State:	*Arkansas*	***Filing Company:***	*American Public Life Insurance Company*
TOI/Sub-TOI:	*H07G Group Health - Specified Disease - Limited Benefit/H07G.001 Critical Illness*		
Product Name:	*GCRIT11APLA.R912*		
Project Name/Number:	*GCRIT11APLA.R912/GCRIT11APLA.R912*		

Filing at a Glance

Company:	American Public Life Insurance Company
Product Name:	GCRIT11APLA.R912
State:	Arkansas
TOI:	H07G Group Health - Specified Disease - Limited Benefit
Sub-TOI:	H07G.001 Critical Illness
Filing Type:	Form
Date Submitted:	09/27/2012
SERFF Tr Num:	AFDL-128705211
SERFF Status:	Closed-Approved-Closed
State Tr Num:	
State Status:	Approved-Closed
Co Tr Num:	GCRIT11APLA.R912
Implementation Date Requested:	On Approval
Author(s):	Shari Vick, Melissa Mahanes, Ashlie Snyder, Ann Hobson
Reviewer(s):	Rosalind Minor (primary)
Disposition Date:	10/01/2012
Disposition Status:	Approved-Closed
Implementation Date:	

State Filing Description:

General Information

Project Name: GCRIT11APLA.R912
Project Number: GCRIT11APLA.R912
Requested Filing Mode: Informational
Explanation for Combination/Other:
Submission Type: New Submission
Group Market Type: Employer, Association
Filing Status Changed: 10/01/2012
State Status Changed: 10/01/2012
Created By: Melissa Mahanes
Corresponding Filing Tracking Number:

Status of Filing in Domicile: Pending
Date Approved in Domicile:
Domicile Status Comments:
Market Type: Group
Group Market Size: Small and Large
Overall Rate Impact:
Deemer Date:
Submitted By: Melissa Mahanes

Filing Description:
American Fidelity Assurance Company is filing the above listed forms for approval with your Department on behalf of American Public Life Insurance Company. A letter of authorization is enclosed.

Enclosed for informational purposes is the above-mentioned application. This is a revised form and will replace the GCRIT11APLA previously approved by your department on 12/20/11 (Serff Tracking Number AFDL-127817728).

We inadvertently placed the Actively at Work question with the Simplified Issue Underwriting Medical questions on page 3. At this time, we are moving this question from page 3 to page 1 of the application. This is the only change being made at this time. We did not change any words on the page. We have not yet issued any Certificates of Insurance at this time; therefore, the enclosed application will be substituted for the GCRIT11APLA previously approved by your department. A changes highlighted document is enclosed for your convenience.

I hereby certify that to the best of my knowledge the forms submitted herewith are in compliance in all respects with the provisions of the insurance laws, rules and regulations of your state and such forms contain no provisions previously disapproved by the Department.

Thank you for your assistance with this matter. If you have any questions, please feel free to call me at contact information shown on the Companies and Contacts tab.

Company and Contact

Filing Contact Information

Melissa Mahanes, Compliance Analyst II
2000 Classen Blvd
Oklahoma City, OK 73106

melissa.mahanes@af-group.com
800-654-8489 [Phone] 2035 [Ext]
405-523-5793 [FAX]

Filing Company Information

American Public Life Insurance Company
2305 Lakeland Drive
Flowood, MS 39232
(601) 936-2157 ext. [Phone]

CoCode: 60801
Group Code: 330
Group Name:
FEIN Number: 64-0349942

State of Domicile: Oklahoma
Company Type: LAH
State ID Number:

State: *Arkansas* ***Filing Company:*** *American Public Life Insurance Company*
TOI/Sub-TOI: *H07G Group Health - Specified Disease - Limited Benefit/H07G.001 Critical Illness*
Product Name: *GCRIT11APLA.R912*
Project Name/Number: *GCRIT11APLA.R912/GCRIT11APLA.R912*

Filing Fees

Fee Required? Yes

Fee Amount: $50.00

Retaliatory? No

Fee Explanation: $50.00 /Form

Per Company: No

Company	Amount	Date Processed	Transaction #
American Public Life Insurance Company	$50.00	09/27/2012	63166899

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	10/01/2012	10/01/2012

State: Arkansas **Filing Company:** American Public Life Insurance Company
TOI/Sub-TOI: H07G Group Health - Specified Disease - Limited Benefit/H07G.001 Critical Illness
Product Name: GCRIT11APLA.R912
Project Name/Number: GCRIT11APLA.R912/GCRIT11APLA.R912

Disposition

Disposition Date: 10/01/2012
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	GCRIT11APLA.R912 Changes Highlighted	Approved-Closed	Yes
Form	Group Critical Illness Certificate Application	Approved-Closed	Yes

State: *Arkansas* **Filing Company:** *American Public Life Insurance Company*
TOI/Sub-TOI: *H07G Group Health - Specified Disease - Limited Benefit/H07G.001 Critical Illness*
Product Name: *GCRIT11APLA.R912*
Project Name/Number: *GCRIT11APLA.R912/GCRIT11APLA.R912*

Form Schedule

Lead Form Number: GCRIT11APLA.R912

Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments
1	Approved-Closed 10/01/2012	GCRIT11APLA. R912	AEF	Group Critical Illness Certificate Application	Initial:	52.000	GCRIT11APLA.R912.pdf

Form Type Legend:

ADV	Advertising	**AEF**	Application/Enrollment Form
CER	Certificate	**CERA**	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	**FND**	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	**NOC**	Notice of Coverage
OTH	Other	**OUT**	Outline of Coverage
PJK	Policy Jacket	**POL**	Policy/Contract/Fraternal Certificate
POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	**SCH**	Schedule Pages

FOR AGENT USE ONLY:
Requested Effective Date:
☐ **New Enrollment**
☐ **Family Status Change**
☐ **Benefit Change**

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: (877) 807-0911

FOR HOME OFFICE USE ONLY:	
Effective Date:	
PRD #:	
Group #:	
Revised:	

Group Products • Application for Critical Illness Insurance • Payroll Market

PROPOSED INSURED'S INFORMATION

	Last Name First Name MI	Sex	Birthdate Mo/Day/Yr	Age	Height Feet/Inches	Weight Lbs.	Social Security #
Applicant		☐M ☐F					
Spouse (must reside w/ applicant)		☐M ☐F					
Child 1		☐M ☐F					
Child 2		☐M ☐F					
Child 3		☐M ☐F					
Child 4		☐M ☐F					

Resident Address: Number & Street City State Zip Home Phone

Mailing Address: (if different) Number & Street City State Zip

Email Address:

APPLICANT	EMPLOYER
Full Time? ☐ Yes ☐ No Hours Per Week: ____	Name: ____
Salary: $____ ☐ Hourly ☐ Weekly ☐ Monthly ☐ Annually	City: ____ State: ____
Occupation: ____ Hire Date: ____	Work Phone: ____
Payroll Deduction Frequency: ☐ 12 ☐ 13 ☐ 24 ☐ 26 ☐ 52 **Skip Mode**: ☐ 8 ☐ 9 ☐ 10 ☐ 11 **Indicate Months**: ____	**Master Policyholder Name:**

BENEFICIARY INFORMATION

APPLICANT: Primary ____ Relationship____
Contingent ____ Relationship____

CITIZENSHIP INFORMATION

Is/Are the person(s) to be insured and the beneficiary(ies) a citizen of the United States? ☐ Yes ☐ No (If No, give details.)

Full Name	Country of Citizenship
____	____
____	____

CRITICAL ILLNESS PRODUCT SELECTION

	Premium
Critical Illness Plan Selected ☐ Applicant Only ☐ Applicant and Spouse ☐ Applicant & Child(ren) ☐ Applicant & Family	
Has any form of nicotine been used in the last 12 months? Applicant: ☐ **Yes** ☐ **No** [**Spouse:** ☐ **Yes** ☐ **No**]	
[☐ [**BASIC**] ☐ [**ENHANCED**] ☐ [**ENHANCED PLUS**]]	
TOTAL AMOUNT OF COVERAGE:	
Critical Illness Benefit Amount (For Applicant's age 18-69): [☐ $5,000 ☐ $10,000 ☐ $15,000 ☐ $20,000 ☐ $25,000]	$
Critical Illness Benefit Amount (For Applicant's age 70+): [☐ $2,500 ☐ $5,000 ☐ $7,500 ☐ $10,000 ☐ $12,500]	$
[**ADDITIONAL BENEFIT RIDERS:**	
☐ Cancer Critical Illness Rider	$]
Total Premium	$

	Applicant	Spouse	Child(ren) (NAME, if Yes)
Are you actively at work on a full time basis as defined by your employer for the last 60 days, except for normal pregnancy, minor illnesses or injury lasting 5 consecutive days or less?	☐Yes ☐No		

SIGNATURE AND ACKNOWLEDGMENT

The statements and answers given in this application (and, if applicable, the Simplified Issue Underwriting and Medical Question section) are true, complete and correctly recorded. I understand that the company will issue this coverage in reliance upon the truthfulness of my responses to the questions contained in this application. I understand the company has the right to rescind coverage(s) or deny claims based on the failure to provide accurate information at the time of application. **I have received and reviewed a copy of consumer brochure(s) # APSB** ______________________________

I understand that coverage as applied for will not take effect until a policy or certificate is issued and the first premium is applied. Any coverage(s) for which I am applying may have wording that may limit benefits for a preexisting medical condition for which treatment has been sought or received, medication has been taken, a diagnosis received, or an expense incurred. Any coverage(s) for which I am applying may also have wording that could limit or reduce benefits.

☐ If I, or any Covered Person, is currently on Medicaid, I acknowledge this coverage may not be appropriate. I further acknowledge that any benefit payable under this product will be paid directly to Medicaid as required by law.

Warning: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes a claim for the proceeds of an insurance policy containing any false, incomplete or misleading information or knowingly presents false information in an application for insurance may be guilty of insurance fraud.

______________________	______________________	______________________
Signed At (City and State)	Date	Signature of Applicant

______________________	______________________
Signature of Licensed Agent	Agent's Printed Name and Agent Number

Soliciting Agents: (Please Print. If split with other Agents, include on a separate sheet.)	**Agent Number**	**Split Percent** (Total = 100%)
Name: ______________________	Agent #: ____________	Split %: ____________
Name: ______________________	Agent #: ____________	Split %: ____________
Name: ______________________	Agent #: ____________	Split %: ____________
Name: ______________________	Agent #: ____________	Split %: ____________

Agent's Special Requests:

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.

SIMPLIFIED ISSUE UNDERWRITING AND MEDICAL QUESTIONS Any person answering YES to the following questions is not eligible for coverage. If multiple children are to be covered, please list the first name of any child answering Yes on the line provided in that area.		Applicant	Spouse	Child(ren) (NAME, if Yes)
[BASIC] [ENHANCED] [ENHANCED PLUS]	If applying for spouse coverage, is the spouse currently disabled?		☐Yes ☐No	
	If applying for child coverage, is any child currently disabled?			☐Yes ☐No
	Is any person to be covered currently covered by Medicaid?	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
	Has any person to be insured had any positive test results indicating Human Immunodeficiency Virus (HIV), or been diagnosed as having Acquired Immunodeficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
	Within the last 10 years, has any person to be insured received medical advice, sought treatment (including medication), or been treated or diagnosed by a member of the medical profession for: heart attack (acute myocardial infarction), coronary artery disease (including coronary angioplasty or bypass surgery), disease of the heart or circulatory system, any abnormality of the heart, transient ischemic attack (TIA), stroke, 3 or more prescriptions taken for the control of high blood pressure, emphysema, chronic obstructive pulmonary disorder (COPD), organ failure or transplant, hepatitis B, C, or D, chronic pancreatitis, liver disease, diabetes, kidney disease (except kidney stones), systemic lupus?	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
	Within the last 12 months, has any person to be insured received medical advice by a member of the medical profession to have any diagnostic tests, examinations, or consultations to determine the existence of any heart or circulatory condition or stroke: that have not been completed; or that results have not been received; or results were abnormal and no follow-up or resolution has occurred?	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
[ENHANCED PLUS]	Within the last 10 years, has any person to be insured received medical advice, sought treatment (including medication), or been treated or diagnosed by a member of the medical profession for: Alzheimer's disease, dementia, senility, or organic brain syndrome?	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
	Within the last 10 years, has any person to be insured received medical advice, sought treatment (including medication), or been treated or diagnosed by a member of the medical profession for: macular degeneration, glaucoma, optic neuritis, or cataracts which have not been corrected?	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
	Within the last 10 years, has any person to be insured had an average hearing threshold sensitivity test for air conduction of 50 decibels or greater?	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
CANCER RIDER	Within the last 10 years, has any person to be insured received medical advice, sought treatment (including medication), or been treated or diagnosed by a member of the medical profession for: cancer, carcinoma, sarcoma, leukemia, lymphoma, Hodgkin's Disease, melanoma, or a malignant tumor in any form?	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
	In the last 3 years has any person to be insured received medical advice, sought treatment (including medication), or been treated or diagnosed by a member of the medical profession for: skin cancer, including but not limited to basal cell carcinoma, squamous cell carcinoma, and carcinoma in-situ?	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
	Has any person to be insured ever received medical advice by a member of the medical profession to have any diagnostic tests, examinations, or consultations to determine the existence of cancer or skin cancer: that have not been completed; or that results have not been received; or results were abnormal and no follow-up or resolution has occurred?	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No

Print Applicant's Name ____________________ Applicant's Initials __________ Date __________

Supporting Document Schedules

		Item Status:	**Status Date:**
Satisfied - Item:	Flesch Certification	Approved-Closed	10/01/2012
Comments:			
Attachment(s):			
FleschCert.pdf			

		Item Status:	**Status Date:**
Satisfied - Item:	Application	Approved-Closed	10/01/2012
Comments:			
Attachment(s):			
GCRIT11APLA.R912.pdf			

		Item Status:	**Status Date:**
Satisfied - Item:	GCRIT11APLA.R912 Changes Highlighted	Approved-Closed	10/01/2012
Comments:			
Attachment(s):			
GCRIT11APLA.R912_RL.pdf			

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READABILITY CERTIFICATION

I hereby certify that policy forms enclosed on the Forms filing tab meet the minimum reading ease score required by the Insurance Code in your state.

The Flesch Score for each form, excluding defined terms and state mandated language, is:

Form Number	Description	Flesch Score	Word Count (For AR, VA)	Sentence Count (For VA)
GCRIT**EP**11APL	Critical Illness Policy – Employer Paid	54	5120	318
GCRIT**EP**11APLC	Critical Illness Certificate – Employer Paid	53	4899	220
GCRIT**V**11APL	Critical Illness Policy – Voluntary	51	5567	343
GCRIT**V**11APLC	Critical Illness Certificate – Voluntary	50	5634	337
DN87APL	Disclosure Notice	50	94	6
GCRIT11APLMA	Master Application	53	462	39
AMDI317APL	Cancer Critical Illness Rider	50	933	51
AMDI318APL	Health Screening Test Rider	64	358	17
AMDI319APL	Accident Critical Illness Rider	54	1094	72
AMDI320APL	Additional Critical Illness Rider	52	1138	67
AMDI321APL	Recurrence Rider	70	436	31
AMDI326APL	Waiver of Premium Rider	65	945	62
AMDI329APL	Amendment Rider	73	115	7
AMDI334APL	COBRA Election Amendment Rider	62	228	14
GCRIT11APLOC	Outline of Coverage (if applicable)	50	2016	118

The Flesch Score for each form, excluding defined terms, medical terminology and state mandated language, is:

GCRIT11APLA	Certificate Application	52	662	41

Our Company uses Microsoft Word to calculate the Flesch Score. Microsoft Word does not provide a syllable count.

[signature]

Alex Bagby, ASA, MAAA
Vice President and Chief Risk Officer

November 8, 2011
Date

FOR AGENT USE ONLY:
Requested Effective Date:

☐ **New Enrollment**
☐ **Family Status Change**
☐ **Benefit Change**

American Public Life Insurance Company

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2305 Lakeland Drive • Flowood, Mississippi 39232
Phone: (601) 936-6600 or (800) 256-8606
Fax: (877) 807-0911

FOR HOME OFFICE USE ONLY:
Effective Date: ______
PRD #: ______
Group #: ______
Revised: ______

Group Products • Application for Critical Illness Insurance • Payroll Market

PROPOSED INSURED'S INFORMATION

	Last Name First Name MI	Sex	Birthdate Mo/Day/Yr	Age	Height Feet/Inches	Weight Lbs.	Social Security #
Applicant		☐M ☐F					
Spouse (must reside w/ applicant)		☐M ☐F					
Child 1		☐M ☐F					
Child 2		☐M ☐F					
Child 3		☐M ☐F					
Child 4		☐M ☐F					

Resident Address: Number & Street City State Zip Home Phone

Mailing Address: (if different) Number & Street City State Zip

Email Address:

APPLICANT

Full Time? ☐ Yes ☐ No Hours Per Week: ______
Salary: $______ ☐ Hourly ☐ Weekly ☐ Monthly ☐ Annually
Occupation: ______ Hire Date: ______

Payroll Deduction Frequency: ☐ 12 ☐ 13 ☐ 24 ☐ 26 ☐ 52
Skip Mode: ☐ 8 ☐ 9 ☐ 10 ☐ 11 **Indicate Months:** ______

EMPLOYER

Name: ______
City: ______ State: ______
Work Phone: ______

Master Policyholder Name:

BENEFICIARY INFORMATION

APPLICANT: Primary ______ Relationship______
Contingent ______ Relationship______

CITIZENSHIP INFORMATION

Is/Are the person(s) to be insured and the beneficiary(ies) a citizen of the United States? ☐ Yes ☐ No (If No, give details.)

______ Full Name ______ Country of Citizenship

______ Full Name ______ Country of Citizenship

CRITICAL ILLNESS PRODUCT SELECTION — Premium

Critical Illness Plan Selected ☐ Applicant Only ☐ Applicant and Spouse ☐ Applicant & Child(ren) ☐ Applicant & Family

Has any form of nicotine been used in the last 12 months? Applicant: ☐ **Yes** ☐ **No** [**Spouse:** ☐ **Yes** ☐ **No**]

[☐ **[BASIC]** ☐ **[ENHANCED]** ☐ **[ENHANCED PLUS]**]

TOTAL AMOUNT OF COVERAGE:

Critical Illness Benefit Amount (For Applicant's age 18-69): [☐ $5,000 ☐ $10,000 ☐ $15,000 ☐ $20,000 ☐ $25,000] .... $

Critical Illness Benefit Amount (For Applicant's age 70+): [☐ $2,500 ☐ $5,000 ☐ $7,500 ☐ $10,000 ☐ $12,500] .... $

[ADDITIONAL BENEFIT RIDERS:

☐ Cancer Critical Illness Rider .... $]

Total Premium $

	Applicant	Spouse	Child(ren) (NAME, if Yes)
Are you actively at work on a full time basis as defined by your employer for the last 60 days, except for normal pregnancy, minor illnesses or injury lasting 5 consecutive days or less?	☐Yes ☐No		

SIGNATURE AND ACKNOWLEDGMENT

The statements and answers given in this application (and, if applicable, the Simplified Issue Underwriting and Medical Question section) are true, complete and correctly recorded. I understand that the company will issue this coverage in reliance upon the truthfulness of my responses to the questions contained in this application. I understand the company has the right to rescind coverage(s) or deny claims based on the failure to provide accurate information at the time of application. **I have received and reviewed a copy of consumer brochure(s) # APSB** ______________________________

I understand that coverage as applied for will not take effect until a policy or certificate is issued and the first premium is applied. Any coverage(s) for which I am applying may have wording that may limit benefits for a preexisting medical condition for which treatment has been sought or received, medication has been taken, a diagnosis received, or an expense incurred. Any coverage(s) for which I am applying may also have wording that could limit or reduce benefits.

☐ If I, or any Covered Person, is currently on Medicaid, I acknowledge this coverage may not be appropriate. I further acknowledge that any benefit payable under this product will be paid directly to Medicaid as required by law.

Warning: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes a claim for the proceeds of an insurance policy containing any false, incomplete or misleading information or knowingly presents false information in an application for insurance may be guilty of insurance fraud.

______________________________	______________________	____
Signed At (City and State)	Date	Signature of Applicant

____	____
Signature of Licensed Agent	Agent's Printed Name and Agent Number

Soliciting Agents: (Please Print. If split with other Agents, include on a separate sheet.)	**Agent Number**	**Split Percent** (Total = 100%)
Name: ______________________________	Agent #: ________________	Split %:____________
Name: ______________________________	Agent #: ________________	Split %:____________
Name: ______________________________	Agent #: ________________	Split %:____________
Name: ______________________________	Agent #: ________________	Split %: ____________

Agent's Special Requests:

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.

SIMPLIFIED ISSUE UNDERWRITING AND MEDICAL QUESTIONS Any person answering YES to the following questions is not eligible for coverage. If multiple children are to be covered, please list the first name of any child answering Yes on the line provided in that area.		Applicant	Spouse	Child(ren) (NAME, if Yes)
[BASIC] [ENHANCED] [ENHANCED PLUS]	If applying for spouse coverage, is the spouse currently disabled?		☐Yes ☐No	
	If applying for child coverage, is any child currently disabled?			☐Yes ☐No
	Is any person to be covered currently covered by Medicaid?	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
	Has any person to be insured had any positive test results indicating Human Immunodeficiency Virus (HIV), or been diagnosed as having Acquired Immunodeficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
	Within the last 10 years, has any person to be insured received medical advice, sought treatment (including medication), or been treated or diagnosed by a member of the medical profession for: heart attack (acute myocardial infarction), coronary artery disease (including coronary angioplasty or bypass surgery), disease of the heart or circulatory system, any abnormality of the heart, transient ischemic attack (TIA), stroke, 3 or more prescriptions taken for the control of high blood pressure, emphysema, chronic obstructive pulmonary disorder (COPD), organ failure or transplant, hepatitis B, C, or D, chronic pancreatitis, liver disease, diabetes, kidney disease (except kidney stones), systemic lupus?	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
	Within the last 12 months, has any person to be insured received medical advice by a member of the medical profession to have any diagnostic tests, examinations, or consultations to determine the existence of any heart or circulatory condition or stroke: that have not been completed; or that results have not been received; or results were abnormal and no follow-up or resolution has occurred?	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
[ENHANCED PLUS]	Within the last 10 years, has any person to be insured received medical advice, sought treatment (including medication), or been treated or diagnosed by a member of the medical profession for: Alzheimer's disease, dementia, senility, or organic brain syndrome?	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
	Within the last 10 years, has any person to be insured received medical advice, sought treatment (including medication), or been treated or diagnosed by a member of the medical profession for: macular degeneration, glaucoma, optic neuritis, or cataracts which have not been corrected?	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
	Within the last 10 years, has any person to be insured had an average hearing threshold sensitivity test for air conduction of 50 decibels or greater?	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
CANCER RIDER	Within the last 10 years, has any person to be insured received medical advice, sought treatment (including medication), or been treated or diagnosed by a member of the medical profession for: cancer, carcinoma, sarcoma, leukemia, lymphoma, Hodgkin's Disease, melanoma, or a malignant tumor in any form?	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
	In the last 3 years has any person to be insured received medical advice, sought treatment (including medication), or been treated or diagnosed by a member of the medical profession for: skin cancer, including but not limited to basal cell carcinoma, squamous cell carcinoma, and carcinoma in-situ?	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
	Has any person to be insured ever received medical advice by a member of the medical profession to have any diagnostic tests, examinations, or consultations to determine the existence of cancer or skin cancer: that have not been completed; or that results have not been received; or results were abnormal and no follow-up or resolution has occurred?	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No

Print Applicant's Name ______________________ Applicant's Initials ____________ Date ____________

FOR AGENT USE ONLY:
Requested Effective Date:
☐ **New Enrollment**
☐ **Family Status Change**
☐ **Benefit Change**

American Public Life Insurance Company

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2305 Lakeland Drive • Flowood, Mississippi 39232
Phone: (601) 936-6600 or (800) 256-8606
Fax: (877) 807-0911

FOR HOME OFFICE USE ONLY:	
Effective Date:	
PRD #:	
Group #:	
Revised:	

Group Products • Application for Critical Illness Insurance • Payroll Market

PROPOSED INSURED'S INFORMATION

	Last Name First Name MI	Sex	Birthdate Mo/Day/Yr	Age	Height Feet/Inches	Weight Lbs.	Social Security #
Applicant		☐M ☐F					
Spouse (must reside w/ applicant)		☐M ☐F					
Child 1		☐M ☐F					
Child 2		☐M ☐F					
Child 3		☐M ☐F					
Child 4		☐M ☐F					

Resident Address: Number & Street City State Zip Home Phone

Mailing Address: (if different) Number & Street City State Zip

Email Address:

APPLICANT

Full Time? ☐ Yes ☐ No Hours Per Week: ____________
Salary: $____________ ☐ Hourly ☐ Weekly ☐ Monthly ☐ Annually
Occupation: ____________ Hire Date: ____________

Payroll Deduction Frequency: ☐ 12 ☐ 13 ☐ 24 ☐ 26 ☐ 52
Skip Mode: ☐ 8 ☐ 9 ☐ 10 ☐ 11 **Indicate Months**: ____________

EMPLOYER

Name: ____________
City: ____________ State: ________
Work Phone: ____________

Master Policyholder Name:

BENEFICIARY INFORMATION

APPLICANT: Primary ____________ Relationship____________
Contingent ____________ Relationship____________

CITIZENSHIP INFORMATION

Is/Are the person(s) to be insured and the beneficiary(ies) a citizen of the United States? ☐ Yes ☐ No (If No, give details.)

____________ Full Name ____________ Country of Citizenship

____________ Full Name ____________ Country of Citizenship

CRITICAL ILLNESS PRODUCT SELECTION

	Premium
Critical Illness Plan Selected ☐ Applicant Only ☐ Applicant and Spouse ☐ Applicant & Child(ren) ☐ Applicant & Family	
Has any form of nicotine been used in the last 12 months? Applicant: ☐ **Yes** ☐ **No** [**Spouse:** ☐ **Yes** ☐ **No**]	
[☐ [**BASIC**] ☐ [**ENHANCED**] ☐ [**ENHANCED PLUS**]]	
TOTAL AMOUNT OF COVERAGE:	
Critical Illness Benefit Amount (For Applicant's age 18-69): [☐ $5,000 ☐ $10,000 ☐ $15,000 ☐ $20,000 ☐ $25,000]	$
Critical Illness Benefit Amount (For Applicant's age 70+): [☐ $2,500 ☐ $5,000 ☐ $7,500 ☐ $10,000 ☐ $12,500]	$
[**ADDITIONAL BENEFIT RIDERS:**	
☐ Cancer Critical Illness Rider	$]
Total Premium	$

MOVED FROM SIMPLIFIED ISSUE UNDERWRITING SECTION TO HERE

	Applicant	Spouse	Child(ren) (NAME, if Yes)
Are you actively at work on a full time basis as defined by your employer for the last 60 days, except for normal pregnancy, minor illnesses or injury lasting 5 consecutive days or less?	☐Yes ☐No		

SIGNATURE AND ACKNOWLEDGMENT

The statements and answers given in this application (and, if applicable, the Simplified Issue Underwriting and Medical Question section) are true, complete and correctly recorded. I understand that the company will issue this coverage in reliance upon the truthfulness of my responses to the questions contained in this application. I understand the company has the right to rescind coverage(s) or deny claims based on the failure to provide accurate information at the time of application. **I have received and reviewed a copy of consumer brochure(s) # APSB** ______________________________

I understand that coverage as applied for will not take effect until a policy or certificate is issued and the first premium is applied. Any coverage(s) for which I am applying may have wording that may limit benefits for a preexisting medical condition for which treatment has been sought or received, medication has been taken, a diagnosis received, or an expense incurred. Any coverage(s) for which I am applying may also have wording that could limit or reduce benefits.

☐ If I, or any Covered Person, is currently on Medicaid, I acknowledge this coverage may not be appropriate. I further acknowledge that any benefit payable under this product will be paid directly to Medicaid as required by law.

Warning: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes a claim for the proceeds of an insurance policy containing any false, incomplete or misleading information or knowingly presents false information in an application for insurance may be guilty of insurance fraud.

______________________	______________________	______________________
Signed At (City and State)	Date	Signature of Applicant

______________________	______________________
Signature of Licensed Agent	Agent's Printed Name and Agent Number

Soliciting Agents: (Please Print. If split with other Agents, include on a separate sheet.)	**Agent Number**	**Split Percent** (Total = 100%)
Name: ______________________	Agent #: ______________	Split %: ____________
Name: ______________________	Agent #: ______________	Split %: ____________
Name: ______________________	Agent #: ______________	Split %: ____________
Name: ______________________	Agent #: ______________	Split %: ____________

Agent's Special Requests:

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.

SIMPLIFIED ISSUE UNDERWRITING AND MEDICAL QUESTIONS Any person answering YES to the following questions is not eligible for coverage. If multiple children are to be covered, please list the first name of any child answering Yes on the line provided in that area.		Applicant	Spouse	Child(ren) (NAME, if Yes)
~~[BASIC] [ENHANCED] [ENHANCED PLUS]~~	~~Are you actively at work on a full time basis as defined by your employer for the last 60 days, except for normal pregnancy, minor illnesses or injury lasting 5 consecutive days or less?~~	~~☐Yes ☐No~~		
[BASIC] [ENHANCED] [ENHANCED PLUS]	If applying for spouse coverage, is the spouse currently disabled?		☐Yes ☐No	
	If applying for child coverage, is any child currently disabled?			☐Yes ☐No
	Is any person to be covered currently covered by Medicaid?	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
	Has any person to be insured had any positive test results indicating Human Immunodeficiency Virus (HIV), or been diagnosed as having Acquired Immunodeficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
	Within the last 10 years, has any person to be insured received medical advice, sought treatment (including medication), or been treated or diagnosed by a member of the medical profession for: heart attack (acute myocardial infarction), coronary artery disease (including coronary angioplasty or bypass surgery), disease of the heart or circulatory system, any abnormality of the heart, transient ischemic attack (TIA), stroke, 3 or more prescriptions taken for the control of high blood pressure, emphysema, chronic obstructive pulmonary disorder (COPD), organ failure or transplant, hepatitis B, C, or D, chronic pancreatitis, liver disease, diabetes, kidney disease (except kidney stones), systemic lupus?	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
	Within the last 12 months, has any person to be insured received medical advice by a member of the medical profession to have any diagnostic tests, examinations, or consultations to determine the existence of any heart or circulatory condition or stroke: that have not been completed; or that results have not been received; or results were abnormal and no follow-up or resolution has occurred?	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
[ENHANCED PLUS]	Within the last 10 years, has any person to be insured received medical advice, sought treatment (including medication), or been treated or diagnosed by a member of the medical profession for: Alzheimer's disease, dementia, senility, or organic brain syndrome?	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
	Within the last 10 years, has any person to be insured received medical advice, sought treatment (including medication), or been treated or diagnosed by a member of the medical profession for: macular degeneration, glaucoma, optic neuritis, or cataracts which have not been corrected?	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
	Within the last 10 years, has any person to be insured had an average hearing threshold sensitivity test for air conduction of 50 decibels or greater?	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
CANCER RIDER	Within the last 10 years, has any person to be insured received medical advice, sought treatment (including medication), or been treated or diagnosed by a member of the medical profession for: cancer, carcinoma, sarcoma, leukemia, lymphoma, Hodgkin's Disease, melanoma, or a malignant tumor in any form?	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
	In the last 3 years has any person to be insured received medical advice, sought treatment (including medication), or been treated or diagnosed by a member of the medical profession for: skin cancer, including but not limited to basal cell carcinoma, squamous cell carcinoma, and carcinoma in-situ?	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
	Has any person to be insured ever received medical advice by a member of the medical profession to have any diagnostic tests, examinations, or consultations to determine the existence of cancer or skin cancer: that have not been completed; or that results have not been received; or results were abnormal and no follow-up or resolution has occurred?	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No

Print Applicant's Name	Applicant's Initials	Date