PLEASE PRINT WITH BLACK INK

APPLICATION FOR LIFE AND HEALTH INSURANCE TO:

Allstate

AMERICAN HERITAGE LIFE INSURANCE COMPANY
1776 AMERICAN HERITAGE LIFE DRIVE
JACKSONVILLE, FLORIDA 32224-6687

Proposed Insured (Last, First, M.I.)	☐ Self ☐ Spouse ☐ Child ☐ Other	☐ M ☐ F	Age	Birthdate	Height	Weight	Social Security Number

Home Address	City	State	Zip	Home Phone Number

Employer	Occupation	Date Hired

Payor (if other than Proposed Insured)	Social Security Number or Tax I.D. Number (Owner or Payor)

Owner's Name and Address (if different than Proposed Insured's)	City	State	Zip

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

INSURANCE PLANS

Universal Life	Face Amount	Riders	Rider	Rider	Rider	Rider	Rider	Rider	Rider	Mode Premium
	Death Benefit Option ☐ 1 ☐ 2	Units/Amt								$
Term Life	Face Amount	Riders	Rider	Rider	Rider	Rider	Rider	Rider	Rider	Mode Premium
		Units/Amt								$
Cancer ☐ Individual ☐ Family		Riders	Rider	Rider	Rider	Rider	Rider			Mode Premium
Benefit / Plan:		Units/Amts.								$
Accident ☐ Individual ☐ Family		Monthly Salary $	Rider APDIR	Rider APBER	Rider APEXT	Rider APOPTR1	Rider APHCR1			Mode Premium
Benefit / Plan:		Units								$
SHOP ☐ Individual ☐ Individual & Children ☐ Individual & Spouse ☐ Family		Base Plan	Rider IHR1	Rider SAR1	Rider IPBR1	Rider OEAR1	Rider OPBR1	Rider AHNR	Rider TR1	Rider ADIR1	Rider SDIR1	Mode Premium
Benefit / Plan:		Units	Units	Units	Units	Units	Units	Units	Units	Units	Units	$
Heart/Stroke ☐ Individual ☐ Family		Riders	Rider CIDR1	Rider ICR	Rider WBR3	Rider	Rider			Mode Premium
Units or Benefit Level:		Units/Amt								$

Cash With Application ☐ Yes ☐ No

PAC Policies Transit Number _____
☐ Checking Account Number _____
☐ Savings Draft Date _____

Premiums/Billing Mode ☐ Annual ☐ PAC

Total Mode Premium
$

Remarks

Home Office Use

Producer Number
1LWP0

NON-MEDICAL QUESTIONNAIRE

All Coverages	1. Is the proposed insured actively at work now and has he/she worked at least 20 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? **(If no, please explain in question 11 below or on supplement on next page.)**	☐ Yes ☐ No

IF ANY QUESTIONS 2-8 BELOW ARE ANSWERED "YES," PLEASE LIST THE REQUIRED HEALTH HISTORY IN QUESTION 11 BELOW.

All Coverages	2. Is any person to be insured now being treated, or in the last 10 years been treated or diagnosed by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? **California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance.**	☐ Yes ☐ No
All Life	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
All Life	4. a) In the last 3 years, has any person to be insured been seen by a physician, been hospitalized, been disabled or treated for a disorder? (This question can be answered no if the person was seen for colds, flu, normal pregnancy or a routine physical examination with no unfavorable results.) b) In the last 3 years, has any person to be insured had diagnostic or therapeutic procedure done? c) In the last 3 years, has any person to be insured been counseled for or excessively used alcohol or any type of drugs?	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No
Cancer (Policies & Riders) & Life	5. Is any person to be insured currently undergoing any diagnostic test for, now being treated for, or in the last 10 years been treated for, cancer or any malignancy which includes: carcinoma; sarcoma; Hodgkin's Disease; leukemia; lymphoma; or any malignant tumor?	☐ Yes ☐ No
Heart/Stroke, ICU & Life	6. a) Is any person to be insured now being treated for, or in the last 10 years been treated for: a stroke; a heart attack; a heart condition; heart trouble; any abnormality of the heart (including artery disease); or diabetes? b) Has any person to be insured ever been diagnosed with hypertension or high blood pressure? c) If the answer to 6b above is yes, in the last year has that person had a systolic blood pressure reading higher than 150 more than once or a diastolic blood pressure reading higher than 100 more than once?	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No
Hosp. Ind. (SHOP) & Sickness Riders to Accident Policy	7. a) In the last 3 years, has any person to be insured had, been treated for, or been told by a member of the medical profession that he/she has: diabetes, emphysema, asthma, epilepsy, hepatitis, mental or nervous illness, ulcers, any disorder of the central nervous system (to include muscular dystrophy (MD) or multiple sclerosis (MS); Parkinson's disease; lupus; rheumatoid arthritis; fibromyalgia; chronic fatigue syndrome; any disorder of the heart, kidneys, liver, lungs, pancreas, or back (including neck); paralysis; optic neuritis; cancer (except basal cell skin cancer), malignant tumor, leukemia, Hodgkin's Disease; or a stroke? b) Has any person to be insured ever been diagnosed with hypertension or high blood pressure? c) If the answer to 7b above is yes, in the last year has that person had a systolic blood pressure reading higher than 150 more than once or a diastolic blood pressure reading higher than 100 more than once? d) Has any person to be insured, in the last 2 years, been treated for or counseled for alcohol or drug abuse? e) 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? f) Has any person to be insured received any advice, treatment, or consultation for Alzheimer's disease, dementia, senility, or organic brain syndrome? g) Is any person to be insured pregnant at this time?	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No
Life & All Accident policies & riders	8. In the last 3 years, has any person to be insured had his/her driver's license suspended or revoked or been arrested for reckless or drunken driving and/or been involved in 3 or more motor vehicle accidents? If yes, provide additional details in #11 below.	☐ Yes ☐ No
All Coverages	9. **Replacement.** Is this insurance to replace or change any existing life or health coverage? If yes, indicate product being replaced or changed and complete replacement form provided by your producer if required by your state. _____	☐ Yes ☐ No
All Coverages	10. **Existing Insurance.** Is there any other life, cancer, heart/stroke, hospital, 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

Required Health History (Please Supply Additional Information On Supplement On Next Page If Needed)	11. Question#	Name	Disease or Injury-Dates	Duration	Result	Name & Address of Doctor

All Health	12. I have received an Outline of Coverage for each health coverage?	☐ Yes ☐ No
Cancer, Heart Stroke & Hosp. Ind. (SHOP)	13. Do you currently have an individual or group policy or contract that arranges or provides medical, hospital or surgical coverage not designed to supplement other private or governmental plans? If you have answered "No", you may not apply for Specified Disease (Cancer and Heart/Stroke) or Hospital Indemnity Coverage.	☐ Yes ☐ No

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 the "effective date" of the insurance coverage(s) will be the policy date recorded on the Policy Specifications page. **The effective date of the policy(ies) is not the date the application is signed.** If the policy(ies) is (are) not issued, American Heritage Life will refund any premiums it receives. I also understand that no producer 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, or the Medical Information Bureau 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 About Privacy and MIB Notice form. A copy of this authorization is as valid as the original. This authorization applies to any dependent on whom insurance is requested. This authorization is valid for a period of 24 months from the date signed. I understand that I may revoke this authorization at any time by notifying American Heritage Life in writing of my desire to do so.

Signed at: City/State: _____ Date Signed: _____

Signature of Proposed Insured _____ Signature of Owner, if other than Insured _____

Producer's Statement.
1. To your knowledge, is change or replacement involved? ☐ Yes ☐ No
2. Did you receive money and give a Receipt for Cash with Application with this application? ☐ Yes ☐ No If yes, record amount here $ _____.
3. I certify that to the best of my knowledge and belief the information in this application is complete, accurate and correctly recorded.

Signature of Producer _____ Print Producer's Name John M. Caris / Sonoma Valley Insurance

PO Box 1669, Sonoma, CA 95476

jcaris@carisagency.com FAX: 707-935-3602

APPLICATION TO AMERICAN HERITAGE LIFE INSURANCE COMPANY
NON-MEDICAL QUESTIONNAIRE - SUPPLEMENTAL EXPLANATIONS (CONT.)

Proposed Insured _____

Quest./#	Name	Disease or Injury - Dates	Duration	Result	Name & Address of Doctor

Other Explanations:

This supplements and is part of my application signed on the same date for the proposed insured above. The information above is true, complete and correctly recorded.

Date: _____

Signature of Proposed Insured _____ Signature of Owner if other than Insured _____

RECEIPT FOR CASH WITH APPLICATION

1. All checks must be made payable to American Heritage Life Insurance Company. Do not make checks payable to the producer or leave the payee blank.
2. If your application is approved and accepted, your coverage will be effective on the date of final underwriting approval.
3. If your application is approved and accepted, the cash submitted with your application will be applied towards your first premium payment due for the coverage applied for.
4. If your application is approved and accepted, there is no coverage between the date of your application and the effective date of the policy.
5. This receipt is issued on the condition that any check or other method of payment is good and collectible. The deposit of your payment to our account does not guarantee acceptance for insurance.
6. If your application is denied, you will receive no coverage and your payment submitted with your application will be refunded to you.

I have read and explained this RECEIPT FOR CASH WITH APPLICATION to the applicant. I have received an amount of $_____ from _____ which I will remit to the home office with the application for insurance.

Signature of Producer: _____ Date: _____

I have personally completed an application for an individually underwritten insurance policy. The producer has read and explained this RECEIPT FOR CASH WITH APPLICATION to me. I understand that I will not receive any insurance coverage unless my application is approved and accepted by American Heritage Life Insurance Company and a policy(ies) is (are) issued.

Signature of Applicant: _____ Date: _____

PRODUCER INSTRUCTIONS

1. Complete the entire application to the extent appropriate for the coverage applied for.
2. Non-Medical Questionnaire - Always complete, even if a medical exam is required.
3. Medical History - If more space is needed to explain answers to the non-medical questions, use the reverse side of this page (top) and get additional signatures requested.
4. Multiple Plans Requested - You may use one application to apply for multiple products only if the primary insured and the owner are the same for all. Otherwise, use separate applications.
5. Signatures - Each proposed insured and the owner (if different) must sign.
6. MIB and Important Notice - Always give this to the applicant.
7. Receipt for Cash with Application - Give this only when the first full payment on the plan, mode of payment, and amount applied for is received.Read the terms of this receipt. Do not take money and give receipt without H.O. approval if life coverage exceeds $100,000. Also, don't give this receipt or take cash if Question 1 is answered "No" and/or any of the Questions 2, 4-8 are answered "Yes." Instead, mark as a trial application and take cash on delivery if issued.
8. Producer's Statement - Check the yes/no boxes appropriately and sign. Print your name legibly.

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 Acquired Immune Deficiency Syndrome (AIDS) will affect the issuance or the underwriting of this policy except, upon written consent, to be medically tested for 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. #866-692-6901 (TTY 866-346-3642 for hearing impaired). 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 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, to the State Department of Health.