											□ Ne	w Policy			Change/	Increase P	olicy #		
APPLICATION FO	RIIF	F AND	HEALTH INSU	RANCE TO:	America	an He	eritage	Life	Insuran	ice Co	mpa	ny 1776	Ame	rican	Heritag	e Life Dri	ive, Jackson	ville,	Florida 32224
APPLICATION FOR LIFE AND HEALTH INSURANCE TO: American American American (if other than Proposed Insured)							Ī	mploye	ee's Date o	f Birth E	mploy	/ee/Payor S	Social	Securit	y Numbe	r Employ	ee's I.D. Numb	er	Date Hired
Proposed Insured	(Last,	First, M.I.	.)							☐ Emp.		□ Spouse	Heig	ht	Weigh	t So	ocial Security N	ımbe	r (if known)
Y						ty				□ Chile	Other State			Zip		Resident Phone Number			
2					Oity			I o.			`	, tato							
Employer								00	ccupation										
Employer Owner's Name and Address (if different than Proposed Insured's) City Primary Beneficiary - Full Name Age					City			State)	Zip	So	cial Security	/ Numb	er or T	ax I.D. N	umber (Ov	vner) Owner's	Emai	il Address
Primary Beneficia	ry - Fu	II Name		Age		Re	lationship	0	Contingen	t Benefic	iary - I	Full Name				Age		R	elationship
	Ple	ase (complete th	is sectio	n for p	erso	ns t	o be	insur	ed (e	хсе	pt infor	mati	on a	Iready	/ provi	ded above)	
Relationship to			Last Name		First Name		Date of B			Sex	1	Actively at Work*		Full Time Student		tudent L	Used tobacco in ar		orm in last 12 months?
Employee	Р											☐ Yes ☐	No	╀	N/A	_		Yes	□ No
Employee Spouse	E S											☐ Yes ☐			N/A				□ No
Dependent											N/A		☐ Yes		A. (20)	□ No		N/A	
Dependent											_	N/A		L	Yes [□ No □		N.	
Dependent Actively at work me	ana ti	ot halah	o is activaly at wa	ork now for wa	ne or profit :	and ha	s worke	d at le	ast 20 ho	urs each) wee	N/A k performi	ng all	duties			r occupation a		
of a marellances and family		2 month	an avant for mina	r illnoce or inii	Irv of 1 WAA	v or ic	ee or n	ormai i	nreananci	1									
ist additional deper		on sepa		ionship Codes	: E-Employe						er), G							er in	Mode Premium
The state of the s	Universal Life		Face Amount		Riders	Rid	Rider		er	Rider		Rider		Rider		Rider	Rider		Wode Premium
□ SI □ CGI			Death Benefit Op	Death Benefit Option □ 1 □ 2															\$
Term Life			Face Amount		Riders	Rider		Ride	r	Rider		Rider R		Rider	F	Rider	Rider		Mode Premium
	□ SI					mt												1	\$
4					Units/Amt			" D : 1				On The Job Rider		or I	Accident Rider		Section 1	25	Mode Premium
Disability			Monthly Salary		^y ^E		Elimination Period Days Acc.		r	Days Sid							□ Ye		Wode Fremium
□ SI □ CGI				Monthly Benef		Be	Benefit Period		o	Buyo olo				Units			_		
Occupation Class Preferred Standard				\$		_		Mont	ths					[□ Individu	al 🗆 Fami	ly		\$
Cancer					Riders		Rider		Rider		Ride	Rider R		Rider		der	Section 12		Mode Premium
(Plan	Type)		☐ Individual ☐ Family														— □ Ye		\$
Accident					Monthly S				Rider	Ride		er Rider			Rider		Section 1	25	Mode Premium
(Plan Type and Units)						_	APDIR	APBE		R APE		EXT APOPT		PTR1	R1 APHCR1		□ Yes □ No		¢
α								PI -			1	PSI		Dide- Di-		Distant	Section 125		\$ Mode Premium
SHOP (Hospital Indemnity)			Units:		Rider IHR1			ider BR1	Rider OPBR1	Ride OEAI	- 1	Rider Rider AHNR TR1			Rider ADIR1	Rider SDIR1	Section 1		MORE LIGHTINI
(Hoopital Illa			☐ Individual☐ Ind. & Children☐ Ind. & Spouse☐ Family		11 11 1	UNIN	' "	2 111	JI DIKI	- C-1	/			Ť			□ N		\$
□ SI □ CGI Heart/Stroke					Riders		Rider					Rider		Rider		er	Section 125		Mode Premium
_				Units/Amt		CIDR1		ICR	÷	WE	WBR					□ Yes		\$	
Units: Critical Illness			□ Indivi	Riders		Rider		Rider		Rider		Rider		Rid	er	Section 1	25	Mode Premium	
Basic Benefit Amount:			□ Single Parent Family		Units/Amt		CICR	R1		VBR									\$
Basic Bollotty Illiamit						\ccour	t Name							Accou	nt Numb	er			Mode Premium:
☐ Savings Routing Number ———————						\$													
Draft Date						Premiums/Billing Mode								Producer Number				Perc	centage Credit %
Remarks						☐ Monthly☐ Semi-Monthly☐ Bi-weekly☐ Other								Servicing Agent					%
						Requested Issue Date										%			
						Date of First Deduction							%						
Date of First Dedu									Deduction										%

IF QUESTIONS	S 1-7 BELOW ARE ANSWERED "YES," PLEASE LIST THE REQUIRED HEALTH HISTORY IN QUESTION 8 BEL	LOW.												
	1) Is any person to be insured now being treated, or ever been treated or diagnosed by a member of the medical profession for Acquired infinitine Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC), or has ever tested positive for antigens or antibodies to an AIDS virus?	Yes 🗆 No												
All CGI	2) Has any person to be insured been disabled or hospitalized on an inpatient basis or had outpatient surgery in the last 6 months?	Yes □ No												
Cancer (policies and		Yes 🗆 No												
riders) "	b) If the answer to 3a 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?	Yes □ No												
& SI Hospital Indemnity	c) Has any person to be insured been diagnosed with or received treatment for any other type of cancer (other than those listed in 3b and/or basal cell skin cancer) during the last 5 years?	Yes □ No												
I loui a ou ono,	4) a) Has any person to be insured had or is now being treated for: a stroke; a heart attack; a heart condition; heart trouble or any abnormality of the heart (including	Yes ☐ No												
Intensive Care, SI Hospital Indemnity & Critical Illness	100 more than once?	Yes □ No												
SI Life, Disability, Critical Illness & SI Sickness (DI) Riders to Accident	tumor, leukemia, Hodgkin's Disease; or stroke? b) Has any person to be insured in the last 2 years had or been treated for asthma or any disorder of the back, neck or stomach?	l Yes □ No l Yes □ No												
	than 100 more than once? All the properties to be incurred in the last 2 years, been treated or counseled by a member of the medical profession or in an accredited alcohol or drug rehabilita-	Yes □ No												
	tion program for alcohol or drug abuse?	Yes □ No												
		Yes □ No Yes □ No												
	1) Has any person to be insured received any advice, treatment, or consultation for Arzheimer's disease, dementia, serially, or organic shall syndrome.													
Critical Illness	disease, stroke, diabetes, cancer, kidney disease, or multiple sclerosis?	Yes 🗆 No												
SI Life	7) Has any person to be insured, in the last 3 years, had his/her driver's license suspended or revoked or been arrested for reckless or drunken driving and/or been involved in 3 or more motor vehicle accidents? If yes, provide additional details below.	☐ Yes ☐ No												
Required Health History (For Critical Illness, list primary physician's name,	8) Name Nature of Illness/Injury or Medical Attention/ Date and/or Duration Name and Address of Physician or Hospital/Clinic													
address and telephone number)	Use additional paper if needed													
All - Replacement	9) a) Proposed Insured. Is this insurance to replace or change any existing life (if applied for) or health (if applied for) coverage? If yes, indicate product being replaced or changed and complete replacement form provided by your producer if required by your state.	Yes □ No												
	b) Producer. To your knowledge, is change or replacement involved?													
All - Existing	10) a) Proposed Incurred, In there any other (not listed in question 9) existing life annuity cancer, heat/stroke disability hospital, critical illness or accident insurance in	Yes □ No												
	b) Producer. To your knowledge, does any person to be insured have existing life, annuity, cancer, heart/stroke, disability, hospital, critical illness or accident coverage in force?	□ Yes □ No												
answers given on this application policy, not the date the application or otherwise modify this application and the date the application of the date the application of the date that I may revoke this a stand that I may revoke this a Signed at: City/State:	e 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 station are true, complete, and correctly recorded. • UNDERSTANDING. I understand that the "effective date" of the policy for health insurance coverages will be the policy date recation is signed. I also understand that, if premiums for the policy(ies) is (are) to be paid by payroll deduction, these deductions may start before the "effective date" of the policy(ies) is (are) to be paid by payroll deduction, these deductions may start before the "effective date" of the policy(ies) is (are) to be paid by payroll deduction, these deductions may start before the "effective date" of the policy(ies) is (are) to be paid by payroll deduction, these deductions may start before the "effective date" of the policy(ies) is (are) to be paid by payroll deduction, these deductions may start before the "effective date" of the policy for health insurance company in the policy date recation is signed. I also understand that no producer (agent) has authority to wait lication, or to bind this company in any way by making any promise or representation that is not set out in writing in this application. • AUTHORIZATION FOR SI LIFE AND C adical practitioner, hospital, clinic or other medical facility, insurance company, the Medical Information Bureau or other organization, institution or person, that has records or knowledge eritage Life, its subsidiaries or its reinsurers any information. I acknowledge receipt of the Important Notice About Privacy and MIB Notice form. A copy of this authorization is valid for a period of 24 months from the date significant any time by notifying American Heritage Life in writing of my desire to do so. Date Signed: Signature of Owner, if other than Insured Signature of Owner, if other than Insured Print Producer's Name	ecorded on the sign and that the sive any answew NESS lige of me or malid as the original signed. I under the signed of the sign												