
State: Arkansas **Filing Company:** American Heritage Life Insurance Company
TOI/Sub-TOI: H21 Health - Other/H21.000 Health - Other
Product Name: ABJ703AR
Project Name/Number: /

Filing at a Glance

Company: American Heritage Life Insurance Company
Product Name: ABJ703AR
State: Arkansas
TOI: H21 Health - Other
Sub-TOI: H21.000 Health - Other
Filing Type: Form
Date Submitted: 08/27/2012
SERFF Tr Num: ALST-128658239
SERFF Status: Closed-Approved-Closed
State Tr Num:
State Status: Approved-Closed
Co Tr Num:

Implementation: On Approval
Date Requested:
Author(s): Patti Hicks, Sara Welch, Josefin Sison
Reviewer(s): Rosalind Minor (primary)
Disposition Date: 09/07/2012
Disposition Status: Approved-Closed
Implementation Date:

State Filing Description:

State: Arkansas
TOI/Sub-TOI: H21 Health - Other/H21.000 Health - Other
Product Name: ABJ703AR
Project Name/Number: /

Filing Company: American Heritage Life Insurance Company

General Information

Project Name: Status of Filing in Domicile: Pending
Project Number: Date Approved in Domicile:
Requested Filing Mode: Review & Approval Domicile Status Comments:
Explanation for Combination/Other: Market Type: Individual
Submission Type: New Submission Individual Market Type: Individual
Overall Rate Impact: Filing Status Changed: 09/07/2012
State Status Changed: 09/07/2012
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
Reinstatement Application ABJ703AR

To Whom It May Concern:

Form ABJ703AR is being submitted for your approval. This form will replace AWD703AR which was approved by your Department on 07-01-2004. This form will be used when persons wish to reinstate their coverage.

We have bracketed certain portions of the form to allow for flexibility as follows:

- The address on the form will be the current address of American Heritage Life Insurance Company.
- We may change the look back period on tobacco use in accordance with our current underwriting standards.
- We may delete use of prescription medication history in accordance with our current underwriting standards.
- We may delete the producer signature if there is no producer involved in the process.

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

Company and Contact

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]

State: Arkansas

Filing Company: American Heritage Life Insurance Company

TOI/Sub-TOI: H21 Health - Other/H21.000 Health - Other

Product Name: ABJ703AR

Project Name/Number: /

Filing Company Information

American Heritage Life Insurance Company
 ATTN: Legal/Compliance
 1776 American Heritage Life Drive
 Jacksonville, FL 32224-9983
 (904) 992-1776 ext. [Phone]

CoCode: 60534
 Group Code: 8
 Group Name: Allstate
 FEIN Number: 59-0781901

State of Domicile: Florida
 Company Type: Life and Health
 State ID Number:

Filing Fees

Fee Required? Yes
 Fee Amount: \$50.00
 Retaliatory? No
 Fee Explanation: \$50.00 x 1 form = \$50.00
 Per Company: No

Company	Amount	Date Processed	Transaction #
American Heritage Life Insurance Company	\$50.00	08/27/2012	62039079

SERFF Tracking #: ALST-128658239

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Company Tracking #:

State: Arkansas

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Filing Company:

American Heritage Life Insurance Company

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	09/07/2012	09/07/2012

SERFF Tracking #:

ALST-128658239

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

Arkansas

Filing Company:

American Heritage Life Insurance Company

TOI/Sub-TOI:

H21 Health - Other/H21.000 Health - Other

Product Name:

ABJ703AR

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/

Disposition

Disposition Date: 09/07/2012

Implementation Date:

Status: Approved-Closed

HHS Status: HHS Approved

State Review: Reviewed-No Actuary

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	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	PPACA Uniform Compliance Summary	Approved-Closed	Yes
Form	Application for Reinstatement	Approved-Closed	Yes

SERFF Tracking #:

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State: Arkansas

TOI/Sub-TOI: H21 Health - Other/H21.000 Health - Other

Product Name: ABJ703AR

Project Name/Number: /

Filing Company:

American Heritage Life Insurance Company

Form Schedule

Lead Form Number: ABJ703AR

Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments
1	Approved-Closed 09/07/2012	ABJ703AR	AEF	Application for Reinstatement	Revised: Replaced Form #: AWD703AR Previous Filing #:	50.200	ABJ703AR.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

AMERICAN HERITAGE LIFE INSURANCE COMPANY (AHL)
[1776 American Heritage Life Drive, Jacksonville, FL 32224]

Policy Number
Amount Due

Life/Health

Application for Reinstatement

(Please Print with Black Ink)

1. NAMES OF PERSONS PROPOSED FOR REINSTATED COVERAGE					Social Security Number	Height (Ft. In.)	Weight (Lbs.)
Last	First	M.I.	Relationship	Sex	Birthdate Mo/Day/Yr		
			Proposed Insured				

2. RESIDENCE ADDRESS No. and St. _____ City _____ State _____ Zip _____ Phone () _____	4. OCCUPATION Employer _____ For Disability Income Only (complete all) Exact Duties _____ Monthly Salary \$ _____ Other Significant Income \$ _____
3. TOBACCO HABITS Has any person to be insured used tobacco in any form in the last [12] months? <input type="checkbox"/> Yes <input type="checkbox"/> No	

(Answers to the questions below refer to the person named above if this is an individual policy; otherwise to all persons proposed for coverage. If any questions are answered "Yes," please list details on the lines provided.)

- Is the proposed insured 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? Yes No
- Has any person to be insured, in the last 5 years, had any impairment, illness or chronic disease, taken medication, consulted a doctor or other member of the medical profession, been a patient in a medical facility, or had any injury, or been told of any abnormal test results? Yes No
- Has any person to be insured, in the last 10 years, been diagnosed with or treated 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? Yes No
- Has any person to be insured been advised to or planned to consult a member of the medical profession for any medical problems he/she is having now? Yes No
- Has any person to be insured, in the last 5 years, been: declined; postponed; rated-up; or limited in connection with any application for, or reinstatement of insurance? Yes No Give full details.

I have read or had read to me the completed application and understand that any misstatement or misrepresentation in the application may result in loss of coverage. I represent that statements and answers given on this application are true, complete, and correctly recorded. **FRAUD NOTICE: Any person who knowingly and with the 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.**

I agree that a reinstatement resulting from this application shall be contestable as to the statements made in it for a period of 2 years from the date of reinstatement. I further agree that any benefit(s) applied for will not be effective until such insurance is issued by AHL and delivered to me while all persons to be insured remain in the same state of health as represented in this application.

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 also authorize AHL, or its reinsurers, to make a brief report of my personal health information to MIB, Inc. I understand that there is a possibility of redisclosure of any information disclosed pursuant to this authorization and that information, once disclosed, may no longer be protected by federal rules governing privacy and confidentiality. 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 a period of 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.

Signed At City/State	Date Signed
Signature of Proposed Insured	[Signature of Producer]

PLEASE KEEP A COPY OF THIS PAGE FOR YOUR RECORDS

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. You may request to be interviewed in connection with the report and may also receive a copy of the report upon request. 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.

IN/MIB-3

(2012)

MIB Notice:

Information regarding your insurability is treated as confidential. We or our reinsurers may, however, make a brief report to MIB, Inc. (MIB), a not-for-profit membership organization of life insurance companies, which operates an information exchange for its members. If you apply to another MIB member company for life or health insurance coverage or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file. Upon receipt of a request from you, MIB arranges disclosure of any information it may have in your file. If you question the accuracy of information in MIB's file, contact MIB and seek a correction in accordance with the procedure set forth in the Federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734, PH. #866-692-6901. American Heritage Life 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.

IN/MIB-3

(2012)

SERFF Tracking #:

ALST-128658239

State Tracking #:

Company Tracking #:

State:

Arkansas

Filing Company:

American Heritage Life Insurance Company

TOI/Sub-TOI:

H21 Health - Other/H21.000 Health - Other

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Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	09/07/2012
Comments:			
Attachment(s):			
Readability Certification AR.pdf			

		Item Status:	Status Date:
Bypassed - Item:	Application	Approved-Closed	09/07/2012
Bypass Reason:	Not applicable to this filing		
Comments:			

		Item Status:	Status Date:
Bypassed - Item:	Health - Actuarial Justification	Approved-Closed	09/07/2012
Bypass Reason:	Not applicable to this filing		
Comments:			

		Item Status:	Status Date:
Bypassed - Item:	Outline of Coverage	Approved-Closed	09/07/2012
Bypass Reason:	Not applicable to this filing		
Comments:			

		Item Status:	Status Date:
Bypassed - Item:	PPACA Uniform Compliance Summary	Approved-Closed	09/07/2012
Bypass Reason:	N/A - This is not a PPACA filing		
Comments:			

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>
ABJ703AR	50.2

Date: August 27, 2012



Diane Ierna
Assistant Vice President, Compliance Department