

FOR HOME OFFICE USE ONLY:

Effective Date: _____

PRD #: _____



American Public Life Insurance Company

A member of the American Fidelity Group

FOR AGENT USE ONLY:

Requested Effective Date: _____

2305 Lakeland Drive • Jackson, Mississippi 39232
Phone: (601) 936-6600 or (800) 256-8606 • Fax: (601) 936-2157

New Enrollment

Reinstatement

Change of Family Status

Application to be used for: Accident • Cancer and Specified Disease • Intensive Care/Coronary Care • Disability (DI-2000 and DI-2005) • Heart Disease/Attack/Stroke • Hospital Indemnity (HI-2000) • Select Dental Insurance

SECTION 1 APPLICANT INFORMATION

1. Persons Proposed For Insurance:			S E X	A G E	Height & Weight Ft./In. Lbs.	BIRTHDATE Mo. Date Yr.			APPLICANT'S SOCIAL SECURITY #:
Last Name	First Name	Initial							
a. Applicant									- -
b. Spouse									- -
c. Children									- -
2.									- -
3.									- -
2. Home Address: _____ _____ City State Zip Home Phone: (____) _____					3. Employer: _____ Address: _____ _____ City State Zip Work Phone: (____) _____ Employment Date: _____				
4. a. What is Your Occupation?			4. b. Full Time: <input type="checkbox"/> Yes <input type="checkbox"/> No No. of Hours Per Week: _____			4. c. Gross Monthly Earnings From Employer: \$ _____			
5. a. Total Monthly Premium Amount (All Products): \$ _____ Payroll Deduction Period: <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Semi-Monthly <input type="checkbox"/> Monthly Bank Draft <input type="checkbox"/> Annual <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Other: _____					5. b. Premium Payor: _____ (other than Applicant) Social Security #: _____				
6. a. Beneficiary:					Relationship:				

SECTION 2 COMPLETE FOR ALL LINES OF INSURANCE APPLIED FOR

- Has any person proposed for insurance ever had or been treated or diagnosed by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or Antibodies to Human T-Lymphotropic Virus Type III (HTLV-III)? Yes No
- Are you actively at work on a regular basis? Yes No

SECTION 3 ACCIDENT INSURANCE

Are you a Diabetic using medication to control your blood sugar level? Yes No If "Yes", list person: _____

ANSWER IF SICKNESS DISABILITY BENEFIT APPLIED FOR (Primary Insured Only):

- a. Have you applied for or received disability benefits for sickness within the last two (2) years? Yes No
- b. Have you been treated for (please circle): Heart Attack, Heart Bypass, Coronary Heart Disease, a Stroke, Internal Cancer, Back Disorder, Fibromyalgia, Chronic Fatigue Syndrome, Diabetes or Hepatitis C? (If none, check here)

SECTION 4 CANCER • INTENSIVE CARE / CORONARY CARE INSURANCE

- a. Has any person proposed for insurance been diagnosed or received care or treatment by a physician for (please circle): Cancer, Carcinoma, Sarcoma, Lymphoma, Leukemia, Hodgkin's Disease, Melanoma or Malignant Tumor of any kind, except _____, who is to be excluded from coverage under this Policy, First Occurrence Rider and Radiation/Chemo Benefit Rider. (If none, check here)
- b. Has any person proposed for insurance been diagnosed or received care or treatment by a physician for (please circle): Addison's Disease, Amyotrophic Lateral Sclerosis, Grand Mal Epilepsy, Systemic Lupus Erythematosus, Multiple Sclerosis, Muscular Dystrophy, Myasthenia Gravis, Niemann-Pick Disease, Osteomyelitis, Reye's Syndrome, Sickle Cell Anemia, Tay-Sachs Disease, Toxic Epidermal Necrolysis, Tuberculosis, or Whipple's Disease in any form, except _____, who is to be excluded from coverage under the Dread Disease Benefit for the Disease circled. (If none, check here)

Applicant Name: _____ Social Security #: _____ Date of Application: _____

Continuation of Application to: American Public Life Insurance Company, P.O. Box 925, Jackson, MS 39205-0925

ACCIDENT								
Insurance Applied for:	Form #:	Accidental Disability Income (Primary Insured only)	Sickness Disability Income (Primary Insured only)	Loss of Time (Primary Insured only)	Hospital Admission Benefit (Units)	Intensive Care Benefit (Units)	Gunshot Wound Rider	Premium
<i>Accident</i>	A-2 Units _____	N/A	N/A		N/A	N/A	N/A	
<i>Accident</i>	A-3 Units _____	<input type="checkbox"/> Monthly Benefit _____	<input type="checkbox"/> Monthly Benefit _____	N/A				\$
Sickness Elimination/Benefit Period: <input type="checkbox"/> 14 Days / 3 Months <input type="checkbox"/> 14 Days / 6 Months <input type="checkbox"/> 30 Days / 6 Months								
<input type="checkbox"/> Individual <input type="checkbox"/> Individual & Spouse <input type="checkbox"/> Single Parent Family <input type="checkbox"/> Family								
TOTAL PREMIUM								\$

CANCER • HEART DISEASE / HEART ATTACK / STROKE • INTENSIVE CARE / CORONARY CARE								
Insurance Applied for:	Form #:	Daily Benefit	1st Occur. Diagnostic Amt.	Heart Attack/Stroke Rider	Intensive Care Rider	Chemo/Radiation Amt.	Lump Sum Amt.	Premium
<i>Cancer & Specified Disease</i>		\$	\$	N/A	\$	\$	N/A	\$
<i>Cancer & Dreaded Disease</i>	CP712 <input type="checkbox"/> Basic <input type="checkbox"/> Enhanced	\$ 200 \$ 300	<input type="checkbox"/> First Occur. Rider \$ 2,500 \$ 2,500	<input type="checkbox"/> Heart Attack/Stroke Rider \$ 400 \$ 400	<input type="checkbox"/> Intensive Care Rider \$ 600 \$ 600	<input type="checkbox"/> Chemo./Radiation Rider Basic: \$ 7,000 Enhanced: \$ 12,000	N/A	\$
<i>Lump Sum Cancer</i>		N/A	N/A	N/A	N/A	N/A	\$	\$
<i>Heart Disease/Heart Attack/Stroke</i>		\$	N/A	N/A	N/A	N/A	\$	\$
<i>Intensive Care Coronary Care</i>		\$	N/A	N/A	N/A	N/A	N/A	\$
<input type="checkbox"/> Individual <input type="checkbox"/> Single Parent Family <input type="checkbox"/> Family								
TOTAL PREMIUM								\$

COMPLETE CARE PRODUCTS	
Option 1: <input type="checkbox"/> (HD/A/S-2, APLIC-1 & IC/CC-2)	Option 2: <input type="checkbox"/> (HD/A/S-2, HD/A/S-2 Rider; APLIC-1; IC/CC-2 & CLS-1000)
<input type="checkbox"/> Individual <input type="checkbox"/> Single Parent Family <input type="checkbox"/> Family	
TOTAL PREMIUM	
\$	

DISABILITY									
Insurance Applied for:	Form #:	Accidental Death and Dismemberment Rider Employee \$ _____ Spouse \$ _____ Children \$ _____	Emergency Accident Rider (\$100, \$200, or \$300)	Injury Hospital Indemnity Rider (Accident only)	Injury & Sickness Hospital Indemnity Rider (Accident & Sickness)	Outpatient Sickness Rider <input type="checkbox"/> Opt. A \$25 Max. \$150-\$450 (in \$50 increments) <input type="checkbox"/> Opt. B \$50 Max. \$300-\$800 (in \$100 increments)		Premium	
<i>Disability</i>	DI-2000	\$	\$	\$	\$	\$	\$	\$	
<i>Disability</i>	DI-2005	\$	\$	\$	\$	\$	\$	\$	
Disability Income (Accident) (Available on Primary Insured Only) \$ _____ per month; _____ elimination period; _____ benefit period								MONTHLY PREMIUM	\$
Disability Sickness Rider (Available on Primary Insured Only) \$ _____ per month; _____ elimination period; _____ benefit period								MONTHLY PREMIUM	\$
<input type="checkbox"/> Individual <input type="checkbox"/> Individual & Spouse <input type="checkbox"/> Single Parent Family <input type="checkbox"/> Family						<input type="checkbox"/> OCC I <input type="checkbox"/> OCC II			
TOTAL PREMIUM								\$	

HOSPITAL INDEMNITY									
Insurance Applied for:	Form #:	Daily Hospital Indemnity Plan	Annual 1 st Occurrence Rider	IC/CC Rider	Accidental Death & Dismemberment Rider	Emergency Accident Rider (\$100, \$200, or \$300)	Outpatient Sickness Rider <input type="checkbox"/> Opt. A \$25 Max. \$150-\$450 (in \$50 increments)	<input type="checkbox"/> Opt. B \$50 Max. \$300-\$800 (in \$100 increments)	Premium
<i>Hospital Indemnity</i>	HI-2000	\$	\$	\$	\$	\$	\$	\$	\$
Injury Hospital Indemnity Rider (<i>Accident Only</i>) (Benefit Amount \$)									\$
Surgical and Anesthesia Rider (Benefit Amount \$)									\$
<input type="checkbox"/> Individual <input type="checkbox"/> Individual & Spouse <input type="checkbox"/> Single Parent Family <input type="checkbox"/> Family									
TOTAL PREMIUM									\$

DENTAL				
Insurance Applied for:	Select Option	Ortho Rider	If Dependent Child(ren) are in College, give College Name and Address: _____	Premium
<i>Select Dental</i>	<input type="checkbox"/> A <input type="checkbox"/> B			\$
<i>Select Dental II</i>	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D			
<input type="checkbox"/> Individual <input type="checkbox"/> Individual & Spouse <input type="checkbox"/> Single Parent Family <input type="checkbox"/> Family				
TOTAL PREMIUM				\$

FRAUD WARNINGS

AR and LA: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

FL: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURER FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THE THIRD DEGREE.

IN and NV: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURER, FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION CONCERNING A MATERIAL FACT IS GUILTY OF INSURANCE FRAUD. IN IN INSURANCE FRAUD IS A FELONY. IN NV INSURANCE FRAUD IS A CATEGORY D FELONY.

KY: ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD.

NM: ANY PERSON WHO KNOWINGLY PRESENTS FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES AND CONFINEMENT IN PRISON.

OH: ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD.

OK: WARNING: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURER, MAKES ANY CLAIM FOR THE PROCEEDS OF AN INSURANCE POLICY CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY.

OR: ANY PERSON WHO MAKES AN INTENTIONAL MISSTATEMENT THAT IS MATERIAL TO THE RISK MAY BE FOUND GUILTY OF INSURANCE FRAUD BY A COURT OF LAW.

TN: IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSES OF DEFRAUDING THE COMPANY. PENALTIES INCLUDE IMPRISONMENT, FINES AND DENIAL OF COVERAGE.

VA: IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES INCLUDE IMPRISONMENT, FINES AND DENIAL OF INSURANCE BENEFITS.

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Is insurance applied for to replace or change any insurance in this or any other Company? Yes No

If "Yes", give details: _____

Soliciting Agents: <i>(Please Print)</i>	Agent Number	State License I.D.#	Split Percent
Signature of Agent			
Signature of Agent	<i>(If split with other Agents attach on separate sheet.)</i>		

REMINDER: Applications received by American Public Life Insurance Company, more than 30 days following the date taken, will have to be rewritten with a current date.