Payroll

SUPPLEMENTAL SPECIFIED HEALTH EVENT PROTECTION INSURANCE POLICY (FORM A71100PA)

Application to: American Family Life Assurance Company of Columbus
(herein referred to as Aflac)
Worldwide Headquarters • Columbus, Georgia 31999

❑ Payroll
❑ New
❑ Conversion

Policy Number:

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

Proposed Insured's/Employee's Name _____
Last First MI

DOB _____ Sex _____ SSN _____ - _____ - _____
Month/Day/Year (Optional)

Address _____
Street or Post Office Box Apt. No.

City _____ State _____ ZIP _____

Home Telephone ( ) _____ Business Telephone ( ) _____

E-Mail Address (optional) _____

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

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

Payroll Account Name _____ Payroll Account No. _____
(Optional)

Name of Employer _____

Is everyone proposed for coverage covered by a comprehensive health care policy, a major medical policy or other health plan? If No, then this policy will not be issued. ❑ Yes ❑ No

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.

Does anyone to be covered have any other Specified Health Event or any Lump Sum Critical Illness coverage with Aflac? ❑ Yes ❑ No

If yes, this must be a conversion of that coverage. If yes, give current policy number and see Applicant's Statements and Agreements concerning conversions.

Policy Number: _____

TO BE COMPLETED BY AFLAC ASSOCIATE/AGENT

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

❑ Plan 1: Critical Care and Recovery Only (Policy Form A71100PA)
❑ First Occurrence Building Benefit Rider (Rider Form A71050) ($500) ❑ Pre-Tax
Options: ❑ **No rider** ❑ **New rider** ❑**Retain current rider** or
❑ Primary Specified Health Event Recovery Rider (Rider Form A71051PA) ❑ After-Tax
Options: ❑ **No rider** ❑ **New rider** ❑**Retain current rider**

Billing Method:
❑ Payroll Deduction
❑ Bank Draft (B/D, ACH)
❑ Credit Card (C/C)

Mode:
❑ 01 Weekly
❑ 01 14-Day Biweekly
❑ 01 28-Day Biweekly
❑ 01 Semimonthly
❑ 01 Monthly
❑ 03 Quarterly
❑ 06 Semiannual
❑ 12 Annual

PLEASE NOTE: If B/D, ACH, 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 _____

PLEASE COMPLETE THE FOLLOWING ELIGIBILITY QUESTION

1. Are you currently employed and actively working at your job with the employer listed on the front of this application? ❑ Yes ❑ No
   If No, you are not eligible for coverage.

PLEASE COMPLETE THE FOLLOWING UNDERWRITING QUESTIONS

1. Within the last five years, have you or anyone to be covered been diagnosed with or treated by a member of the medical profession at a health facility for any of the following: ❑ Yes ❑ No

   Heart Attack
   Stroke or Transient Ischemic Attack (TIA)
   Impaired kidney function (other than stones or acute infection)

2. Within the last five years, have you or anyone to be covered had or been advised by a member of the medical profession of the need to have any of the following: ❑ Yes ❑ No

   Major organ transplant
   Coronary artery bypass surgery
   Angioplasty or stent placement

If either underwriting Question 1 or 2 directly above is answered yes, was it the:

❑ Proposed Insured/Employee? ❑ Spouse? ❑ Child? If child, please list the name of the child(ren)

_____ .

Any person(s) indicated above will not be covered under this policy. If the Proposed Insured/Employee, a policy will not be issued; therefore, do not submit this application.

If a Child, are there other children to be covered? ❑Yes ❑ No

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 policy I am applying for will not cover any person who has attained age 71 before the Effective Date of the policy.
- I understand that coverage is not provided for Specified Health Events for which medical advice or treatment was recommended or received within the six-month period before the Effective Date of coverage unless the Specified Health Event occurs more than 30 days after the Effective Date of coverage.
- I understand that Dependent Children, if any, must be under age 26 at the time of application. Once covered, Dependent Children will continue to be covered until their 26th birthday.
- I acknowledge receipt of, if applicable:
  - ❑ Replacement Notice
  - ❑ Outline of Coverage
  - ❑ *Guide To Health Insurance for People with Medicare*
- If this is an application for a conversion of coverage, the following conditions will apply: (1) If anyone covered under the previous policy is not eligible for coverage under the new policy, the policy for which this application is made for the person(s) identified will be void, and coverage will continue for this person only under the terms of the previous policy; (2) The "Time Limit on Certain Defenses" provision in your policy will run from the Effective Date of the new policy, and the original policy will be terminated as of the Effective Date of the new policy; and (3) The "Pre-existing Condition Limitations" in the new policy will run from the original policy's Effective Date for the benefits provided under the original policy. For the increased benefit amount, the "Pre-existing Condition Limitations" in the new policy will run from the new policy's Effective Date.
- I understand that (1) the policy of insurance I am now applying for will be issued based upon the written answers to the questions and information asked for in this application and any other pertinent information Aflac may require for proper underwriting; (2) the policy, together with this application, endorsements, benefit agreements, riders, and attached papers, if any, constitutes the entire contract of insurance; and (3) 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 may have different benefits and that I should make a comparison to personally determine which is best for me. I understand and agree that I am terminating my current Aflac policy and its benefits for the benefits provided in this Aflac policy.

  Proposed Insured's Initials _____
- I have reviewed 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 would prefer to receive an electronic copy of my policy instead of paper. ❑ Yes ❑ No

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/Employee's Signature _____

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

Associate's/Agent's Signature _____ Date _____
Licensed Resident 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 WEB SITE AT AFLAC.COM.

For policies that pay fixed dollar amounts for specified diseases or other specified impairments. This includes cancer, specified disease, and other health insurance policies that pay a scheduled benefit or specific payment based on diagnosis of the conditions named in the policy.

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 amount, regardless of your expenses, if you meet the policy conditions, for one of the specific diseases or health conditions named in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

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).