

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: (601) 936-2157

FOR HOME OFFICE USE ONLY:

Effective Date: _____
 PRD #: _____
 Group #: _____
 Revised: _____

Individual Products • Application for Life and Health Insurance • Payroll Market/Direct Bill

PROPOSED INSURED'S INFORMATION

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

Resident Address: Number & Street City State Zip Home Phone Email Address

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

APPLICANT

EMPLOYER

Full Time? Yes No Hours Per Week: _____
 Salary: \$ _____ Hourly Weekly Monthly Annually
 Occupation: _____ Hire Date: _____
 Name: _____
 City: _____ State: _____
 Work Phone: _____

Payroll Deduction Frequency: 12 13 24 26 52
 Skip Mode: 8 9 10 11 Indicate Months: _____
 Direct Bill Frequency: Monthly Bank Draft - Attach form
 Semi-Annual Annual

Owner: (For life products, complete if other than applicant) Last Name, First Name, MI Social Security # Resident Address, City, State, Zip

Premium Payor: (Complete if other than applicant.) Last Name, First Name, MI Social Security # Resident Address, City, State, Zip

BENEFICIARY INFORMATION

APPLICANT Primary _____ Relationship _____
 Contingent _____ Relationship _____
 Beneficiary of children's life coverage is, in all cases, the applicant.

Beneficiary of Spouse's life coverage is the applicant unless named otherwise.
 SPOUSE (applicable to life products only): Primary _____ Relationship _____
 Contingent _____ Relationship _____

CITIZENSHIP INFORMATION

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

Full Name Country of Citizenship Permanent VISA (resident) card # or application receipt #

REPLACEMENT INFORMATION

For All: Does any person applying for coverage intend to replace, discontinue or change any health or individual life insurance policy?
 Yes No (If Yes, complete and return any required state specific forms for each applicable product and list policy information.)

Company Name Policy Number Product Type

For LIFE Products Only: Does any person applying for life insurance have any existing coverage or pending applications for individual life insurance with this or any other company? Yes No (If Yes, complete state specific replacement form, if required.)

PRODUCT SELECTION

ACCIDENT

Premium

Accident Only A-3 <input type="checkbox"/> Individual Only <input type="checkbox"/> Individual and Spouse <input type="checkbox"/> One Parent Family <input type="checkbox"/> Two Parent Family	
Unit(s): <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4.....	\$
Optional Policy Benefits:	
<input type="checkbox"/> Accidental Disability Income (Applicant Only) <input type="checkbox"/> \$400 <input type="checkbox"/> \$500 <input type="checkbox"/> \$600 <input type="checkbox"/> \$700 <input type="checkbox"/> \$800 <input type="checkbox"/> \$900 <input type="checkbox"/> \$1,000.....	\$
<input type="checkbox"/> Accident Hospital Admission <input type="checkbox"/> \$100 <input type="checkbox"/> \$200 <input type="checkbox"/> \$300 <input type="checkbox"/> \$400.....	\$
<input type="checkbox"/> Accident Only Intensive Care <input type="checkbox"/> \$150 <input type="checkbox"/> \$300 <input type="checkbox"/> \$450 <input type="checkbox"/> \$600.....	\$
Additional Benefit Riders:	
<input type="checkbox"/> Total Disability - Sickness (Applicant Only) <input type="checkbox"/> \$400 <input type="checkbox"/> \$500 <input type="checkbox"/> \$600 <input type="checkbox"/> \$700 <input type="checkbox"/> \$800 <input type="checkbox"/> \$900 <input type="checkbox"/> \$1,000 Sickness Elimination/Benefit Period <input type="checkbox"/> 14 Days/3Months <input type="checkbox"/> 14 Days/6Months <input type="checkbox"/> 30 Days/6 Months.....	\$
<input type="checkbox"/> Gunshot Wound (Public Safety Personnel Only).....	\$
Total Premium	\$

HOSPITAL INDEMNITY		<i>Premium</i>
Hospital Indemnity HI-2200 <input type="checkbox"/> Individual Only <input type="checkbox"/> Individual & Spouse <input type="checkbox"/> One Parent Family <input type="checkbox"/> Two Parent Family Age Band: <input type="checkbox"/> 17-34 <input type="checkbox"/> 35-44 <input type="checkbox"/> 45-54 <input type="checkbox"/> 55-59 <input type="checkbox"/> 60+ Daily Hospital Confinement Benefit Amount: \$ _____ (Available from \$50 to \$1,000 in \$50 units).....		\$
Additional Benefit Riders: <input type="checkbox"/> Intensive Care/Coronary Care (per day) <input type="checkbox"/> \$200 <input type="checkbox"/> \$400 <input type="checkbox"/> \$600 <input type="checkbox"/> \$800 <input type="checkbox"/> \$1,000.....		\$
<input type="checkbox"/> Annual First Occurrence Hospital <input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,000 <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$3,000.....		\$
<input type="checkbox"/> Surgical & Anesthesia \$ _____ (Available from \$1,000 to \$10,000 in \$1,000 units.).....		\$
<input type="checkbox"/> Outpatient Surgical Facility <input type="checkbox"/> \$200 <input type="checkbox"/> \$400 <input type="checkbox"/> \$600 <input type="checkbox"/> \$800 <input type="checkbox"/> \$1,000.....		\$
<input type="checkbox"/> Hospital Emergency Accident <input type="checkbox"/> \$100 <input type="checkbox"/> \$200 <input type="checkbox"/> \$300 <input type="checkbox"/> \$400 <input type="checkbox"/> \$500.....		\$
<input type="checkbox"/> Outpatient Physician (per visit) <input type="checkbox"/> \$25 <input type="checkbox"/> \$50 <input type="checkbox"/> \$75.....		\$
<input type="checkbox"/> Medical Testing <input type="checkbox"/> 1 Unit <input type="checkbox"/> 2 Unit <input type="checkbox"/> 3 Units.....		\$
Imaging Tests (per test) \$100 \$200 \$300 Other Diagnostic Tests (per test) \$25 \$50 \$75 Wellness Tests (per test) \$25 \$50 \$75		\$
Total Premium		\$

LIFE		<i>Premium</i>																																
Has any form of nicotine been used in the past 12 months? Applicant: <input type="checkbox"/> Yes <input type="checkbox"/> No Spouse: <input type="checkbox"/> Yes <input type="checkbox"/> No																																		
A P P L I C A N T	<input type="checkbox"/> Whole Life Face Amount Premium <input type="checkbox"/> ADB \$ _____ \$ _____ <input type="checkbox"/> Waiver \$ _____ \$ _____ <input type="checkbox"/> Child Rider <input type="checkbox"/> \$10,000 <input type="checkbox"/> \$20,000 \$ _____ <input type="checkbox"/> _____ \$ _____ \$ _____ <input type="checkbox"/> _____ \$ _____ \$ _____ Total Premium \$ _____	Total Applicant Premium																																
	<input type="checkbox"/> Level Term Life Face Amount Premium <input type="checkbox"/> 10 Yr <input type="checkbox"/> 20 Yr <input type="checkbox"/> 30 Yr \$ _____ \$ _____ <input type="checkbox"/> ADB \$ _____ \$ _____ <input type="checkbox"/> Waiver \$ _____ \$ _____ <input type="checkbox"/> Child Rider <input type="checkbox"/> \$10,000 <input type="checkbox"/> \$20,000 \$ _____ <input type="checkbox"/> Spouse Rider \$ _____ \$ _____ Total Premium \$ _____																																	
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	<table border="0" style="width:100%;"> <tr> <td style="width:25%;">Face Amount for All Policies</td> <td style="width:15%;">Premium</td> <td style="width:15%;">ADB/Premium</td> <td style="width:15%;">Waiver/Premium</td> <td style="width:30%;">Young Advantage Life</td> <td style="width:10%;">Premium</td> </tr> <tr> <td>1. <input type="checkbox"/> Whole Life</td> <td>\$ _____</td> <td>\$ _____</td> <td><input type="checkbox"/> \$ _____</td> <td><input type="checkbox"/> \$15,000</td> <td rowspan="4" style="text-align: center; vertical-align: middle;">Total Child Premium</td> </tr> <tr> <td>2. <input type="checkbox"/> Whole Life</td> <td>\$ _____</td> <td>\$ _____</td> <td><input type="checkbox"/> \$ _____</td> <td>\$ _____ X # of children</td> </tr> <tr> <td>3. <input type="checkbox"/> Whole Life</td> <td>\$ _____</td> <td>\$ _____</td> <td><input type="checkbox"/> \$ _____</td> <td><input type="checkbox"/> \$30,000</td> </tr> <tr> <td>4. <input type="checkbox"/> Whole Life</td> <td>\$ _____</td> <td>\$ _____</td> <td><input type="checkbox"/> \$ _____</td> <td>\$ _____ X # of children</td> </tr> <tr> <td>Total Premium</td> <td>\$ _____</td> <td>\$ _____</td> <td>\$ _____</td> <td>Total Premium</td> <td>\$ _____</td> </tr> </table>		Face Amount for All Policies	Premium	ADB/Premium	Waiver/Premium	Young Advantage Life	Premium	1. <input type="checkbox"/> Whole Life	\$ _____	\$ _____	<input type="checkbox"/> \$ _____	<input type="checkbox"/> \$15,000	Total Child Premium	2. <input type="checkbox"/> Whole Life	\$ _____	\$ _____	<input type="checkbox"/> \$ _____	\$ _____ X # of children	3. <input type="checkbox"/> Whole Life	\$ _____	\$ _____	<input type="checkbox"/> \$ _____	<input type="checkbox"/> \$30,000	4. <input type="checkbox"/> Whole Life	\$ _____	\$ _____	<input type="checkbox"/> \$ _____	\$ _____ X # of children	Total Premium	\$ _____	\$ _____	\$ _____	Total Premium
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Total Premium	\$ _____	\$ _____	\$ _____	Total Premium	\$ _____																													
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CANCER (An applicant may only be covered by one APL cancer product.)		<i>Premium</i>
Cancer CPA 2200 <input type="checkbox"/> Individual Only <input type="checkbox"/> One Parent Family <input type="checkbox"/> Two Parent Family Age Band: <input type="checkbox"/> 18-40 <input type="checkbox"/> 41-50 <input type="checkbox"/> 51-60 <input type="checkbox"/> 61+ Level: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4		\$
Additional Benefit Riders: <input type="checkbox"/> Critical Illness <input type="checkbox"/> Internal Cancer <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$7,500 <input type="checkbox"/> \$10,000..... <input type="checkbox"/> Heart Attack/Stroke <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$7,500 <input type="checkbox"/> \$10,000..... <input type="checkbox"/> Internal Cancer & Heart Attack/Stroke <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$7,500 <input type="checkbox"/> \$10,000..... <input type="checkbox"/> Intensive Care Unit		\$
Total Premium		\$
Cancer CPM 2200 <input type="checkbox"/> Individual Only <input type="checkbox"/> One Parent Family <input type="checkbox"/> Two Parent Family Age Band: <input type="checkbox"/> 18-40 <input type="checkbox"/> 41-50 <input type="checkbox"/> 51-60 <input type="checkbox"/> 61+ Level: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> C1 <input type="checkbox"/> C2.....		\$
Additional Benefit Riders: <input type="checkbox"/> Critical Illness <input type="checkbox"/> Internal Cancer <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$2,000 <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$7,500 <input type="checkbox"/> \$10,000..... <input type="checkbox"/> Heart Attack/Stroke <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$2,000 <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$7,500 <input type="checkbox"/> \$10,000..... <input type="checkbox"/> Internal Cancer & Heart Attack/Stroke <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$2,000 <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$7,500 <input type="checkbox"/> \$10,000..... <input type="checkbox"/> Intensive Care Unit		\$
Total Premium		\$
Cancer Lump Sum CLS-1000 <input type="checkbox"/> Individual Only <input type="checkbox"/> One Parent Family <input type="checkbox"/> Two Parent Family Age Band: <input type="checkbox"/> 18-39 <input type="checkbox"/> 40-49 <input type="checkbox"/> 50-59 <input type="checkbox"/> 60-69 <input type="checkbox"/> 70-79 <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$10,000 <input type="checkbox"/> \$15,000 <input type="checkbox"/> \$20,000 <input type="checkbox"/> \$25,000 <input type="checkbox"/> \$30,000 <input type="checkbox"/> \$35,000 <input type="checkbox"/> \$40,000 <input type="checkbox"/> \$45,000 <input type="checkbox"/> \$50,000		\$
Total Premium		\$

INTENSIVE CARE / CORONARY CARE (Direct Bill Limitation: Must be sold in addition to another policy.)		<i>Premium</i>
Intensive Care Coronary Care IC/CC3 <input type="checkbox"/> Individual Only <input type="checkbox"/> One Parent Family <input type="checkbox"/> Two Parent Family Daily Hospital Benefit: <input type="checkbox"/> \$325 <input type="checkbox"/> \$650		\$
Total Premium		\$

HEART DISEASE / HEART ATTACK / STROKE		Premium
Heart Disease/Heart Attack/Stroke HD/A/S-2 <input type="checkbox"/> Individual Only <input type="checkbox"/> One Parent Family <input type="checkbox"/> Two Parent Family		
Daily Hospital Benefit: <input type="checkbox"/> \$100 <input type="checkbox"/> \$200 <input type="checkbox"/> \$300.....		\$
Additional Benefit Riders:		
<input type="checkbox"/> First Occurrence Lump Sum <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$2,000 <input type="checkbox"/> \$3,000 <input type="checkbox"/> \$4,000 <input type="checkbox"/> \$5,000.....		\$
Total Premium		\$

DENTAL		Premium
Select Dental II <input type="checkbox"/> Individual Only <input type="checkbox"/> Individual and Spouse <input type="checkbox"/> One Parent Family <input type="checkbox"/> Two Parent Family		
Option: <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D.....		\$
Additional Benefit Riders:		
<input type="checkbox"/> Children's Orthodontic		\$
Total Premium		\$

TOTAL BILLED PREMIUM ALL PRODUCTS ALL POLICIES **\$**

GENERAL UNDERWRITING AND MEDICAL QUESTIONS		Applicant	Spouse	Child(ren) (NAME, if Yes)
ALL COVERAGES	Is the applicant actively at work and able to perform the regular duties of his/her occupation?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Any person answering YES to the following questions is not eligible for that coverage. If multiple children are to be covered, please list the first name of any child(ren) answering Yes on the line provided in that area.				
ACCIDENT	Is the insurance applied for to be in addition to any other Accident Only coverage with us or any other company?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
SICKNESS DISABILITY INCOME RIDER for ACCIDENT	Within the last 3 years has any person to be insured received medical advice or sought treatment (including medication) for: heart or circulatory disease or disorder, diabetes treated with insulin, chronic liver condition or disease, stroke, transient ischemic attack, cancer (excluding non-melanoma skin cancer), back disorders, fibromyalgia, or chronic fatigue syndrome?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
CANCER LIFE HEART/STROKE INTENSIVE CARE HOSPITAL INDEMNITY	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)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
HOSPITAL INDEMNITY	Is the insurance applied for to be in addition to any other Hospital Indemnity coverage with us or any other company?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
	In the last 3 years has any person to be insured received medical advice or sought treatment (including medication) for: ulcerative colitis, Crohn's disease, Parkinson's disease, sickle-cell anemia, systemic lupus, Chronic Obstructive Pulmonary Disease (COPD), Alzheimer's disease or dementia, lymphatic disorder, paralysis, cirrhosis, rheumatoid arthritis, lung/respiratory disorder, tuberculosis, seizures, or thyroid disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Within the last year has any person to be insured been hospitalized (inpatient or outpatient), had surgery, or been recommended to be hospitalized, or have surgery for anything other than pregnancy?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
HOSPITAL INDEMNITY LIFE	In the last 3 years has any person to be insured received medical advice or sought treatment (including medication) for: heart or circulatory disease or disorder, 3 or more medications taken at the same time for the control of high blood pressure; diabetes treated with insulin, chronic kidney disease (excluding stones), liver condition or disease, stroke, transient ischemic attack, cancer (excluding non-melanoma skin cancer), alcohol or drug problems?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
LIFE	Within the last 3 years has any person to be insured been rated or declined for life insurance by any insurance company?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
LIFE	If applying for spouse coverage, is the spouse currently disabled?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
	If applying for child coverage, is any child currently disabled?			<input type="checkbox"/> Yes <input type="checkbox"/> No
	Within the last year has any person to be insured been hospitalized (inpatient or outpatient), or been recommended to be hospitalized, for anything other than routine well care, pregnancy or back problems?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
CANCER	Has any person to be insured received medical advice to have any diagnostic tests, examinations, or consultations to determine the existence of cancer that have not been completed; or had tests and results have not been received; or test results were abnormal and no follow-up or resolution has occurred?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Has any person to be insured received medical advice or sought treatment (including medication) for: Addison's disease, amyotrophic lateral sclerosis, grand mal epilepsy, systemic lupus erythematosus, multiple sclerosis, muscular dystrophy, myasthenia gravis, Niemann-Pick disease, osteomyelitis, Reye's syndrome, sickle-cell anemia, Tay-Sachs disease, toxic epidermal necrolysis, tuberculosis, or Whipple's disease in any form? If YES, who and which disease(s)? _____ Any person(s) answering YES to this section will be excluded from coverage for the listed disease.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

CANCER	In the last 10 years has any person to be insured received medical advice or sought treatment (including medication) for: cancer, including but not limited to, carcinoma, sarcoma, lymphoma, leukemia, Hodgkin's disease, melanoma or a malignant condition of any kind?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	In the last 3 years has any person to be insured received medical advice or sought treatment (including medication) for: skin cancer, including but not limited to basal cell carcinoma, squamous cell carcinoma, and carcinoma in-situ? If YES, who and which disease(s)? _____ Any person(s) answering YES to this section will be excluded from coverage for the listed disease.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
CRITICAL ILLNESS RIDER for CANCER INTENSIVE CARE HEART/STROKE	Has any person to be insured ever received medical advice or sought treatment (including medication) for: heart attack or myocardial infarction, coronary angioplasty or artery bypass, any arterial disease, angina, cardiovascular disease, stroke, transient ischemic attack, or any abnormal condition or disease of the heart, arteries or circulatory system, or carotid artery disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Has any person to be insured received medical advice to have any diagnostic tests, examinations, or consultations for the heart or circulatory system that have not been completed; or had tests and results have not been received; or test results were abnormal and no follow-up or resolution has occurred?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
HEART/STROKE	Has any person to be insured ever used or been told to use insulin for the treatment or control of diabetes?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

SIGNATURE AND ACKNOWLEDGMENT

To the best of my knowledge and belief, the statements and answers given in this application 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** _____

And, if applying for Term or Whole Life insurance, the required Accelerated Benefit Summary and Disclosure Notice.

Whole/Cash Value Life product, Complete This Section:

I understand that I will be asked to show a government issued photo ID, such as a driver's license, in order to identify myself.

Type of ID Provided: Driver's License, State _____ Passport Other _____

For ID Provided: ID # _____ Issue Date (if applicable) _____ Expiration Date _____

Life Insurance: I understand coverage, as applied for, will be in force on the date of this application if the Applicant(s) is insurable for the requested insurance on the date the policy takes effect and the first monthly premium is applied. This Interim Coverage will cease when the policy applied for has been issued or declined; or a policy other than as applied for is offered to the Owner. I have considered my present insurance needs and determined that the purchase of this insurance is suitable for me.

Health Insurance: I understand that coverage as applied for will not take effect until a policy 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.

Cancer Insurance: No person to be covered by this policy is covered by Medicaid or any similar program.

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 Owner (If other than Applicant)

AGENT STATEMENT

To the best of my knowledge the person(s) to be insured do(es) do(es) not have any existing individual life insurance; and, the person(s) to be insured do(es) do(es) not intend to replace, discontinue or change any such individual life coverage.

Whole/Cash Value Life product, I have verified that the identification shown is that of the owner and it corresponds with the information provided as a part of the application process. I understand that my signature verifies I have seen the identification and the information is correct.

Signature of Licensed Agent

Chris Burton 5461574
Agent's Printed Name and Agent Number

Soliciting Agents: (Please Print. If split with other Agents, include on a separate sheet.)

Name:	Agent Number	Split Percent (Total = 100%)
Chris Burton	Agent #: 5461574	Split %: 100%
_____	Agent #: _____	Split %: _____
_____	Agent #: _____	Split %: _____
_____	Agent #: _____	Split %: _____

Agent's Special Request :

REMINDER: Applications received by American Public Life Insurance Company more than 30 days following the date taken will have to be rewritten with a current date.

American Public Life Insurance Company

2305 Lakeland Dr.

Jackson, MS 39232

Acknowledgment

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

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

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

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

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

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

Signed _____

Date _____

Social Security Number



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: American Public Life Insurance Company
Attn: Customer Service
P. O. Box 925
Jackson, MS 39205

G-112R (12/02)