

FOR HOME OFFICE USE ONLY:

Effective Date: \_\_\_\_\_

PRD #: \_\_\_\_\_



# American Public Life Insurance Company

A member of the American Fidelity Group

2305 Lakeland Drive • Flowood, Mississippi 39232  
Phone: (601) 936-6600 or (800) 256-8606 • Fax: (601) 932-9011

FOR AGENT USE ONLY:

Requested Effective Date:  
\_\_\_\_\_

New Enrollment

Reinstatement

Change of Family Status

Application to be used for Group: Disability (DI-3300) • Hospital Indemnity (HI-4005)  
MEDlink • MEDlink II • Dental (D-3 and D-4) Insurance • Cancer (GCI-732)

## SECTION 1

## APPLICANT INFORMATION

1. Proposed Insured(s):	S E X	A G E	Height & Weight		BIRTHDATE			SOCIAL SECURITY NUMBER
			Ft./In.	LBS	Mo.	Date	Yr.	
Last Name	First Name	Initial						
a. Applicant								
b. Spouse								
c. Children								

Please list any Proposed Insured who is not a United States Citizen. \_\_\_\_\_

2. Home Address: \_\_\_\_\_  
 \_\_\_\_\_  
 City State Zip  
 Home Phone: ( ) \_\_\_\_\_

3. Master Policyholder: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 \_\_\_\_\_  
 City State Zip  
 Work Phone: ( ) \_\_\_\_\_  
 Employment Date: \_\_\_\_\_

If Master Policyholder is not your Employer, please complete the following:

Employer: \_\_\_\_\_ Address: \_\_\_\_\_  
 \_\_\_\_\_ Phone: ( ) \_\_\_\_\_  
 City State Zip  
 Employment Date: \_\_\_\_\_

4. a. What is Your Occupation? \_\_\_\_\_  
 4. b. Full Time:  Yes  No  
 No. of Hours Per Week: \_\_\_\_\_  
 4. c. Gross Monthly Earnings From Employer: \$ \_\_\_\_\_

5. a. Total Monthly Premium Amount (All Products): \$ \_\_\_\_\_  
 Payroll Deduction Period:  Weekly  Bi-Weekly  Monthly  Semi-Monthly  Paid by Master Policyholder  
 Other: \_\_\_\_\_

6a. Beneficiary: \_\_\_\_\_ Relationship: \_\_\_\_\_  
 b. Is the beneficiary a United States Citizen?  Yes  No  
 c. Contingent Beneficiary: \_\_\_\_\_ Relationship: \_\_\_\_\_  
 d. Is the contingent beneficiary a United States Citizen?  Yes  No

## SECTION 2

## COMPLETE FOR ALL LINES OF INSURANCE

1. Have you been actively at work on a full time basis, as defined by your employer, for the last six months, except for minor illnesses or injury for 1 week or less, or for normal pregnancy?  Yes  No

**SECTION 3**

**MEDICAL QUESTIONS**

*If only applying for Cancer insurance, answer questions 1, 2 and 3 only.*

1. Has any proposed insured 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
2. In the past 10 years, has any proposed insured been diagnosed or treated by a member of the medical profession as having:
  - a. Cancer or any malignancy, including carcinoma, sarcoma, Hodgkin's Disease, lymphoma, leukemia and malignant tumors?  Yes  No
  - b. Stroke, heart attack or any disease or disorder of the heart, circulatory system, lungs, liver, kidneys, nervous system or digestive system?  Yes  No
  - c. Insulin dependent diabetes or uncontrollable high blood pressure?  Yes  No
3. Has any proposed insured been recommended to have diagnostic tests or treatment by a physician for any other health conditions that have not been performed?  Yes  No
4. Has any proposed insured received counseling, or been advised to seek treatment or counseling for alcohol or drug abuse?  Yes  No
5. Has any proposed insured been hospitalized or had surgery within the past year?  Yes  No

***If a proposed insured answers "Yes" to any of these questions, details must be provided.***

Proposed Insured's Name	Physician's Name & Address	Treatment Date	Reasons	Results

**I have reviewed all of the above medical conditions and believe my answers to be complete. (Please initial)** \_\_\_\_\_

Will this Policy replace or change any Health Insurance in this or any other Company?  Yes  No  
 If "Yes", give Company Name: \_\_\_\_\_ Policy Number: \_\_\_\_\_ Amount: \$ \_\_\_\_\_

**FRAUD WARNINGS**

**LA NM:** 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 (IN NM CIVIL FINES AND CRIMINAL PENALTIES) 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.

**OH, 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.

**OK NV:** 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 CONCERNING A MATERIAL FACT IS GUILTY OF A FELONY. (IN NV INSURANCE FRAUD IS A CATEGORY D FELONY)

**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.

**I UNDERSTAND THAT OTHER INCOME I AM ENTITLED TO RECEIVE WILL REDUCE MY MONTHLY DISABILITY BENEFIT. I SHOULD READ MY CERTIFICATE FOR MORE DETAILED INFORMATION REGARDING HOW OTHER INCOME WILL REDUCE MY MONTHLY BENEFIT.**

I understand that: "Pre-Existing Conditions" may not be covered under the coverage(s) for which I have applied; and I should read my Certificate for a more detailed explanation of the Pre-Existing Conditions Exclusion, if any.

I declare that all statements and answers in this application are complete, true and correct to the best of my knowledge and belief and are made as a consideration of the insurance herein applied for. I agree that the insurance issued thereon shall not take effect unless and until a Policy is actually issued and in no event shall the insurance be in force except as provided in the Policy(ies) under which this application is hereby made.

**DATED AT:** \_\_\_\_\_  
**AGENT (print):** \_\_\_\_\_ **APPLICANT:** \_\_\_\_\_ **DATE:** \_\_\_\_\_  
**AGENT (signature):** \_\_\_\_\_ **STATE LIC. #:** \_\_\_\_\_ **AGENT #:** \_\_\_\_\_

**MATERIAL OMISSIONS OR MISSTATEMENTS IN THIS APPLICATION MAY VOID INSURANCE.**

Applicant Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_ Date of Application: \_\_\_\_\_

Continuation of Application to: American Public Life Insurance Company, 2305 Lakeland Drive, Flowood, MS 39232

DISABILITY			
Insurance Applied for:	Form #:	Monthly Total Disability Insurance Applied For: \$ _____ <i>(Available on Primary Insured Only)</i>	Premium
Disability	DI-3300	Elimination Period for Total Disability Benefits: Injury _____ Days    Sickness _____ Days Maximum Benefit Period for Total Disability Benefits: Injury or Sickness _____ Months	\$
Optional Family Accident Rider applied for: <input type="checkbox"/> Yes <input type="checkbox"/> No                      Units: <input type="checkbox"/> ½ Unit <input type="checkbox"/> 1 Unit <input type="checkbox"/> 1½ Units			\$
<input type="checkbox"/> Employee <input type="checkbox"/> Family			
<b>TOTAL PREMIUM</b>			<b>\$\$</b>

HOSPITAL INDEMNITY									
Insurance Applied for:	Form #:	Daily Hospital Indemnity Expense Plan	Annual 1 <sup>st</sup> Occurrence Rider (Hospital Confinement)	IC/CC Rider	Emergency Accident Rider	Outpatient Sickness Rider	Surgical & Anesthesia Rider - 2	Wellness/Diagnostic Test Rider	Premium
Hospital Indemnity	HI-4005	\$	\$	\$	\$	\$	\$	\$	\$
No. of Units									
<input type="checkbox"/> Voluntary <input type="checkbox"/> Employer Paid									
<input type="checkbox"/> Employee <input type="checkbox"/> Employee & Spouse <input type="checkbox"/> Employee & Children <input type="checkbox"/> Family									
<b>TOTAL PREMIUM</b>									<b>\$</b>

TERM LIFE INSURANCE RIDER	
Employee Benefit Amount: <input type="checkbox"/> \$10,000 <input type="checkbox"/> \$20,000	
<input type="checkbox"/> Employee <input type="checkbox"/> Employee & Spouse <input type="checkbox"/> Employee & Children <input type="checkbox"/> Employee & Family	
<b>TOTAL PREMIUM</b>	<b>\$\$</b>

MEDlink • MEDlink II		
Inpatient Benefit Amount: _____	MEDlink II    Outpatient Benefit Amount: _____	\$
Optional Physician Rider applied for: <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Employee <input type="checkbox"/> Employee & Spouse <input type="checkbox"/> Employee & Children <input type="checkbox"/> Employee & Family	\$
<b>TOTAL PREMIUM</b>		<b>\$</b>

**CANCER**

Form #:	Cancer Indemnity Applied For:	Hospital Intensive Care Rider	Heart Attack and Stroke Rider	Premium
GCI-732	<input type="checkbox"/> Premier <input type="checkbox"/> Deluxe      \$ <input type="checkbox"/> Ultimate	\$	\$	\$
<input type="checkbox"/> Employee <input type="checkbox"/> Employee & Spouse <input type="checkbox"/> Employee & Children <input type="checkbox"/> Employee & Family				
<b>TOTAL PREMIUM</b>				\$

**DENTAL**

Insurance Applied for:	Children's Ortho Rider	D-4 Only (Riders)	Premium
<input type="checkbox"/> D-3 <input type="checkbox"/> D-4	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Prior Coverage Credit Rider <input type="checkbox"/> TMJ Rider	
If Dependent Child(ren) are in College, give College Name and Address: _____ _____			
<input type="checkbox"/> Employee <input type="checkbox"/> Employee & Spouse <input type="checkbox"/> Employee & Children <input type="checkbox"/> Employee & Family			
<b>TOTAL PREMIUM</b>			\$

**FOR AGENT USE ONLY**

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			

**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.

# American Public Life Insurance Company

2305 Lakeland Dr.

Jackson, MS 39232

## Acknowledgment

Thank you for considering American Public Life in planning for your financial security. We appreciate the opportunity you have given us to present our products to you.

In order for you to make an informed decision regarding application for coverage(s), we have developed a detailed brochure(s) that outlines the provisions of the insurance plan(s). Please read the brochure(s) carefully and ask a company representative any questions you may have regarding information contained in the brochure(s).

Our Company will rely on answers given on your application(s) for coverage(s) in order to determine if coverage(s) can be issued. Moreover, we have the right to rescind coverage(s) or deny claims based on the failure to provide accurate information at the time of application. If you are applying for any coverage(s) that is (are) subject to insurability it may result in additional investigations while the application(s) is (are) being underwritten and at time of any claim. Any underwriting decision will rely upon the cooperation of medical providers and pro-active assistance from you, the applicant, in obtaining medical information needed to determine eligibility for coverage(s).

Please remember some group coverage(s) may require you to be on Active Service on the effective date of your certificate of coverage in order for your coverage(s) to begin. Any health coverage(s) for which you are applying may have wording that may limit benefits for a preexisting medical condition for which you had treatment, took medication, received a diagnosis, or incurred expense. Any health coverage(s) for which you are applying may also have wording that could limit or reduce your benefits.

PLEASE ACKNOWLEDGE THAT BROCHURE(S) (List form number(s) from brochure)

\_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_,  
HAS (HAVE) BEEN EXPLAINED TO YOU AND THAT YOU HAVE RECEIVED  
A COPY OF THE BROCHURE(S) BY SIGNING BELOW. A COPY OF THIS FORM  
WILL BE ENCLOSED WITH YOUR CERTIFICATE AND/OR POLICY.

Signed \_\_\_\_\_

Date \_\_\_\_\_

\_\_\_\_\_  
Social Security Number