FOR AGENT USE ONLY:

Requested Effective Date:

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

AMERICAN PUBLIC LIFE®

FOR HOME OFFICE USE ONLY:

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

[2305 Lakeland Drive ● Flowood, Mississippi 39232]
Phone: (800) 256-8606 ● Fax: (877) 807-0911

Application for Cancer Insurance

PROPOSED INSURED'S INFORMATION

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

Resident Address: Number & Street City State Zip Home Phone

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

Email Address:

APPLICANT

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

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

EMPLOYER

Name: _____
City: _____ State: _____
Work Phone: _____

Master Policyholder Name:

BENEFICIARY INFORMATION

APPLICANT: Primary _____ Relationship _____
Contingent _____ Relationship _____

CITIZENSHIP INFORMATION

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

Full Name _____ Country of Citizenship _____

Full Name _____ Country of Citizenship _____

CANCER PRODUCT SELECTION

Premium

Plan Selected:

☐ Individual ☐ Individual and Spouse ☐ Single Parent Family ☐ Two Parent Family

[☐ Plan 1 ☐ Plan 2 ☐ Plan 3 ☐ Plan 4] $

Total Premium $

SIGNATURE AND ACKNOWLEDGMENT

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

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

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

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

Signed At (City and State)	Date	Signature of Applicant

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

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

Agent's Special Requests:

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

SIMPLIFIED ISSUE UNDERWRITING AND MEDICAL QUESTIONS

Any person answering YES to the following questions is not eligible for coverage. If multiple children are to be covered, please list the first name of any child answering Yes on the line provided in that area.

		Applicant	Spouse	Child(ren) (NAME, if Yes)
1.	Within the last 10 years, has any person to be insured received medical advice, sought treatment (including medication), or been treated or diagnosed by a member of the medical profession for: cancer, carcinoma, sarcoma, leukemia, lymphoma, Hodgkin's Disease, melanoma, or a malignant tumor in any form?	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No _____
2.	In the last 3 years has any person to be insured received medical advice, sought treatment (including medication), or been treated or diagnosed by a member of the medical profession for: skin cancer, including but not limited to basal cell carcinoma, squamous cell carcinoma, and carcinoma in-situ?	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No _____
3.	Has any person to be insured ever received medical advice by a member of the medical profession to have any diagnostic tests, examinations, or consultations to determine the existence of cancer or skin cancer: that have not been completed; or that results have not been received; or results were abnormal and no follow-up or resolution has occurred?	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No _____
4.	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?	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No _____
5.	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?	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No _____

Print Applicant's Name	Applicant's Initials	Date