☒ Producer Assisted ☐ Self Enrollment ☐ 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 (if other than Proposed Insured)	Employee's Date of Birth	Employee/Payor Social Security Number	Employee's I.D. Number	Date Hired

PROPOSED INSURED INFORMATION

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

Residence Address	City	State	Zip	Phone Number

Employer	Occupation

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

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

Primary Beneficiary's Full Name and Address	City	State	Zip	Relationship	Phone Number	Date of Birth	Social Security Number
Contingent Beneficiary's Full Name 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^	Tobacco Use [1]^
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

*Actively at work means that he/she is actively at work now for wage or profit and has 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.

[1]Has anyone to be insured used tobacco in the last 12 months? (****If applying for Life or Critical Illness. ^For dependents ages 19 and older, if applying for Life.**)

INSURANCE PLANS

Abbreviations: GI - Guaranteed Issue CGI - Contingent Guaranteed Issue SI - Simplified Issue

Accident _____ ☐ GI ☐ CGI ☐ SI (Plan Type and Units) | ☐ AP2 ☐ AP3 | ☐ Individual ☐ Family | Monthly Salary $_____ | Section 125 ☐ Yes ☐ No | Mode Premium $_____

Riders	Rider APDIR	Rider APBER	Rider APOPTR1	Rider APHCR1	Rider	Rider	Rider	Rider
Units/Amt								

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

Riders	Rider CER	Rider ICR	Rider CLR	Rider CPR	Rider CFR	Rider WBR	Rider	Rider
Units/Amt								

Critical Illness _____ ☐ GI ☐ SI (Plan Type) | Basic Benefit Amount $_____ | ☐ Individual ☐ Family ☐ Single Parent Family | Section 125 ☐ Yes ☐ No | Mode Premium $_____

Riders	Rider CICR1	Rider WBR	Rider	Rider	Rider	Rider	Rider	Rider
Units/Amt								

Disability (DI) _____ ☐ GI ☐ CGI ☐ SI

Occupation Class ☐ Preferred ☐ Standard

Monthly Salary $_____ | Monthly Benefit $_____ | Elimination Period _____ Days Acc. _____ Days Sick. | Benefit Period _____ Months | Section 125 ☐ Yes ☐ No | Mode Premium $_____

Heart/Stroke _____ Units _____ ☐ GI ☐ CGI ☐ SI (Plan Type) | ☐ Individual ☐ Family | Section 125 ☐ Yes ☐ No | Mode Premium $_____

Riders	Rider CIDR1	Rider ICR	Rider	Rider	Rider	Rider	Rider	Rider
Units/Amt								

Hospital Indemnity (SHOP) _____ (Plan Type) Units _____ ☐ CGI ☐ SI	☐ Individual ☐ Individual & Children ☐ Individual & Spouse ☐ Family	Section 125 ☐ Yes ☐ No	Mode Premium $ _____

Riders	Rider IHR1	Rider SAR1	Rider IPBR1	Rider OPBR1	Rider OEAR1	Rider AHNR	Rider TR1	Rider ADIR1	Rider SDIR1
Units/Amt									

Life ☐ Universal (UL20) ☐ Universal (UL21) ☐ GI (Employee Only) ☐ CGI ☐ SI	Death Benefit Option ☐ 1 ☐ 2 Universal Life ONLY	Face Amount $ _____	Mode Premium $ _____

Riders	Rider ADB	Rider PW	Rider STR	Rider CTR	Rider LBR	Rider FPOR	Rider OIR	Rider TIR	Rider	Rider
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 ☐ Semi-Monthly ☐ Bi-weekly ☐ Weekly ☐ Other _____	Coverage Effective Date _____ Date of First Deduction _____	Total Mode Premium: $ _____

Remarks	Account (Case) Name	Account (Case) Number

IF REQUESTING GUARANTEED ISSUE, PLEASE PROCEED TO QUESTION 15 BELOW. FOR ALL OTHER ENROLLMENTS, IF ANY UNDERWRITING QUESTIONS BELOW ARE ANSWERED "YES", PLEASE LIST THE REQUIRED HEALTH HISTORY IN QUESTION 14 ON PAGE 4.

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

	UNDERWRITING QUESTIONS	EE	SP	CH
CGI & SI Accident w/ Sickness DI Rider, Cancer, SI Critical Illness, CGI & SI Disability, Heart/Stroke, Hospital Indemnity & CGI & SI Life	1. To the best of your knowledge, has any person to be insured, in the last 10 years, been diagnosed with or treated 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.**	☐Y ☐N	☐Y ☐N	☐Y ☐N
All CGI	2. To the best of your knowledge, has any person to be insured, in the last 6 months, been disabled or hospitalized for anything other than normal pregnancy, lacerations or broken bones due to an accident?	☐Y ☐N	☐Y ☐N	☐Y ☐N
Cancer, SI Critical Illness Cancer Rider & SI Hospital Indemnity	3a. To the best of your knowledge, has any person to be insured, in the last 10 years, 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
	3b. If the answer to 3a. is yes, to the best of your knowledge, has that person(s), in the last 10 years, 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
	3c. If the answer to 3a. is yes, to the best of your knowledge, 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 3b. and/or basal cell carcinoma)?	☐Y ☐N	☐Y ☐N	☐Y ☐N
Heart/Stroke, Cancer w/ Intensive Care & SI Hospital Indemnity	4. To the best of your knowledge, 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), heart disease or disorder requiring hospitalization, resulting in disability from work, or a severe episode (including but not limited to heart attack, cardiomyopathy, congestive heart failure, heart murmur (unless taking medications), angioplasty, coronary artery bypass surgery, coronary artery disease, stent, pacemaker, and heart valve replacement, or any artery disease)?	☐Y ☐N	☐Y ☐N	☐Y ☐N

IF REQUESTING GUARANTEED ISSUE, PLEASE PROCEED TO QUESTION 15 BELOW. FOR ALL OTHER ENROLLMENTS, IF ANY UNDERWRITING QUESTIONS BELOW ARE ANSWERED "YES", PLEASE LIST THE REQUIRED HEALTH HISTORY IN QUESTION 14 ON PAGE 4.

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

	UNDERWRITING QUESTIONS (Continued)	EE	SP	CH
SI Life	5. To the best of your knowledge, has any person to be insured, in the last 2 years, been diagnosed with, treated, or counseled by a member of the medical profession for any of the following? • Anemia (other than iron deficiency) • Anxiety, depression or other mental or nervous illness (that would include hospitalizations, disability from work, or suicide attempts) • Asthma (other than taking non-steroidal medication as needed with no hospitalizations), or any other severe lung or respiratory disorder (including but not limited to chronic obstructive pulmonary disease, sarcoidosis, cystic fibrosis, and obstructive sleep apnea) • Cancer, except basal cell carcinoma • Diabetes • Epilepsy with a seizure • Heart attack, cardiomyopathy, congestive heart failure, heart murmur (and taking medication(s)), angioplasty, coronary artery bypass surgery, coronary artery disease, stent, pacemaker, heart valve replacement or any other severe heart disorder that has involved surgery, hospitalization, or any disability from work • Hemophilia • Hepatitis • Kidney Disease involving dialysis or chronic renal failure • Liver Disease • Lou Gehrig's Disease (ALS) • Lupus • Multiple Sclerosis • Muscular Dystrophy • Parkinson's Disease, scleroderma, polymyositis, or fibromyalgia • Stroke including aneurysm, transient ischemic attack (TIA), or arteriovenous malformation • Transplant of any organ • An addiction to alcohol or any type of illegal or prescription drug use	☐Y ☐N	☐Y ☐N	☐Y ☐N
SI Accident w/ Sickness DI Rider, SI Critical Illness, SI Disability, SI Hospital Indemnity & SI Life	6. To the best of your knowledge, has any person to be insured, in the last 5 years, had any medical or surgical procedures (including organ transplant) recommended by a member of the medical profession, but not done at this time for any disorder of any kind?	☐Y ☐N	☐Y ☐N	☐Y ☐N
SI Life	7. To the best of your knowledge, has any person to be insured, in the last 3 years: had his/her driver's license suspended or revoked; been convicted of reckless or drunken driving; or been involved in 3 or more motor vehicle accidents?	☐Y ☐N	☐Y ☐N	☐Y ☐N
SI Accident w/ Sickness DI Rider, Cancer w/ Intensive Care, SI Critical Illness, SI Disability, SI Heart/Stroke, Hospital Indemnity & SI Life	8. To the best of your knowledge, 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
SI Accident w/ Sickness DI Rider & SI Disability	9. To the best of your knowledge, has any person to be insured, in the last 2 years, had any disease, impairment of, or treatment by a member of the medical profession (other than minor llness) for the following? • Any disease or disorder of the back requiring hospitalization, resulting in disability from work, or a severe episode (including but not limited to any form of arthritis, scoliosis, disc disease, sciatica, and spondylolisthesis) • Asthma	☐Y ☐N	☐Y ☐N	☐Y ☐N

IF REQUESTING GUARANTEED ISSUE, PLEASE PROCEED TO QUESTION 15 BELOW. FOR ALL OTHER ENROLLMENTS, IF ANY UNDERWRITING QUESTIONS BELOW ARE ANSWERED "YES", PLEASE LIST THE REQUIRED HEALTH HISTORY IN QUESTION 14 ON PAGE 4.

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

	UNDERWRITING QUESTIONS (Continued)	EE	SP	CH
SI Accident w/ Sickness DI Rider, SI Critical Illness & SI Disability	10. To the best of your knowledge, has any person to be insured, in the last 2 years, had or been diagnosed with or treated by a member of the medical profession for any of the following that would include hospitalization, disability from work, or a severe episode? • Central Nervous System Disease (including but not limited to Multiple Sclerosis, Muscular Dystrophy, Parkinson's, Encephalitis, Meningitis, Alzheimer's, and Huntington's) • Chronic Fatigue Syndrome • Diabetes • Emphysema • Fibromyalgia • Heart Disease (including but not limited to heart attack, cardiomyopathy, congestive heart failure, heart murmur (unless not taking any medications), angioplasty, coronary artery bypass surgery, coronary artery disease, stent, pacemaker, and heart valve replacement) • Liver Disease (including but not limited to hepatitis, fatty liver, cirrhosis, primary sclerosing, colangitis, or hemachromatosis) • Lung Disease (including but not limited to chronic obstructive pulmonary disease, sarcoidosis, Cystic Fibrosis, and obstructive sleep apnea) • Lupus • Optic Neuritis • Parkinson's Disease • Paralysis • Rheumatoid Arthritis	☐Y ☐N	☐Y ☐N	☐Y ☐N
SI Accident w/ Sickness DI Rider & SI Disability	11. To the best of your knowledge, has any person to be insured, in the last 2 years, had or been diagnosed with, treated, or counseled by a member of the medical profession for any of the following? • Alcohol or drug abuse • Pancreas Disease (including but not limited to congenital malformations, cystic fibrosis, or Zollinger-Ellison Syndrome)	☐Y ☐N	☐Y ☐N	☐Y ☐N
SI Accident w/ Sickness DI Rider, Cancer w/ Intensive Care, SI Critical Illness, SI Disability, SI Heart/Stroke, SI Hospital Indemnity & SI Life	12. Provide Height and Weight of Proposed Insured: Height: Weight:			
SI Critical Illness (over $50,000) & SI Life (over $150,000)	13. Provide the names and addresses of all physicians (or other members of the medical profession) for each person to be insured; the required health history section may be used if additional space is needed.			
Required Health History	14. 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	15. 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	16. If you are applying for the type of coverage listed, is there any other (not listed in question 15) insurance of that type in force or applied for (other than this application) on any person to be insured: Coverage Type: life, cancer, heart/stroke, disability, hospital, critical illness or accident? If yes, list company name, policy number, year issued, type of coverage, and amount of benefit.	☐Y ☐N	☐Y ☐N	☐Y ☐N

IF REQUESTING GUARANTEED ISSUE, PLEASE PROCEED TO QUESTION 15 BELOW. FOR ALL OTHER ENROLLMENTS, IF ANY UNDERWRITING QUESTIONS BELOW ARE ANSWERED "YES", PLEASE LIST THE REQUIRED HEALTH HISTORY IN QUESTION 14 ON PAGE 4.

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

	UNDERWRITING QUESTIONS (Continued)		EE	SP	CH
GI, CGI & SI Life	17.	**Illustration Certification. Owner.** The owner certifies that no illustration conforming to the coverage applied for was provided, but that an illustration conforming to the coverage issued will be provided upon delivery of the policy. If no, complete the applicable illustration certification form provided, if required in your state.	☐Y ☐N	☐Y ☐N	☐Y ☐N
All Health	18.	I have received an Outline of Coverage for each health coverage.	☐Y ☐N	N/A	N/A
Cancer, Heart/Stroke, SI Critical Illness & SI Hospital Indemnity	19.	Do you currently have an individual or group policy that arranges or provides medical, hospital or surgical coverage not designed to supplement other private government plans? If you have answered "No", you may not apply for Specified Disease (Cancer, Critical Illness and Heart/Stroke) or Hospital Indemnity coverage.	☐Y ☐N	☐Y ☐N	☐Y ☐N

ELECTRONIC ACCEPTANCE (Please check YES or NO)

By checking the "Yes" box, I elect electronic delivery of my policy(ies), including all documents accompanying my policy(ies). If electronically delivered, I understand that I will receive instructions at the email address I have provided on how to receive my policy and accompanying documents at: www.allstatebenefits.com/mybenefits.

☐ Yes ☐ No

By checking the "Yes" box, I elect electronic delivery of all contractual, regulatory and administrative correspondence (correspondence) regarding my policy(ies), to include claim correspondence, explanations of benefits, periodic notices (such as privacy notices) and other correspondence. If electronically delivered, I understand that I will receive instructions at the last email address I have provided on how to receive correspondence at: www.allstatebenefits.com/mybenefits.

☐ Yes ☐ No

I understand and agree that to receive electronic delivery, I must have a computer with internet access, a web browser that is Microsoft Internet Explorer version 5.0 or greater, an e-mail account, and the ability to download PDF files using Adobe Acrobat Reader version 5.0 or higher and a printer or other device to download and print or save any documents I wish to retain.

I understand and I agree that my consent is valid while I remain covered. At any time, I may withdraw my consent for any reason and receive future correspondence in paper to include a paper copy of my policy(ies), free of charge, by calling toll-free: 1-800-521-3535; or by writing to: Customer Care Center, American Heritage Life Insurance Company, 1776 American Heritage Life Drive, Jacksonville, Florida, 32224.

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 during the first two years of coverage. I represent that statements and answers given on this application are representations, not warranties and are true, complete, and correctly recorded to the best of my knowledge and belief. **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. **AUTHORIZATION TO OBTAIN AND DISCLOSE CERTAIN DATA (FOR SI LIFE AND CRITICAL ILLNESS).** I authorize any physician, medical practitioner, hospital, clinic or other medical facility, Pharmacy Benefit Managers, insurance company or the Medical Information Bureau (MIB, Inc.) that has records or knowledge of me or my health including my prescription medication history to give to AHL, its subsidiaries or its reinsurers any information. I understand that the information obtained by use of this authorization will be used to determine eligibility for insurance and/or benefits. I also authorize AHL, or its reinsurers, to make a brief report of my health information to MIB, Inc. I understand that there is a possibility of redisclosure of any information disclosed pursuant to this authorization and that information, once disclosed, may no longer be protected by federal rules governing privacy and confidentiality. 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 24 months from the date signed. I understand that I may revoke this authorization at any time by notifying AHL 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 _____

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
GI, CGI & SI Life	2. The producer certifies that no illustration conforming to the coverage applied for was provided, but that an illustration conforming to the coverage issued will be provided upon delivery of the policy. If no, complete the applicable illustration certification form provided, if required in your state.	☐ 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:			%
Soliciting Producer:			%
			%
			%

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. You may request to be interviewed in connection with the report and may also receive a copy of the report upon request. This inquiry includes information as to your character, general information and personal characteristics. In certain limited circumstances, we are allowed by law to disclose necessary items of personal information to third parties without your specific authorization. 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.

IN/MIB-3 **(2012)**

MIB Notice:

Information regarding your insurability is treated as confidential. We or our reinsurers may, however, make a brief report to MIB, Inc. (MIB), a not-for profit membership organization of life insurance companies, which operates an information exchange for its members. If you apply to another MIB member company for life or health insurance coverage or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file. Upon receipt of a request from you, MIB arranges disclosure of any information it may have in your file. If you question the accuracy of information in the MIB file, contact MIB and seek a correction in accordance with the procedure set forth in the Federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734, PH. #866-692-6901. 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.

IN/MIB-3 **(2012)**

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 that result from accidental injury. 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
- 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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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).

AWD3431-1

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(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 pays a fixed dollar amount, regardless of your expenses, for each day you meet the policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when:

- any expenses or services covered by the policy are also covered by Medicare

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.
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