

Decide
Today
To Protect
Tomorrow.®

Policy Benefit Highlights

Daily Hospital Confinement Benefit

Pays a daily indemnity benefit for each day an Insured Person is Hospital Confined for each One Period of Confinement. The maximum benefit period for this benefit is 90 days.

Hospital Confinement (Hospital Confined) means the Insured Person must be confined to a bed as a resident Inpatient in a Hospital at the direction of and under the supervision of a Physician due to Injury or Sickness for at least 24 consecutive hours to be considered one day of Hospital Confinement.

Sickness means a disease or illness, which first manifests after the coverage becomes effective for the Insured Person. Sickness includes a pregnancy that commences after the Effective Date of coverage.

An Injury means a sudden, unexpected and unintended bodily injury which is caused directly by an accident; is independent of Sickness, disease, bodily infirmity or any other cause; over which the Insured Person has no control; and occurs while the policy is in force for the person on whom claim is made.

Inpatient means an Insured Person who is admitted and confined as a resident patient to a Hospital for at least 24 continuous hours and is being charged for room and board facilities.

Intensive Care/Coronary Care Unit Rider

Pays an indemnity benefit if an Insured Person is confined in a Hospital's Intensive Care or Coronary Care Unit due to an Injury or Sickness. We will pay the indemnity benefit for each day of such confinement, but not to exceed 20 days during any One Period of Confinement. Confinement in the Intensive Care Unit or Coronary Care Unit must begin after the Effective Date of this Rider. This benefit will be paid in addition to the Hospital Confinement Benefit in the Policy. One Period of Confinement means continuous Hospital Confinement as a resident Inpatient. Successive Hospital stays will be considered One Period of Confinement if they are due to the same or related cause and are separated by less than 180 days.

Annual First Occurrence Hospital Rider

Pays an indemnity benefit for an Insured Person's First Occurrence Hospital Confinement. The Hospital Confinement must be due to a covered Injury or Sickness; begin while this rider is in force; be for at least one day (24 hours); and be at the direction of and under the supervision of a Physician. First Occurrence Hospital Confinement means the first time an Insured Person is confined to a Hospital in a Calendar Year for a period of confinement for which benefits are payable under the policy to which this rider is attached.

Surgical and Anesthesia Benefits Rider

Pays an indemnity benefit when surgery is performed by a Physician due to a covered Injury or Sickness. We will pay the lesser of the surgical unit value assigned to the procedure multiplied by the Unit Dollar Amount*; or the Maximum Surgical Benefit* amount. We will use the most current Physicians' Fee Reference Manual and the Current Procedural Terminology (CPT) Code to determine the surgical unit value assigned to each procedure. A benefit will be calculated as follows: Unit Dollar Amount shown x surgical unit value = Benefit Amount (up to the maximum amount shown per operation). The surgery can be performed in a Hospital (on an inpatient or outpatient basis), in an Ambulatory Surgical Center, or in a Physician's office.

Anesthesia Benefits

Pays 25% of the indemnity benefit paid under the Surgical Benefits when a covered surgical procedure is performed and anesthesia is administered on the Insured Person by a Physician in connection with the covered surgical procedure.

Outpatient Surgical Facility Benefit Rider

Pays an indemnity benefit when an Insured Person has a surgical procedure performed due to a covered Sickness or Injury as an outpatient in a Hospital or at an Ambulatory Surgical Facility. This benefit is paid once per Insured Person per 24-hour period even if more than one surgical procedure is performed.

Hospital Emergency Accident Rider

Pays an indemnity benefit if an Insured Person sustains an Injury which requires Emergency Care by a Physician. The treatment must be rendered in an Emergency Room of a Hospital and received within three days of the Injury. Emergency Care means medical treatment for an Injury demanding immediate attention.

Outpatient Physician Benefit Rider

Pays an indemnity benefit for an Insured Person for outpatient treatment of a covered Sickness or Injury by a Physician or Surgeon. The treatment must be rendered personally by a Physician or Surgeon in that Physician's or Surgeon's office, clinic, or other Out-Of-Hospital facilities.

Medical Testing Benefit Rider

Imaging Test Benefits

Pays an indemnity benefit when an Insured Person receives one of the following Imaging tests: a Magnetic Resonance Imaging (MRI); Computerized Tomography Scan (CT); Computerized Axial Tomography Scan (CAT); Positron Emission Tomography Scan (PET); Multiple Gated Acquisition (MUGA); Single Photon Emission Computer Tomography (SPECT); Pulmonary Ventilation/Perfusion Scan (V/Q); or an Ultrasound. The Imaging Test must be performed on the advice of a Physician for the purpose of diagnosis of a Sickness or Injury.

Other Diagnostic Test Benefit

Pays an indemnity benefit for other Diagnostic Tests when an Insured Person receives a diagnostic test not covered under the Imaging Tests Benefit. The test must be performed on the advice of a Physician for the purpose of diagnosis of a Sickness or Injury.

Wellness Test Benefit

Pays an indemnity benefit when an Insured Person receives a routine examination or other preventive test.

*The Maximum Surgical Benefit and the Unit Dollar Amount are listed on the policy schedule page included in the policy.

Limitations and Exclusions

Eligibility

This policy will be issued to those persons who meet American Public Life Insurance Company's insurability requirements. Persons not meeting American Public Life Insurance Company's insurability requirements will be excluded from coverage by an endorsement attached to the policy.

Base Policy and Riders

No benefits are payable for the first twelve (12) months as a result of a Pre-Existing Condition. A Pre-Existing Condition is a disease or physical condition for which the Insured Person had treatment; incurred expense; took medication; or received a diagnosis or advice from a Physician; during the twelve (12) month period of time immediately prior to the Effective Date of coverage. The term "Pre-Existing Condition" will also include conditions that are related to such disease or physical condition and any pregnancy that commences before the Effective Date of the Insured Person's coverage. Complications of Pregnancy that begin after the Policy Date shown on the Policy Schedule page will be covered as any other Sickness regardless of when the pregnancy commenced. Routine follow-up care to determine whether a breast cancer has recurred in an Insured Person who has been previously determined to be free of breast cancer does not constitute medical advice, diagnosis, care, or treatment for the purposes of determining Pre-Existing Conditions unless evidence of breast cancer is found during or as a result of the follow-up care. Pre-Existing Conditions specifically named or described as permanently excluded in any part of this contract are never covered. Pre-Existing Conditions specifically named or described as excluded for a limited time will be covered after the excluded period expires. If the Insured Person was continuously covered under previous hospital indemnity coverage at least 62 days prior to the Effective Date of coverage under this policy, credit will be given for the time the Insured Person was covered under the previous coverage. All benefits payable only up to the maximum benefit listed on the Policy Schedule in the policy.

Daily Hospital Confinement Benefit

Benefits payable will not exceed the Maximum Benefit Period for any One Period of Confinement. The Hospital Confinement must begin while this policy is in force for the Insured Person. The Daily Benefit is shown in the Policy Schedule. The maximum benefit period for this benefit is 90 days.

A Hospital is not an institution or part of an institution used as a hospice unit, including any bed designated as a hospice or a swing bed; a convalescent home; a rest or nursing facility; a rehabilitative facility (unless rehabilitation is specifically for treatment of physical disability); an extended-care facility; a skilled nursing facility; or a facility primarily affording custodial, educational care, or care or treatment for persons suffering from mental diseases or disorders, or care for the aged, or drug or alcohol addiction.

Intensive Care/Coronary Care Unit Rider

A step-down unit is not considered an Intensive Care Unit.

Annual First Occurrence Hospital Rider

Benefits for this rider will be limited to the benefit amount each Calendar Year for each Insured Person. The first day of confinement must be in the Calendar Year for which the benefit amount is payable.

Surgical and Anesthesia Benefits Rider

Two or more surgical procedures performed through the same incision will be considered one operation and benefits will be limited to the most expensive procedure. In no case will the benefit payable for one operation exceed the maximum amount per operation in the Policy Schedule. If the surgery is performed in an Ambulatory Surgical Facility, the patient must be admitted, treated and released within a 24-hour period.

Outpatient Surgical Facility Benefit Rider

The patient must be admitted, treated and released within a 24-hour period. If the Insured Person's outpatient surgery in a Hospital requires a stay of 24 hours or longer, this benefit will not be paid. In such case, the Hospital Confinement Benefit in the Policy will be paid in lieu of this benefit. This benefit will not be paid for any surgical procedure performed in a Hospital emergency room.

Hospital Emergency Accident Rider

Benefits for Emergency Care are limited to two treatments, per Insured Person, in a Calendar Year, with the exception of Eligible Dependent Children. The benefits for Eligible Dependent Children are limited to a total of two Emergency Care treatments, for ALL children, in a Calendar Year. This benefit is not payable for treatment received in a Physician's office, clinic, or urgent care facility.

Outpatient Physician Benefit Rider

This benefit is limited to five visits in a Calendar Year per Insured Person with the exception of a total of five visits for all Eligible Dependent Children. A maximum of 10 visits per Calendar Year for all covered persons. Treatment received in a hospital emergency room is not covered under this Rider. Treatment must occur after the Insured Person's effective date of coverage under this rider and occur while this rider is in effect for the Insured Person.

Medical Testing Benefit Rider

Imaging Test Benefit

Benefits for Imaging Tests are limited to one such test, per Insured Person, in a Calendar Year, with the exception of Eligible Dependent Children. The benefits for Eligible Dependent Children are limited to a total of two Imaging Tests, for ALL children combined, in a Calendar Year. The test must be performed while the person is covered under this Rider.

Other Diagnostic Tests Benefit

Benefits for Other Diagnostic Tests are limited to two such tests, per Insured Person, in a Calendar Year, with the exception of Eligible Dependent Children. The benefits for Eligible Dependent Children are limited to a total of two Other Diagnostic Tests, for ALL children combined, in a Calendar Year. This benefit is not payable for any test covered under the Imaging Tests Benefit or Wellness Test Benefit. The test must be performed while the person is covered under this Rider.

Wellness Test Benefit

Benefits for Wellness Tests are limited to one such test, per Insured Person, in a Calendar Year. This benefit is not payable for any test covered under the Imaging Tests Benefit or the Other Diagnostic Tests Benefit. The test must be performed while the person is covered under this Rider.

Guaranteed Renewable

You have the right to renew this Policy until: the first premium due date on or after Your 65th birthday; or, if the Policy Date is after Your 60th birthday, the fifth Policy Anniversary; if You pay the correct premium when due or within the Grace Period. We have the right to change premium rates by class.

Family Coverage:

You can take advantage of several options to extend coverage to your family:

- Family Plan – You and your spouse and any Eligible Child* under age 25.
- Single Parent Family – You and any Eligible Child* under age 25.

*Please consult the policy for the definition of Eligible Child.

All Riders are subject to all the Provisions, Conditions, Limitations and Exclusions of the Policy to which it is attached, which are not in conflict with those of the Rider.

Limitations and Exclusions *continued*

We do not cover Hospital Confinements or other losses in the Policy or Riders attached thereto that are caused by or occur as a result of:

- (1) hernia, adenoids, tonsils, varicose veins, appendix, disorder of the reproduction organs or elective sterilization within six months after the Effective Date unless due to an emergency;
- (2) Injury or Sickness for which benefits are paid under Workers' Compensation, an Employers Liability Law, benefits provided by the Federal Employee Liability Act or similar law;
- (3) Injury or Sickness due to war or act of war, whether declared or undeclared;
- (4) Dental Treatment unless due to Injury;
- (5) Injuries that are intentionally self-inflicted;
- (6) Injury or Sickness incurred while committing or attempting to commit a felony (A felony is as defined by the law of the jurisdiction in which the activity takes place.);
- (7) Injury or Sickness incurred while engaging in an illegal occupation;
- (8) cosmetic care, except when the Hospital Confinement is due to medically necessary reconstructive surgery. Medically necessary reconstructive surgery is defined as:
 - (a) surgery to restore a normal bodily function.
 - (b) surgery to improve functional impairment by anatomic alteration made necessary as a result of a congenital birth defect.
 - (c) breast reconstruction following mastectomy.
- (9) rest care, convalescent care or for rehabilitation;
- (10) being intoxicated or under the influence of any narcotic unless administered by a Physician or taken according to the Physician's instructions (Intoxication means that which is determined and defined by the laws and jurisdiction of the geographical area in which the loss or cause of loss was incurred);
- (11) Injury sustained or Sickness, which manifests itself while on full-time duty in the armed forces. Upon notice, We will refund the proportion of unearned premium paid while in such forces;
- (12) treatment of Mental or Nervous Disorders;
- (13) treatment of alcoholism or drug addiction;
- (14) routine newborn care that is not due to such newborn child's Sickness or Injury;
- (15) treatment or Hospital Confinement rendered outside the United States, its possessions, or Canada, except for emergency care for acute onset of Sickness or accidental Injury sustained while traveling for business or pleasure; nor,
- (16) services for which payment is not legally required, except for:
 - (a) Medicaid;
 - (b) treatment of non-service connected disabilities in Veteran Administration hospitals; and,
 - (c) inpatient care rendered to armed services retirees and dependents in military medical facilities of the United States Government.

HI-2200 Hospital Indemnity Insurance

Hospital Indemnity Monthly Premiums

	Issue Ages	Employee	Employee & Spouse	1 Parent Family	2 Parent Family
Level 1	17-24	\$18.05	\$34.60	\$36.20	\$52.75
	25-34	\$20.65	\$39.55	\$41.25	\$60.15
	35-44	\$26.45	\$51.00	\$45.65	\$70.20
	45-54	\$32.70	\$63.65	\$48.65	\$79.60
	55-59	\$40.75	\$79.55	\$55.40	\$94.20
	60-64	\$53.20	\$101.70	\$66.55	\$115.05
Level 2	17-24	\$28.10	\$54.70	\$59.05	\$85.65
	25-34	\$32.05	\$62.35	\$67.20	\$97.50
	35-44	\$41.20	\$80.50	\$74.15	\$113.45
	45-54	\$52.50	\$103.25	\$79.65	\$130.40
	55-59	\$65.95	\$129.95	\$91.00	\$155.00
	60-64	\$84.95	\$165.20	\$108.05	\$188.30
Level 3	17-24	\$37.50	\$73.50	\$79.35	\$115.35
	25-34	\$42.65	\$83.55	\$90.20	\$131.10
	35-44	\$55.55	\$109.20	\$99.75	\$153.40
	45-54	\$71.75	\$141.75	\$107.75	\$177.75
	55-59	\$90.50	\$179.05	\$123.65	\$212.20
	60-64	\$115.90	\$227.10	\$146.85	\$258.05
Level 4	17-24	\$51.05	\$100.60	\$107.65	\$157.20
	25-34	\$58.10	\$114.45	\$122.40	\$178.75
	35-44	\$75.55	\$149.20	\$135.80	\$209.45
	45-54	\$97.35	\$192.95	\$146.70	\$242.30
	55-59	\$123.20	\$244.45	\$168.90	\$290.15
	60-64	\$157.40	\$310.10	\$200.00	\$352.70
Level 5	17-24	\$60.45	\$119.40	\$127.95	\$186.90
	25-34	\$68.70	\$135.65	\$145.40	\$212.35
	35-44	\$89.90	\$177.90	\$161.40	\$249.40
	45-54	\$116.60	\$231.45	\$174.80	\$289.65
	55-59	\$147.75	\$293.55	\$201.55	\$347.35
	60-64	\$188.35	\$372.00	\$238.80	\$422.45

Selected Benefits

Hospital Indemnity Plan	
<input type="checkbox"/> Level 1 <input type="checkbox"/> Level 2 <input type="checkbox"/> Level 3 <input type="checkbox"/> Level 4 <input type="checkbox"/> Level 5	
Issue Ages	
<input type="checkbox"/> 17-24 <input type="checkbox"/> 25-34 <input type="checkbox"/> 35-44 <input type="checkbox"/> 45-54 <input type="checkbox"/> 55-59 <input type="checkbox"/> 60-64	
Benefit Selected	
<input type="checkbox"/> Employee	<input type="checkbox"/> 1 Parent Family
<input type="checkbox"/> Employee & Spouse	<input type="checkbox"/> 2 Parent Family
Total \$ _____ per _____ pay period	

Underwritten by:



This is a brief description of the coverage. For actual benefits and other provisions, please refer to the policy. This coverage does not replace Workers' Compensation Insurance. This product is inappropriate for people who are eligible for Medicaid coverage. ■ Policy Form HI-2200 Florida ■ Hospital Indemnity Insurance. ■ Employee Brochure ■ (07/09)

**AMERICAN PUBLIC LIFE INSURANCE COMPANY
2305 LAKELAND DRIVE, FLOWOOD, MISSISSIPPI 39332
(800) 256 - 8606**

HOSPITAL INDEMNITY INSURANCE APPLICATION

1. Names of persons proposed for insurance:			<u>Relationship to Primary Insured</u>	<u>Birthdate</u> Mo. Day Yr.	<u>S</u> <u>e</u> <u>x</u>	<u>Country of Citizenship</u>	<u>Social Security Number</u>
<u>Last Name</u>	<u>First</u>	<u>Middle</u>	Primary Insured				
			Spouse				

2. Address _____ Anywhere _____ City _____ State _____ Zip _____ Home Phone () _____ Bus. Phone () _____	3. Employer: _____ Full Time: (30 Hours) <input type="checkbox"/> Yes <input type="checkbox"/> No Occupation: (Exact Duties) _____ Date of Employment: _____ Group No.: _____
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4. Insurance Plan applied for: <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:30%;"><input type="checkbox"/> HI-2200 - Daily Indemnity</td> <td style="width:20%; text-align: right;">Indemnity Amount</td> <td style="width:20%; text-align: right;">Monthly Premium</td> </tr> <tr> <td><input type="checkbox"/> Annual First Occurrence Rider</td> <td style="text-align: right;">\$ _____</td> <td style="text-align: right;">\$ _____</td> </tr> <tr> <td><input type="checkbox"/> IC/CC Rider</td> <td style="text-align: right;">\$ _____</td> <td style="text-align: right;">\$ _____</td> </tr> <tr> <td><input type="checkbox"/> Hospital Emergency Acc. Rider</td> <td style="text-align: right;">\$ _____</td> <td style="text-align: right;">\$ _____</td> </tr> <tr> <td><input type="checkbox"/> Surgical & Anesthesia Rider</td> <td style="text-align: right;">\$ _____</td> <td style="text-align: right;">\$ _____</td> </tr> <tr> <td><input type="checkbox"/> Outpatient Surgical Facility Rider</td> <td style="text-align: right;">\$ _____</td> <td style="text-align: right;">\$ _____</td> </tr> <tr> <td><input type="checkbox"/> Outpatient Physician Rider</td> <td style="text-align: right;">\$ _____</td> <td style="text-align: right;">\$ _____</td> </tr> <tr> <td><input type="checkbox"/> Medical Testing Rider</td> <td style="text-align: right;">\$ _____</td> <td style="text-align: right;">\$ _____</td> </tr> </table>	<input type="checkbox"/> HI-2200 - Daily Indemnity	Indemnity Amount	Monthly Premium	<input type="checkbox"/> Annual First Occurrence Rider	\$ _____	\$ _____	<input type="checkbox"/> IC/CC Rider	\$ _____	\$ _____	<input type="checkbox"/> Hospital Emergency Acc. Rider	\$ _____	\$ _____	<input type="checkbox"/> Surgical & Anesthesia Rider	\$ _____	\$ _____	<input type="checkbox"/> Outpatient Surgical Facility Rider	\$ _____	\$ _____	<input type="checkbox"/> Outpatient Physician Rider	\$ _____	\$ _____	<input type="checkbox"/> Medical Testing Rider	\$ _____	\$ _____	Primary Proposed Insured's Age Band: <input type="checkbox"/> 17-24 <input type="checkbox"/> 25-34 <input type="checkbox"/> 35-44 <input type="checkbox"/> 45-54 <input type="checkbox"/> 55-59 <input type="checkbox"/> 60+ Monthly Premium Amount \$ _____ Cafeteria Plan: <input type="checkbox"/> Yes <input type="checkbox"/> No Payroll Deduction Period: <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Bi-Weekly <input type="checkbox"/> Semi-Monthly <input type="checkbox"/> Monthly Bank Draft <input type="checkbox"/> Other _____
<input type="checkbox"/> HI-2200 - Daily Indemnity	Indemnity Amount	Monthly Premium																							
<input type="checkbox"/> Annual First Occurrence Rider	\$ _____	\$ _____																							
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<input type="checkbox"/> Outpatient Surgical Facility Rider	\$ _____	\$ _____																							
<input type="checkbox"/> Outpatient Physician Rider	\$ _____	\$ _____																							
<input type="checkbox"/> Medical Testing Rider	\$ _____	\$ _____																							

Beneficiary	Relationship to Primary Insured	Country of Citizenship
Contingent Beneficiary	Relationship to Primary Insured	Country of Citizenship

5. Is any proposed insured currently covered by or eligible for Medicare? YES NO
6. Is any proposed insured currently covered by or eligible for Medicaid?
7. Is the insurance applied for to be in addition to any other Hospital Indemnity coverage with us or any other company?
8. Has any person or persons to be covered, ever been tested positive for exposure to the HIV infection or been diagnosed by a member of the medical profession as having AIDS Related Complex (ARC) or Acquired Immune Deficiency Syndrome (AIDS) caused by the HIV infection or other sickness or condition derived from such infection? Yes No If "yes," list name and relationship

(Name and Relationship to Proposed Insured)

is to be excluded from coverage under this policy and any rider(s) attached to the policy.

9. I represent that no person or persons to be covered has been treated (including prescription medication), diagnosed, or received medical advice by a member of the medical profession within the last 36 months for the following conditions:

- a. any disease, disorder, or abnormality of the heart or coronary arteries, cartoid artery disease, stroke, transient ischemic attack (TIA) or other circulatory or vascular disease;
- b. internal cancer, including Hodgkin's Disease, Leukemia, Melanoma or malignant tumor of any kind (except skin cancer) (if breast cancer, within the last 24 months);
- c. ulcerative colitis, Crohn's Disease, kidney disease - excluding stones, liver disease - including Hepatitis B & C, Parkinson's Disease, sickle-cell anemia, systemic lupus, insulin dependent diabetes, chronic obstructive pulmonary disease (COPD); or
- d. Alzheimer's Disease or dementia.

except (if none check here) _____
 (Name and Relationship to Proposed Insured)

who is to be excluded from coverage under this policy and any rider(s) attached to the policy.

10. I represent that no person or persons to be covered has, other than due to pregnancy, been recommended by a physician within the last 12 months to be hospitalized or have surgery that has not yet occurred except (if none, check here)

(Name and Relationship to Proposed Insured)

who is to be excluded from coverage under this policy and any rider(s) attached to the policy.

11. Will this policy replace or change any Health Insurance in this or any other company? Yes No. If "Yes", complete replacement form where required.

Policy # _____ **Company:** _____ **Amount:** _____

12. I, the undersigned applicant, represent that the statements and answers in this application are complete and true to the best of my knowledge and belief. I agree that: (1) this application and any amendment to it shall be the basis of any coverage granted; (2) no agent has authority to (a) waive the answer to any question in the application; (b) pass on insurability; (c) waive any of the Company's rights or requirements; or (d) make or alter this contract. Furthermore, no insurance shall take effect, if applied for through a Cafeteria Benefit program, until the application is approved by the Company. Such insurance will then take effect on the Policy Date in the Policy. It is understood that any deductions made by my employer for this insurance prior to the policy date are in anticipation of future due premiums. I hereby acknowledge receipt of an Outline of Coverage.

_____ X _____ Date: _____

Signed at City, State _____

Signature of Person Insured (Parent, If Insured is less than 15 years old)

AGENT (Please Print) _____

SIGNATURE OF AGENT _____

Agent's No.: _____

State
License #: _____

WARNING: 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.

PAYOR, IF DIFFERENT FROM PROPOSED PRIMARY INSURED

Last Name

First Name

Full Middle Name

Soc Sec Number

NOTE: The Primary Proposed Insured must sign the application. If the Proposed Primary Insured is not the employee, premiums are not eligible to be payroll-deducted on a pre-tax basis under Section 125.

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



American Public Life Insurance Company

A member of the American Fidelity Group

AUTHORIZATION TO HONOR CHECKS OR ELECTRONIC TRANSFER OF FUNDS DRAWN BY
AND PAYABLE TO THE AMERICAN PUBLIC LIFE INSURANCE COMPANY
JACKSON, MISSISSIPPI

TO: _____(BANK)

BRANCH NAME, IF ANY _____

BANK ADDRESS _____

BANK ADDRESS _____

As a convenience to me, I hereby request and authorize you to pay and charge to my bank checking account checks or electronic transfer of funds drawn by and payable to the order of American Public Life Insurance Company, Jackson, Mississippi, provided there are sufficient collected funds in said account to pay the same upon presentation. It will not be necessary for any officer or employee of American Public Life Insurance Company to sign such checks or electronic transfer of funds. I agree that your rights in respect to each check or electronic transfer of funds shall be the same as if it were a check drawn on you and signed personally by me. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice I agree that you shall be fully protected in honoring any such check or electronic transfer of funds.

I further agree that if any such check or electronic transfer of funds be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

Account Holder Name _____(please print)

Account Holder Address _____

Account Holder Address _____

Account Number _____

Bank Routing Number _____

Account Holder Signature _____

Date _____

Please mail form to:

G-112R (12/02)

