type="checkbox"/> F					
Child 3			<input type="checkbox"/> M <input type="checkbox"/> F					
Child 4			<input type="checkbox"/> M <input type="checkbox"/> F					

Resident Address: Number & Street _____ City _____ State _____ Zip _____ Home Phone _____

Mailing Address: (if different) Number & Street _____ City _____ State _____ Zip _____

Email Address: _____

APPLICANT

EMPLOYER

Full Time? Yes No Hours Per Week: _____
 Salary: \$ _____ Hourly Weekly Monthly Annually
 Occupation: _____ Hire Date: _____

Name: _____
 City: _____ State: _____
 Work Phone: _____

Payroll Deduction Frequency: 12 13 24 26 52
 Skip Mode: 8 9 10 11 Indicate Months: _____

Master Policyholder Name: _____

BENEFICIARY INFORMATION

APPLICANT: Primary _____ Relationship _____
 Contingent _____ Relationship _____

CITIZENSHIP INFORMATION

Is/Are the person(s) to be insured and the beneficiary(ies) a citizen of the United States? Yes No (If No, give details.)

Full Name _____ Country of Citizenship _____
 Full Name _____ Country of Citizenship _____

CRITICAL ILLNESS PRODUCT SELECTION

Critical Illness Plan Selected Applicant Only Applicant and Spouse Applicant & Child(ren) Applicant & Family
 Has any form of nicotine been used in the last 12 months? Applicant: Yes No [Spouse: Yes No]
 [[BASIC] [ENHANCED] [ENHANCED PLUS]]

Premium

TOTAL AMOUNT OF COVERAGE:
 Critical Illness Benefit Amount (For Applicant's age 18-69): [\$5,000 \$10,000 \$15,000 \$20,000 \$25,000] ... \$
 Critical Illness Benefit Amount (For Applicant's age 70+): [\$2,500 \$5,000 \$7,500 \$10,000 \$12,500] \$

[ADDITIONAL BENEFIT RIDERS:
 Cancer Critical Illness Rider \$]
Total Premium \$

Child(ren) (NAME, if Yes)

Are you actively at work on a full time basis as defined by your employer for the last 60 days, except for normal pregnancy, minor illnesses or injury lasting 5 consecutive days or less? Yes No

SIMPLIFIED ISSUE UNDERWRITING AND MEDICAL QUESTIONS

Any person answering YES to the following questions is not eligible for coverage. If multiple children are to be covered, please list the first name of any child answering Yes on the line provided in that area.

	Applicant	Spouse	Child(ren) (NAME, if Yes)
[BASIC] [ENHANCED] [ENHANCED PLUS]		<input type="checkbox"/> Yes <input type="checkbox"/> No	
If applying for spouse coverage, is the spouse currently disabled?			
[ENHANCED PLUS]			<input type="checkbox"/> Yes <input type="checkbox"/> No
If applying for child coverage, is any child currently disabled?			
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is any person to be covered currently covered by Medicaid?			
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has any person to be insured had any positive test results indicating Human Immunodeficiency Virus (HIV), or been diagnosed as having Acquired Immunodeficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?			
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Within the last 10 years, has any person to be insured received medical advice, sought treatment (including medication), or been treated or diagnosed by a member of the medical profession for: heart attack (acute myocardial infarction), coronary artery disease (including coronary angioplasty or bypass surgery), disease of the heart or circulatory system, any abnormality of the heart, transient ischemic attack (TIA), stroke, 3 or more prescriptions taken for the control of high blood pressure, emphysema, chronic obstructive pulmonary disorder (COPD), organ failure or transplant, hepatitis B, C, or D, chronic pancreatitis, liver disease, diabetes, kidney disease (except kidney stones), systemic lupus?			
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Within the last 12 months, has any person to be insured received medical advice by a member of the medical profession to have any diagnostic tests, examinations, or consultations to determine the existence of any heart or circulatory condition or stroke; that have not been completed; or that results have not been received; or results were abnormal and no follow-up or resolution has occurred?			
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
[ENHANCED PLUS]			<input type="checkbox"/> Yes <input type="checkbox"/> No
Within the last 10 years, has any person to be insured received medical advice, sought treatment (including medication), or been treated or diagnosed by a member of the medical profession 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
Within the last 10 years, has any person to be insured received medical advice, sought treatment (including medication), or been treated or diagnosed by a member of the medical profession for: macular degeneration, glaucoma, optic neuritis, or cataracts which have not been corrected?			
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Within the last 10 years, has any person to be insured had an average hearing threshold sensitivity test for air conduction of 50 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
CANCER RIDER			<input type="checkbox"/> Yes <input type="checkbox"/> No
Within the last 10 years, has any person to be insured received medical advice, sought treatment (including medication), or been treated or diagnosed by a member of the medical profession for: cancer, carcinoma, sarcoma, leukemia, lymphoma, Hodgkin's Disease, melanoma, or a malignant tumor in any form?			
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
In the last 3 years has any person to be insured received medical advice, sought treatment (including medication), or been treated or diagnosed by a member of the medical profession for: skin cancer, including but not limited to basal cell carcinoma, squamous cell carcinoma, and carcinoma in-situ?			
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has any person to be insured ever received medical advice by a member of the medical profession to have any diagnostic tests, examinations, or consultations to determine the existence of cancer or skin cancer: that have not been completed; or that results have not been received; or results were abnormal and no follow-up or resolution has occurred?			
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Print Applicant's Name _____ Applicant's Initials _____ Date _____

FOR AGENT USE ONLY:

Requested Effective Date:

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- Family Status Change
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Effective Date: _____

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Revised: _____

Group Products • Application for Critical Illness Insurance • Payroll Market

PROPOSED INSURED'S INFORMATION

Last Name	First Name	MI	Sex	Birthdate Mo/Day/Yr	Age	Height Feet/Inches	Weight Lbs.	Social Security #
Applicant			<input type="checkbox"/> M <input type="checkbox"/> F					
Spouse (must reside w/ applicant)			<input type="checkbox"/> M <input type="checkbox"/> F					
Child 1			<input type="checkbox"/> M <input type="checkbox"/> F					
Child 2			<input type="checkbox"/> M <input type="checkbox"/> F					
Child 3			<input type="checkbox"/> M <input type="checkbox"/> F					
Child 4			<input type="checkbox"/> M <input type="checkbox"/> F					

Resident Address: Number & Street City State Zip Home Phone

Mailing Address: (if different) Number & Street City State Zip

Email Address:

APPLICANT

EMPLOYER

Full Time? Yes No Hours Per Week: _____
 Salary: \$ _____ Hourly Weekly Monthly Annually
 Occupation: _____ Hire Date: _____

Payroll Deduction Frequency: 12 13 24 26 52
 Skip Mode: 8 9 10 11 Indicate Months: _____

Master Policyholder Name: _____
 Relationship: _____
 Contingent: _____ Relationship: _____

BENEFICIARY INFORMATION

CITIZENSHIP INFORMATION

Is/Are the person(s) to be insured and the beneficiary(ies) a citizen of the United States? Yes No (If No, give details.)

Full Name _____ Country of Citizenship _____
 Full Name _____ Country of Citizenship _____

CRITICAL ILLNESS PRODUCT SELECTION

Critical Illness Plan Selected Applicant Only Applicant and Spouse Applicant & Child(ren) Applicant & Family
 Has any form of nicotine been used in the last 12 months? Applicant: Yes No [Spouse: Yes No]
 [[BASIC] [ENHANCED] [ENHANCED PLUS]]

TOTAL AMOUNT OF COVERAGE:
 Critical Illness Benefit Amount (For Applicant's age 18-69): [\$5,000 \$10,000 \$15,000 \$20,000 \$25,000] ... \$
 Critical Illness Benefit Amount (For Applicant's age 70+): [\$2,500 \$5,000 \$7,500 \$10,000 \$12,500] \$
 [ADDITIONAL BENEFIT RIDERS:
 Cancer Critical Illness Rider \$]
 Total Premium \$

MOVED FROM SIMPLIFIED ISSUE UNDERWRITING SECTION TO HERE

Are you actively at work on a full time basis as defined by your employer for the last 60 days, except for normal pregnancy, minor illnesses or injury lasting 5 consecutive days or less? Yes No

Applicant Spouse Child(ren)
(NAME, if Yes)

SIMPLIFIED ISSUE UNDERWRITING AND MEDICAL QUESTIONS

Any person answering YES to the following questions is not eligible for coverage. If multiple children are to be covered, please list the first name of any child answering Yes on the line provided in that area.

		Applicant	Spouse	Child(ren) (NAME, if Yes)
[BASIC] [ENHANCED] [ENHANCED PLUS]	Are you actively at work on a full time basis as defined by your employer for the last 60 days, except for normal pregnancy, minor illnesses or injury lasting 5 consecutive days or less?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
[BASIC] [ENHANCED] [ENHANCED PLUS]	If applying for spouse coverage, is the spouse currently disabled?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
	If applying for child coverage, is any child currently disabled?			<input type="checkbox"/> Yes <input type="checkbox"/> No
	Is any person to be covered currently covered by Medicaid?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Has any person to be insured had any positive test results indicating Human Immunodeficiency Virus (HIV), or been diagnosed as having Acquired Immunodeficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Within the last 10 years, has any person to be insured received medical advice, sought treatment (including medication), or been treated or diagnosed by a member of the medical profession for: heart attack (acute myocardial infarction), coronary artery disease (including coronary angioplasty or bypass surgery), disease of the heart or circulatory system, any abnormality of the heart, transient ischemic attack (TIA), stroke, 3 or more prescriptions taken for the control of high blood pressure, emphysema, chronic obstructive pulmonary disorder (COPD), organ failure or transplant, hepatitis B, C, or D, chronic pancreatitis, liver disease, diabetes, kidney disease (except kidney stones), systemic lupus?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Within the last 12 months, has any person to be insured received medical advice by a member of the medical profession to have any diagnostic tests, examinations, or consultations to determine the existence of any heart or circulatory condition or stroke: that have not been completed; or that results have not been received; or results were abnormal and no follow-up or resolution has occurred?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
[ENHANCED PLUS]	Within the last 10 years, has any person to be insured received medical advice, sought treatment (including medication), or been treated or diagnosed by a member of the medical profession 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
	Within the last 10 years, has any person to be insured received medical advice, sought treatment (including medication), or been treated or diagnosed by a member of the medical profession for: macular degeneration, glaucoma, optic neuritis, or cataracts which have not been corrected?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Within the last 10 years, has any person to be insured had an average hearing threshold sensitivity test for air conduction of 50 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
CANCER RIDER	Within the last 10 years, has any person to be insured received medical advice, sought treatment (including medication), or been treated or diagnosed by a member of the medical profession for: cancer, carcinoma, sarcoma, leukemia, lymphoma, Hodgkin's Disease, melanoma, or a malignant tumor in any form?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	In the last 3 years has any person to be insured received medical advice, sought treatment (including medication), or been treated or diagnosed by a member of the medical profession for: skin cancer, including but not limited to basal cell carcinoma, squamous cell carcinoma, and carcinoma in-situ?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Has any person to be insured ever received medical advice by a member of the medical profession to have any diagnostic tests, examinations, or consultations to determine the existence of cancer or skin cancer: that have not been completed; or that results have not been received; or results were abnormal and no follow-up or resolution has occurred?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Print Applicant's Name _____ Applicant's Initials _____ Date _____