

PLEASE PRINT WITH BLACK INK

APPLICATION FOR LIFE AND HEALTH INSURANCE TO:

<input type="checkbox"/> <b>American Heritage Life Insurance Company</b> 1776 American Heritage Life Drive, Jacksonville, Florida 32224					Wholly owned subsidiary of American Heritage Life <input type="checkbox"/> <b>Concord Heritage Life Insurance Company, Inc.</b> One Pillsbury Street, Concord, NH 03301				
Proposed Insured (Print) (Last, First, M.I.)			<input type="checkbox"/> Emp. <input type="checkbox"/> Spouse <input type="checkbox"/> M <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/> F	Age	Birthdate	Social Security Number			
Home Address			City		State	Zip	Home Phone Number		
Height	Weight	Employer (if not same as case)		Occupation			Date Hired		
Payor or Owner (if other than Proposed Insured)			<input type="checkbox"/> Payor <input type="checkbox"/> Owner	Social Security Number or Tax I.D. Number (Owner or Payor)			Birthdate		
Primary Beneficiary - Full Name   Age   Relationship				Contingent Beneficiary - Full Name   Age   Relationship					

DEPENDENTS PROPOSED FOR COVERAGE

Last Name	First Name	M.I.	Relationship	Date of Birth	Age	Sex

PLANS COVERAGE INSURANCE	<b>Universal Life</b> _____ <input type="checkbox"/> Simplified Issue <input type="checkbox"/> Select CGI	Face Amount	Life Riders	Rider	Rider	Rider	Rider	Rider	Rider	Rider	Mode Premium
	Death Benefit Option <input type="checkbox"/> 1 <input type="checkbox"/> 2	Units/Amt									\$
	<b>Term Life</b> _____ <input type="checkbox"/> Simplified Issue <input type="checkbox"/> Select CGI	Face Amount	Life Riders	Rider	Rider	Rider	Rider	Rider	Rider	Rider	Mode Premium
	Units/Amt										\$
	<b>Disability</b> _____   Elimination Period <input type="checkbox"/> Simplified Issue   Accident _____ Days   Sickness _____ Days <input type="checkbox"/> Select CGI <input type="checkbox"/> Full Underwriting	Occupational Class <input type="checkbox"/> Preferred <input type="checkbox"/> Standard <input type="checkbox"/> Other _____	Benefit Period	Months	Monthly Benefit	\$	Section 125	Mode Premium			
	On The Job Rider: <input type="checkbox"/> Yes <input type="checkbox"/> No   Accident Rider: <input type="checkbox"/> Yes <input type="checkbox"/> No   Units _____ <input type="checkbox"/> Individual <input type="checkbox"/> Family	Monthly Salary	\$				<input type="checkbox"/> Yes <input type="checkbox"/> No	\$			
	<b>Cancer</b> _____ <input type="checkbox"/> Individual <input type="checkbox"/> Family	Cancer Riders	Rider	Rider	Rider	Rider	Rider	Rider	Section 125	Mode Premium	
	Units or Benefit Level:	Units/Amts.							<input type="checkbox"/> Yes <input type="checkbox"/> No	\$	
	<b>Accident</b> _____ <input type="checkbox"/> Individual <input type="checkbox"/> Family	Monthly Salary	\$	Rider	Rider	Rider	Rider	Rider	Section 125	Mode Premium	
	Units								<input type="checkbox"/> Yes <input type="checkbox"/> No	\$	
<b>Hospital Indemnity</b> _____ <input type="checkbox"/> Simplified Issue <input type="checkbox"/> Individual <input type="checkbox"/> Ind. & Children <input type="checkbox"/> Select CGI <input type="checkbox"/> Ind. & Spouse <input type="checkbox"/> Family	Base Plan	Rider	Rider	Rider	Rider	Rider	Rider	Section 125	Mode Premium		
Units	Units	Units	Units	Units	Units	Units	Units	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$		
<b>Heart/Stroke</b> _____ <input type="checkbox"/> Individual <input type="checkbox"/> Family	HSP2 Riders	Rider	Rider	Rider	Rider	Rider	Rider	Section 125	Mode Premium		
Units or Benefit Level:	Units/Amt							<input type="checkbox"/> Yes <input type="checkbox"/> No	\$		
<b>Critical Illness</b> _____ <input type="checkbox"/> Individual <input type="checkbox"/> Family <input type="checkbox"/> Single Parent Family	CI Riders	Rider	Rider	Rider	Rider	Rider	Rider	Section 125	Mode Premium		
Basic Benefit Amount:	Units/Amt							<input type="checkbox"/> Yes <input type="checkbox"/> No	\$		

Cash With Application _____		Case Name	Case Number	Total Mode Premium:
PAC Policies   Transit Number _____ <input type="checkbox"/> Checking   Account Number _____ <input type="checkbox"/> Savings   Draft Date _____		Premiums/Billing Mode <input type="checkbox"/> Monthly <input type="checkbox"/> Semi-Monthly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Weekly <input type="checkbox"/> Other Requested Issue Date _____   Date of First Deduction _____		\$
Remarks	Agent Number	Percentage Credit		
Home Office Use	_____	_____ %		
	_____	_____ %		
	_____	_____ %		
	_____	_____ %		

**NON-MEDICAL QUESTIONNAIRE**

<b>All Coverages</b>	1. Is the proposed insured actively at work now and has he/she worked at least 25 hours each week performing all duties at his/her regular occupation at his/her regular place of employment for the last 3 months except for minor illness or injury of 1 week or less, or normal pregnancy?	□ Yes □ No
<b>IF ANY QUESTIONS 2-10 BELOW ARE ANSWERED "YES," PLEASE LIST THE REQUIRED HEALTH HISTORY IN QUESTION 11 BELOW.</b>		
<b>All Coverages</b>	2. Has any person to be insured ever been diagnosed by a member of the medical profession as having Acquired Immune Deficiency Syndrome (AIDS) or "AIDS" Related Complex (ARC), or ever tested positive for antigens or antibodies to an "AIDS" virus?	□ Yes □ No
<b>All Life &amp; Critical Illness</b>	3. Has any person to be insured used tobacco in any form in the last 12 months? If so, who and what type? _____	□ Yes □ No
<b>All Select CGI (Life, Hosp. Ind. &amp; Disability)</b>	4. Has any person to be insured been disabled or hospitalized in the last 6 months?	□ Yes □ No
<b>Simplified Issue Life \$100,000 Or Below</b>	5. a) In the last 3 years, has any person to be insured: had a chronic disease (including but not limited to heart disorder, stroke, cancer, diabetes, etc.); been hospitalized; seen a physician (other than for colds, flu or normal pregnancy or a routine physical with no unfavorable results); or been counseled for or excessively used alcohol or any type of drugs? b) Is any person to be insured currently under the care of a physician? c) Has any person to be insured ever been rated or declined for life insurance?	□ Yes □ No □ Yes □ No □ Yes □ No
<b>Cancer (policies and riders), SI Hosp. Ind. &amp; Critical Illness</b>	6. Is any person to be insured now being treated for, or has any person ever been treated for, cancer or any malignancy which includes: carcinoma; sarcoma; Hodgkin's Disease; leukemia; lymphoma; or any malignant tumor?	□ Yes □ No
<b>Heart/Stroke, ICU, SI Hosp. Ind. &amp; Critical Illness</b>	7. Is any person to be insured now being treated for, or has any person ever been treated for: a stroke; a heart attack; a heart condition; heart trouble; any abnormality of the heart (including artery disease); diabetes; or high blood pressure not controlled by medication?	□ Yes □ No
<b>Simplified Issue Disability, Critical Illness &amp; Sickness Riders (Use Supplement for Disability Over \$3,000)</b>	8. a) Has any person to be insured, in the last 2 years, had, been treated for, or been told by a member of the medical profession that he or she has: diabetes, emphysema, asthma, epilepsy, hepatitis, mental or nervous illness, ulcers, any disorder of the central nervous system (to include muscular dystrophy or multiple sclerosis); Parkinson's disease; lupus; rheumatoid arthritis; fibromyalgia; chronic fatigue syndrome; any disorder of the heart, kidneys, liver, lungs, pancreas, or back; paralysis; optic neuritis; cancer (except basal cell skin cancer), malignant tumor, leukemia, Hodgkin's Disease; or high blood pressure not controlled by medication, or stroke? b) Has any person to be insured, in the last 2 years, been treated for or counseled for alcohol or drug abuse? c) Has any person to be insured had any medical or surgical procedures (including major organ transplant) advised or recommended by a doctor but not done at this time? d) Has any person to be insured received any advice, treatment, or consultation for Alzheimer's disease, dementia, senility, or organic brain syndrome?	□ Yes □ No □ Yes □ No □ Yes □ No □ Yes □ No
<b>All Accident (policies and riders)</b>	9. a) Has any person to be insured engaged in, or is any person contemplating engaging in: skydiving ____; hang gliding ____; underwater diving ____; organized racing events ____; rodeo ____; mountaineering ____; professional sports ____; or piloting a plane ____? If yes, place an "X" after the sport and furnish details. b) 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 received 3 or more moving violations or been involved in 3 or more motor vehicle accidents? If yes, provide that person's driver's license information here and additional details below. Driver's License Number _____ State _____	□ Yes □ No □ Yes □ No
<b>Critical Illness</b>	10. Has any person to be insured or ANY 2 of their natural parents or natural siblings been diagnosed with the same disease before age 60, based on this list: heart disease, stroke, diabetes, cancer, kidney disease, or multiple sclerosis?	□ Yes □ No
<b>Required Health History (For Critical Illness, list primary physician's name, address and telephone number)</b>	11. Name _____ Nature of Illness/Injury or Medical Attention/Reason Last Consulted _____ Date and/or Duration _____ Name and Address of Physician or Hospital/Clinic _____  <p align="center"><b>Use additional paper if needed</b></p>	
<b>All Coverages</b>	12. <b>Replacement.</b> Is this insurance to replace or change any existing life or health coverage? If yes, complete replacement form provided by your agent if required by your state.	□ Yes □ No
<b>All Coverages</b>	13. <b>Existing Insurance.</b> Is there any other life, cancer, heart/stroke, disability, hospital income, critical illness or accident insurance in force or applied for on proposed insured? If yes, list company name, policy number, year issued, type of coverage, and amount of benefit. _____ _____	□ Yes □ No
<b>All Health</b>	14. I have received an Outline of Coverage for each health coverage?	□ Yes □ No

**REPRESENTATION.** I have read or had read to me the completed application and understand that any intentional material misstatement or intentional material 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. • **UNDERSTANDING.** I understand that the "effective date" of the policy for health insurance coverages will be the policy date recorded on the Policy Specifications page, not the date the application 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) and that this does not change my effective date of coverage. If the policy(ies) is (are) not issued, American Heritage Life will refund any deductions it receives. I also understand that no agent has authority to waive any answer or otherwise modify this application, 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.** I authorize any physician, medical practitioner, hospital, clinic or other medical facility, insurance company, the Medical Information Bureau or other organization, institution or person, that has records or knowledge of me or my health to give to American Heritage Life, its subsidiaries or its reinsurers any information. I acknowledge receipt of the Important Notice and M. I. B. Notice form. A copy of this authorization is as valid as the original. This authorization applies to any dependent on whom insurance is requested.

Signed at: City/State: \_\_\_\_\_ Date Signed: \_\_\_\_\_

Signature of Proposed Insured \_\_\_\_\_ Signature of Owner, if other than Insured \_\_\_\_\_

**Agent's Statement.** To your knowledge, is change or replacement involved? □ Yes □ No I certify that I have asked the applicant every question which is answered and have accurately recorded the answers.

Signature of Agent or Witness \_\_\_\_\_ Print Agent'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. 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 policy except, upon written consent, to be medically tested for HIV or AIDS and the results of such testing proved positive.

**MIB Notice:**

Information regarding your insurability is treated as confidential. We or our reinsurers may, however, make a brief report to the Medical Information Bureau, a non-profit membership 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 P.O. Box 105, Essex Station, Boston, MA 02112, PH. #617-426-3660. 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. 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, only where authorized by written consent.