☒ Producer Assisted ☐ New Policy ☐ Change/Increase Policy #_____

APPLICATION FOR LIFE AND HEALTH INSURANCE TO: American Heritage Life Insurance Company (AHL) 1776 American Heritage Life Drive, Jacksonville, Florida 32224

EMPLOYEE INFORMATION

Employee/Payor Name (if other than Proposed Insured)	Employee Date of Birth	Employee/Payor Social Security Number	Employee I.D. Number	Date Hired

PROPOSED INSURED INFORMATION

Proposed Insured Name (Last, First, M.I.)	☐ M ☐ F	☐ Employee ☐ Spouse ☐ Child ☐ Other	Social Security Number

Residence Address	City	State	Zip	Phone Number

Employer	Occupation
Green State Credit Union	

Owner Name and Address (if different than Proposed Insured)	City	State	Zip	Owner Phone Number

Owner Date of Birth (if different than Proposed Insured)	Owner Social Security Number or Tax I.D. Number (if different than Proposed Insured)	Owner Email Address

Primary Beneficiary Name (Last, First, M.I.) and Address	City	State	Zip	Relationship	Phone Number	Date of Birth	Social Security Number

Contingent Beneficiary Name (Last, First, M.I.) and Address	City	State	Zip	Relationship	Phone Number	Date of Birth	Social Security Number

COMPLETE THIS SECTION FOR PERSONS TO BE INSURED

Relationship to Employee	Last Name	First Name	Date of Birth	Sex	Relationship	Actively at Work*	Full Time Student^	Has any adult (19 and older) person to be insured used tobacco in the last 12 months?
Employee					Employee	☐ Yes ☐ No	N/A	**☐ Yes ☐ No
Spouse					Spouse	☐ Yes ☐ No	N/A	**☐ Yes ☐ No
Dependent						^☐ Yes ☐ No	☐ Yes ☐ No	^☐ Yes ☐ No
Dependent						^☐ Yes ☐ No	☐ Yes ☐ No	^☐ Yes ☐ No
Dependent						^☐ Yes ☐ No	☐ Yes ☐ No	^☐ Yes ☐ No

*Is the employee and the employee's spouse if applying for life and/or accident with sickness disability rider actively at work now, for wage or profit, 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 the last 3 months except for minor illness or injury of 1 week or less, or normal pregnancy? ^For dependents ages 19 and older, if applying for Life policy. **If applying for Life or Critical Illness.

INSURANCE PLANS

Cancer _____ (Plan Type)	☐ CP10A ☐ CP10B	☐ Individual ☐ Family	Section 125 ☐ Yes ☐ No	Mode Premium $_____

Policy Options	Hospital		Radiation/Chemotherapy		Surgery Related	Misc.
Units/Amt						
Riders	Rider CABR	Rider ICR	Rider CLR	Rider CPR	Rider WBR-Fixed	Rider CP12WBR-Variable
Units/Amt						

Billing Method: ☐ Payroll Deduction ☐ Bank/Credit Union Draft (Authorization Required)* *Complete form ABJ062	Name on Bank/Credit Union Account _____ Bank/Credit Union Account Number _____ Routing Number _____ Draft Date _____	Billing Mode: ☐ Monthly (12) ☒ Semi-Monthly (24) ☐ Bi-weekly (26) ☐ Weekly (52) ☐ Other _____	Coverage Effective Date _____ Date of First Deduction _____	Total Mode Premium: $ _____

Remarks	Account (Case) Name	Account (Case) Number
	Green State Credit Union	

IF REQUESTING GUARANTEED ISSUE, PLEASE PROCEED TO QUESTION 7. FOR ALL OTHER ENROLLMENTS, IF ANY UNDERWRITING QUESTIONS BELOW ARE ANSWERED "YES", PLEASE LIST THE REQUIRED HEALTH HISTORY IN QUESTION 6.

Abbreviations: EE - Employee SP - Spouse CH - Child(ren) Y - Yes N - No

	UNDERWRITING QUESTIONS	EE	SP	CH
Cancer	1. Has any person to be insured, in the last 5 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?	☐Y ☐N	☐Y ☐N	☐Y ☐N
Cancer	2a. Has any person to be insured ever been diagnosed with or treated by a member of the medical profession for any type of cancer, other than basal cell carcinoma?	☐Y ☐N	☐Y ☐N	☐Y ☐N
	2b. If the answer to 2a. is yes, has that person(s) been diagnosed with or treated by a member of the medical profession for Leukemia, Hodgkin's Disease, Lymphoma, or Cancer with any lymph node involvement or more than one metastasis?	☐Y ☐N	☐Y ☐N	☐Y ☐N
	2c. If the answer to 2a. is yes, has that person(s), in the last 5 years, been diagnosed with or treated by a member of the medical profession for any other type of cancer (other than those listed in 2b. and/or basal cell carcinoma)?	☐Y ☐N	☐Y ☐N	☐Y ☐N
Cancer w/ Intensive Care	3. Has any person to be insured, in the last 5 years, been diagnosed with or treated by a member of the medical profession for a stroke or transient ischemic attack (TIA), a heart attack, a heart condition, heart trouble, any abnormality of the heart, or any artery disease?	☐Y ☐N	☐Y ☐N	☐Y ☐N
Cancer w/ Intensive Care	4. Has any person to be insured, in the last year, been diagnosed by a member of the medical profession with a systolic blood pressure reading higher than 150 more than once or a diastolic blood pressure reading higher than 100 more than once?	☐Y ☐N	☐Y ☐N	☐Y ☐N
Height and Weight	5. Provide Height and Weight Employee (Cancer w/ Intensive Care Option): Height:____ ft. ____ in. Weight: ____ lbs.			
Required Health History	6. Provide health history for any "Yes" answers to the Underwriting questions. Include physician's (or other members of the medical profession) name, address and telephone number: _____			
All-Replacement (Answer for Proposed Insured)	7. 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 if required by your state. _____	☐Y ☐N	☐Y ☐N	☐Y ☐N
All-Existing Insurance (Answer for Proposed Insured)	8. If you are applying for the type of coverage in the following list, is there any other insurance of that type (not listed in your answer to the Replacement Question) in force or applied for other than this application on any person to be insured (Coverage Type: cancer)? If yes, list company name, policy number, year issued, type of coverage and amount of benefit. _____	☐Y ☐N	☐Y ☐N	☐Y ☐N

REPRESENTATION. 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. **UNDERSTANDING**. I understand that: if premiums for the coverage(s) is (are) to be paid by payroll deductions, these deductions may start before the "effective date" of coverage(s) and that this does not change the effective date of coverage; and the “effective date” for health insurance coverages will be the date recorded on the policy/certificate/benefit statement, not the date the application is signed. If the coverage(s) is (are) not issued, American Heritage Life will refund any deductions it receives. I also understand that no producer (agent) has authority to waive any answer or otherwise modify this application, or to bind AHL in any way by making any promise or representation that is not set out in writing in this application. **PREMIUM DEDUCTION AUTHORIZATION. I AUTHORIZE** my employer to deduct from my salary or wages, if applicable, the necessary premium for the coverages requested.

Signed at: City/State _____ Date Signed _____

Signature of Proposed Insured _____

Signature of Owner, if other than Insured _____

Signature of Employee/Payor, if not Insured or Owner _____

SOLICITING PRODUCER MUST COMPLETE AND SIGN WHEN APPLICATION IS PRODUCER ASSISTED

All-Replacement	1. To your knowledge, is change or replacement involved?	☐ Yes ☐ No
All-Existing Insurance	2. To your knowledge, does any person to be insured have existing coverage in force?	☐ Yes ☐ No

Producer’s Statement. I certify that to the best of my knowledge and belief the information on this form is complete, accurate and correctly recorded.

Signature of Soliciting Producer _____ Print Soliciting Producer Name _____

To be completed by home office or producer, prior to issue:

Producer Name	Producer Number	National Producer Number (NPN)	Percentage Credit
Servicing Producer: Rhonda Pape	4PCH0		%
Soliciting Producer:			%
			%
			%

AMERICAN HERITAGE LIFE INSURANCE COMPANY
HOME OFFICE:
1776 AMERICAN HERITAGE LIFE DRIVE
JACKSONVILLE, FLORIDA 32224-6688
(904) 992-1776

A Stock Company

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses only when you are treated for one of the specific diseases or health conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when it pays:

- hospital or medical expenses up to the maximum stated in the policy

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- outpatient prescription drugs if you are enrolled in Medicare Part D
- other approved items and services

Before You Buy This Insurance

- ✓ Check the coverage in **all** health insurance policies you already have.
- ✓ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- ✓ For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program (SHIIP).

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