Payroll

**Application for Hospital Confinement Indemnity Insurance**
**(Policy Forms A49100PA, A49200PA, A49300PA, A49400PA, and A4910HPA)**
Application to: American Family Life Assurance Company of Columbus
(herein referred to as Aflac)
Worldwide Headquarters • Columbus, Georgia 31999

| |
|---|
| ❑ New |
| ❑ Conversion<br>❑ Downgrade |
| Policy Number: |

**Please Print in Black Ink – To Be Completed by Proposed Insured**

Proposed Insured's Name _____
Last First MI

DOB _____ Sex _____ SSN _____ - _____ - _____
Month/Day/Year

Address _____
Street or Post Office Box Apt. No.

City _____ State _____ ZIP _____

Telephone ( ) _____
❑ Home ❑ Work ❑ Cell

Email Address (optional) _____

Are you applying for Dependent Child(ren) coverage? ❑ Yes ❑ No
If yes, Dependent Children must be under age 26 as of the Effective Date of coverage.

**Write Spouse's name below if you are applying for Two-Parent Family or Named Insured/Spouse Only coverage; if you have no Spouse or your Spouse is not to be covered, put N/A in the space below.**

Spouse's Name _____ DOB _____ Sex _____
Last First MI Month/Day/Year

Account Name _____ Account No. _____

Name of Employer _____

**PLEASE COMPLETE THE FOLLOWING ELIGIBILITY QUESTIONS (NOT REQUIRED FOR A DOWNGRADE)**

1. **Are you, the Proposed Insured, actively working with the employer listed above? If no, a policy will not be issued; therefore, do not submit this application.** **❑ Yes ❑ No**
2. **(a) Is your Spouse, if applying for coverage, actively working?** **❑ Yes ❑ No ❑ N/A**
   **(b) If no, is your Spouse now hospitalized or unable to perform his or her normal duties and activities? *If yes to 2(b), your Spouse is not eligible for coverage.*** **❑ Yes ❑ No ❑ N/A**

| **Check Coverage Desired:** | ❑ Individual | ❑ Named Insured/ Spouse Only | ❑ One-Parent Family | ❑ Two-Parent Family |
|---|---|---|---|---|

| **Hospital Confinement Benefit Amount:** | | | |
|---|---|---|---|
| **❑ Essentials ($500)** | **❑ Preferred ($1,000)** | **❑ Select 1500 ($1,500)** | ❑ Pre-Tax<br>❑ After-Tax |
| **❑ Select 2000 ($2,000)** | **❑ Select 2500 ($2,500)** | **❑ Select 3000 ($3,000)** | |
| **❑ Option 1 (Form A49100PA)** | | | |
| **❑ Option 2 (Form A49200PA)** | | | |
| **❑ Option 3 (Form A49300PA)** | | | |
| **❑ Option 4 (Form A49400PA)** | | | |
| **❑ Option H (Form A4910HPA) Not available with $500 or $1,000 Hospital Confinement Benefit** | | | |

| **Billing Method:** | **Mode:** | |
|---|---|---|
| ❑ Payroll Deduction | ❑ 01 Weekly | ❑ 01 Monthly |
| ❑ Bank Draft (B/D) | ❑ 01 14-Day Biweekly | ❑ 03 Quarterly |
| ❑ Credit Card (C/C) | ❑ 01 Semimonthly | ❑ 06 Semiannual |
| | ❑ 01 28-Day Biweekly | ❑ 12 Annual |

**PLEASE NOTE: If the B/D or C/C billing method is checked, only the following modes of payment are available: Monthly, Quarterly, Semiannual, or Annual.**

Employee No. _____ Dept. No. _____ Assoc./Agent's No. _____

Billable Premium $ _____ Premium Collected $ _____ Sit. Code _____

Is this insurance intended to replace any other health insurance now in force? **❑ Yes ❑ No**
If yes, please read and sign the Replacement Notice provided by your associate/agent, if applicable.

Do you have **BOTH** hospital confinement indemnity **AND** hospital confinement **sickness** indemnity coverage with Aflac? **❑ Yes ❑ No**
If yes, do you wish to convert both policies to this one new hospital confinement indemnity policy? **❑ Yes ❑ No ❑ N/A**

If not converting both, this must be a conversion of the hospital confinement indemnity coverage. Please indicate the current policy number(s) below, see the Applicant's Statements and Agreements concerning conversions, and complete the Conversion Notice.

Policy Number(s) to Be Converted: _____

Do you have **EITHER** hospital confinement indemnity **OR** hospital confinement **sickness** indemnity coverage with Aflac? **❑ Yes ❑ No**
If yes, this must be a conversion of that coverage. Please indicate the current policy number(s) below, see the Applicant's Statements and Agreements concerning conversions, and complete the Conversion Notice.

Policy Number(s) to Be Converted: _____

**PLEASE NOTE: If anyone other than the Proposed Insured is to be covered and has any other hospital confinement indemnity or hospital confinement sickness indemnity coverage with Aflac, the existing coverage must be cancelled in order to be covered under this policy. Please submit a request to cancel the existing coverage.**

**PLEASE COMPLETE THE FOLLOWING UNDERWRITING QUESTIONS IF YOU ARE APPLYING FOR: OPTION H, OPTION 3, OR OPTION 4; OR ANY CONVERSION. (NOT REQUIRED FOR A DOWNGRADE)**

**1.** Is anyone to be covered the mother or father of a child currently conceived but as yet unborn, or within the last 12 months, has anyone to be covered been diagnosed with or treated by a member of the medical profession for infertility? **❑ Yes ❑ No**

**2.** Is anyone to be covered currently confined in a Hospital or nursing home, or has a member of the medical profession recommended hospitalization or nursing home confinement? **❑ Yes ❑ No**

**3.** Does anyone to be covered have a condition for which a medical procedure (including but not limited to surgery, organ or bone marrow transplant, or joint replacement) has been planned or the possibility of which has been discussed with a member of the medical profession within the past 12 months? **❑ Yes ❑ No**

**4.** Within the last six months, has anyone to be covered been advised by a member of the medical profession to have tests or treatment that has not yet been done or is anyone undergoing evaluation following an abnormal test result? **❑ Yes ❑ No**

**5.** Has anyone to be covered been diagnosed with diabetes before the age of 30 (except for gestational diabetes)? **❑ Yes ❑ No**

**6.** Within the last five years, has anyone to be covered been medically treated or diagnosed by a member of the medical profession as having any of the following? ❑ **Yes** ❑ **No**

Chronic obstructive lung disease
Cerebral vascular disease
Heart attack
Uncorrected congenital heart defect
Congestive heart failure
Sickle cell anemia
Systemic lupus
Multiple sclerosis
Diabetes treated with insulin or other injectable medication
Diabetes and used tobacco after the diagnosis
Liver disease or disorder
Alcohol or drug abuse
Pulmonary fibrosis
Stroke or transient ischemic attack (TIA)
Heart bypass surgery, stent placement, or angioplasty
Cardiomyopathy
Cystic fibrosis
Cancer, other than nonmelanoma skin cancer
Muscular dystrophy
Psoriatic arthritis
Diabetes with complications, including but not limited to nephropathy, neuropathy, or retinopathy
Kidney disease or disorder (except kidney stones)
Organ or bone marrow transplant

**7.** Within the last five years, has anyone to be covered been diagnosed with or treated for acquired immune deficiency syndrome (AIDS) by a member of the medical profession, or has anyone to be covered tested positive for human immunodeficiency virus (HIV)? ❑ **Yes** ❑ **No**

**8.** Within the last three years, has anyone to be covered been medically treated or diagnosed by a member of the medical profession for any of the following? ❑ **Yes** ❑ **No**

Angina (heart related chest pain)
Pancreatitis
Crohn's disease
Arrhythmia with pacemaker or defibrillator implant
Alzheimer's disease
Peripheral vascular disease (circulatory problems)
Ulcerative colitis or proctitis
Atrial fibrillation
Parkinson's disease
Senile dementia

**9. If any one of Questions 1 through 8 is answered yes and:**

**a. this is an application for a new policy, is it the:**

❑ Proposed Insured? ❑ Spouse? ❑ Child? If "Child," please list the name(s) of the child(ren).

_____

**Any person(s) so designated will not be covered under the policy. If the named person is the Proposed Insured, a policy will not be issued; therefore, do not submit this application.**

**If a child, are any other children to be covered?** ❑**Yes** ❑ **No**

**b. this is an application for a conversion policy, you are not eligible for conversion to this policy; therefore, do not submit this application.**

## APPLICANT'S STATEMENTS AND AGREEMENTS

- I understand that the Effective Date of the policy will be the date recorded in the Policy Schedule by Aflac Worldwide Headquarters. It is not the date I signed this application.
- I understand that the following conditions apply:
  - Coverage is not provided for any illness, disease, infection, disorder, or injury for which, within the 12-month period before the Effective Date of coverage, prescription medication was taken or medical testing, medical advice, or treatment was recommended or received from a Physician. Care or treatment of a Pre-existing Condition will not be covered unless the loss occurs 12 months or more after the Effective Date of coverage. This policy does not cover losses caused by or resulting from donating an organ within the first 12 months of the Effective Date of this policy; and
  - Aflac will not pay benefits for a loss that is caused by or occurs as a result of pregnancy or childbirth within the first ten months of the Effective Date of coverage, if the pregnancy is in existence on the Effective Date of coverage (Complications of Pregnancy will be covered to the same extent as a Sickness).

**Proposed Insured's Initials** _____

- This policy contains a 30-day waiting period for Sickness that begins on the Effective Date of the policy. **Illnesses, diseases, infections, or disorders that are medically evaluated, diagnosed, or treated by a Physician within the 30 day waiting period will not be covered, unless the loss begins more than 12 months after the Effective Date of coverage.**

  **Proposed Insured's Initials** _____

- I understand that the policy I am applying for will not cover any person who has reached his or her 76th birthday before the Effective Date of the policy.
- I understand that Dependent Children, if any, must be under age 26 as of the Effective Date of coverage. Once covered, Dependent Children will continue to be covered until their 26th birthday.
- I acknowledge receipt of, if applicable:
  - ❑ Replacement Notice
  - ❑ *Guide to Health Insurance for People with Medicare*
  - ❑ Outline of Coverage
  - ❑ Conversion Notice
- If this is an application for a conversion or downgrade of coverage, I understand that: (1) for a conversion only, if any of Questions 1 through 8 is answered yes, the coverage for which this application is made will be void, and coverage will continue under the terms of the existing policy(s), which will remain in force. Also, the waiting period and the Time Limit on Certain Defenses provision will run from the Effective Date of the new coverage; and (2) for a conversion or a downgrade, the original coverage(s) will be terminated as of the Effective Date of the new coverage, and the Pre-existing Conditions provision in the new coverage will run from the original coverage's Effective Date.

  **Proposed Insured's Initials** _____

- I understand that (1) the policy, together with this application, endorsements, benefit agreements, riders, and attached papers, if any, constitutes the entire contract of insurance, and (2) no change to the policy will be valid until approved by Aflac's president and secretary, and noted in or attached to the policy.
- I understand that (1) Aflac is not bound by any statement made by me, or any associate/agent of Aflac, unless written herein, and (2) the associate/agent cannot change the provisions of the policy or waive any of its provisions either orally or in writing.
- I understand that the premium amount listed on this application represents the premium amount that my employer will remit to Aflac on my behalf. I further understand that this amount, because of my employer's billing/payroll practices, may differ from the amount being deducted from my paycheck or the premium amount quoted to me on an online enrollment system, if applicable.
- If I am applying to replace existing Aflac coverage with this policy, I acknowledge that the policies have different benefits and that I have made a comparison to personally determine which is best for me. I understand and agree that I am terminating my current Aflac policy(s) and its benefits for the benefits provided in this Aflac policy.

  **Proposed Insured's Initials** _____

- I have read, or had read to me, the statements and answers I have provided on this application. I understand that this policy is to be issued based upon these statements and answers, and any other pertinent information Aflac may require for proper underwriting. The answers are complete and true. I understand that all statements made in this application are deemed representations and not warranties, but that material misrepresentations herein may result in loss of coverage under this policy.
- I understand that the purchase of this policy is intended to supplement my existing comprehensive health care coverage. It is not intended to replace or be issued in lieu of that coverage.

I prefer to receive an electronic copy of my policy instead of a paper copy. ❑ Yes ❑ No
If yes, please enter your email address on Page 1.

**Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.**

Signed and Dated At _____ on _____
City and State Date

Proposed Insured's Signature _____

**I certify that I personally saw the Proposed Insured when the application was written, and each question was asked of the Proposed Insured and answered as recorded. All answers above are correct to the best of my knowledge.**

Associate's/Agent's Signature _____ Date _____
Licensed Associate/Agent

**MAKE CHECK OR MONEY ORDER PAYABLE TO AFLAC.**
**FOR INFORMATION, CALL TOLL-FREE 1.800.99.AFLAC (1.800.992.3522).**
**VISIT OUR WEBSITE AT AFLAC.COM.**

For indemnity policies and other policies that pay a fixed dollar amount per day, excluding long-term care policies.

## IMPORTANT NOTICE TO PERSONS ON MEDICARE
## THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

**Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.**

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.

**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

**This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.**

### 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 (SHIP).