Application for Accident Insurance (A-34000 Series) with disability riders
Application to American Family Life Assurance Company of Columbus (AFLAC)
Worldwide Headquarters: Columbus, Georgia 31999

❑ New
❑ Conversion
Policy Number

Please print in black ink.

TO BE COMPLETED BY APPLICANT

Applicant's Name ______________________ DOB ____________ Sex ______
Last First MI Month/Day/Year

Applicant's SS No. ______ - ______ - ________ Dependent Children ❑ Yes ❑ No

(Write spouse's name below if you are applying for family coverage; if no spouse or if spouse is not to be covered, put N/A in space below.)

Spouse's Name ______________________ DOB ____________ Sex ______
Last First MI Month/Day/Year

Applicant's Address ______________________
Street or Post Office Box Apt. No.

City ____________ State ________ ZIP ________

Home Telephone (   ) ____________ Business Telephone (   ) ____________ Best Time to Call ______

Name of Employer ____________ Type of Business ____________

Job Duties ______________________

Job Title ______________________

Occupation Class ____________ Industry Code ____________
(Completed by associate/agent) (Completed by associate/agent)

Do you have another accident policy with AFLAC? ❑ Yes ❑ No
If yes, is this a change of that coverage? ❑ Yes ❑ No If yes, give current policy number: ____________
Is the purchase of this coverage intended to replace any other health insurance now in force? ❑ Yes ❑ No
If yes, please read and sign the Replacement Notice, if applicable, provided by your associate/agent and provide the policy number here ____________

If applying for any disability rider, are you covered under California's Temporary Disability Insurance (TDI) or an equivalent state-mandated disability insurance plan? ❑ Yes ❑ No

TO BE COMPLETED BY AFLAC ASSOCIATE/AGENT

Billing Method:	**Mode:**		**Disability Benefit Period:**	**Accident Disability Elimination Period:**
☒ Payroll Deduction	❑ 01 Weekly	❑ 01 Monthly	❑ 6 Months	❑ 0 Days
	❑ 01 Biweekly	❑ 03 Quarterly	❑ 12 Months	❑ 7 Days
	❑ 01 Semimonthly	❑ 06 Semiannual		
	❑ 01 28-Day	❑ 12 Annual		

Employee No. ____________ Dept. No. ____________ Assoc./Agent No. ____________

Billable Premium $ ____________ Premium Collected $ ____________ Sit. Code ____________

CHECK COVERAGE DESIRED: ❑ Individual ❑ Two-Parent Family
❑ One-Parent Family ❑ Named Insured/Spouse Only

Class: ☐ A ☐ B ☐ C ☐ D ☐ E

	Total No. of Units	Premium	
❑ Level 1 Policy Series A-34100			❑ Pre-Tax or ❑ After-Tax
❑ Level 2 Policy Series A-34200			❑ Pre-Tax or ❑ After-Tax

The Disability Riders shown below do not apply to your spouse or dependents.

❑ Off-the-Job Accident Disability Rider			❑ Pre-Tax or ❑ After-Tax
❑ On-the-Job Accident Disability Rider			
❑ Sickness Disability Rider 14-Day Elimination Period			

The Disability Rider shown below applies only to your spouse.

❑ Spouse Off-the-Job Accident Disability Rider 0 Day Elimination Period/ 6-Month Benefit Period			After-Tax Only
	Total Premium		

PLEASE COMPLETE

Do you or anyone to be covered by this policy drive a taxi for wage, compensation or profit? If yes, please list the name and the relationship of the person(s) in the following space. Any person(s) so named will not be covered under the policy. ❑ Yes ❑ No

____

If the person so named is the primary insured, then a policy will not be issued; therefore, do not submit this application.

PLEASE COMPLETE QUESTIONS 1 THROUGH 8 IF APPLYING FOR ANY DISABILITY RIDER

1. I certify that my gross annual income (without overtime, unless contractual, bonuses or other incentives) for my full-time job is $ __________. If you are self-employed, your gross annual income is your net earnings.
I understand that this information will be verified at the time of claim. Annual income must be [$10,000] or greater for coverage to be issued.

1a. If applying for the Spouse Disability Rider, I further certify that my spouse's gross annual income (without overtime, unless contractual, bonuses or other incentives) for his/her full-time job is $ __________________.
If your spouse is self-employed, his/her gross annual income is his/her net earnings.
Spouse's Employer ____________________________________ Spouse's Job Title _______________________

1b. If your Industry Class is E, have you been employed for less than 12 months with the employer listed on the front page of this application? ❑ Yes ❑ No ❑ N/A

2. Do you or does anyone to be covered have a short-term disability policy with AFLAC? ❑ Yes ❑ No
If yes, please complete the Supplemental Notification section at the end of this application and be aware that you or anyone to be covered cannot have this policy with the disability riders without canceling your short-term disability policy with AFLAC.

3. Do you or does anyone to be covered currently have disability coverage, that you purchased, that will remain in force which, combined with this applied-for coverage, exceeds 70% of your monthly gross (pre-tax) income? ❑ Yes ❑ No

4. Have you or has anyone to be covered been charged with driving under the influence of alcohol or any narcotic within the last 12 months or been charged two or more times within the last five years? ❑ Yes ❑ No

5. Are you or is anyone to be covered currently on leave or not working because of Sickness, maternity or Injury? ❑ Yes ❑ No

6. Are there any material or substantial duties of your job that you or anyone to be covered are unable to perform because of Sickness, maternity or Injury? ❑ Yes ❑ No

7. Do you or does anyone to be covered work fewer than [30] hours per week in your primary (full-time) occupation with the employer listed on the first page of the application? ❑ Yes ❑ No

8. Within the last six weeks, have you or has anyone to be covered taken prescribed medication for the treatment of Injury, disease, or disorder of the back, neck, or joints? ❑ Yes ❑ No

If you answered yes, to Question 1b or any one of Questions 3 through 8, you are not eligible for any disability rider coverage; and therefore, no disability rider will be issued. Please indicate to which person any "yes" answer applies.

❑ Named Insured ❑ Spouse

The person indicated will not be covered by any disability rider.

PLEASE COMPLETE QUESTION 9 IF APPLYING FOR THE ON-THE-JOB DISABILITY RIDER

9. Are you covered by workers' compensation or a similar law in your full-time job? ❑ Yes ❑ No

If you answered yes, you are not eligible for On-the-Job Rider coverage; and therefore, this rider will not be issued.

PLEASE COMPLETE QUESTIONS 10 THROUGH 16 IF APPLYING FOR THE SICKNESS DISABILITY RIDER

10. Has a member of the medical profession ever diagnosed you with or ever treated you for any of the following: ❑ Yes ❑ No
    - Stroke or TIA (mini-stroke)
    - Heart valve replacement
    - Vascular insufficiency (circulatory problems)
    - Multiple sclerosis
    - Emphysema
    - Chronic liver disease
    - Chronic hepatitis (other than Type A)
    - Fibromyalgia
    - Chronic obstructive pulmonary disease
    - Cardiomyopathy
    - Systemic lupus
    - Chronic fatigue syndrome
    - Rheumatoid arthritis
    - Psoriatic arthritis
    - Crohn's disease
    - Regional enteritis/ileitis
    - Ulcerative colitis
    - Muscular dystrophy
    - Pulmonary fibrosis
11. Have you ever been diagnosed with acquired immune deficiency syndrome (AIDS) by a member of the medical profession? ❑ Yes ❑ No
12. In the past five years, has a member of the medical profession diagnosed you with or treated you for cancer (other than nonmelanoma skin cancers)? ❑ Yes ❑ No
13. Have you ever been diagnosed with or received treatment by a member of the medical profession for Type I diabetes; or Type II diabetes (1) diagnosed prior to age 30, or (2) with complications to include retinopathy, neuropathy, or nephropathy, or (3) with continued tobacco use, or (4) requiring the use of insulin within the past five years? ❑ Yes ❑ No
14. In the past 24 months, has surgery been performed for any of the following or has a member of the medical profession diagnosed you with or treated you for any of the following: ❑ Yes ❑ No
    - Heart attack
    - Congestive heart failure
    - Coronary angioplasty (or stents)
    - Angina (heart-related chest pains)
    - Coronary bypass surgery
    - Sciatica
    - Carpal tunnel syndrome
    - Atrial fibrillation
    - Drug or alcohol abuse
    - Kidney disease (not including kidney stones)
15. In the past 12 months, have you received treatment in an emergency room or Hospital by a member of the medical profession or missed ten total days of work for any of the following: ❑ Yes ❑ No
    - Chronic bronchitis
    - Asthma
    - Diverticulitis
    - Type II diabetes
    - Hypertension (high blood pressure)
    - Joint replacement
    - Pancreatitis
    - Seizures
    - Gastric bypass
    - Blood disorders
16. Have you been advised by a Physician to be hospitalized or to have surgery that has not yet been performed (excluding routine childbirth)? ❑ Yes ❑ No

If you answered yes to any one of Questions 10 through 16, you are not eligible for Sickness Disability Rider coverage; therefore, this rider will not be issued.

IF YOU ARE APPLYING FOR MORE THAN 4 UNITS OF SICKNESS DISABILITY COVERAGE, PLEASE COMPLETE QUESTIONS 17 THROUGH 21. IF NOT, PROCEED TO ITEM 25.

17. Have you received disability benefits or claimed workers' compensation in the last five years? ❑ Yes ❑ No
18. In the past 12 months, have you missed five consecutive days or ten total days of work because of your Sickness or Injury (not related to routine childbirth)? ❑ Yes ❑ No
19. In the past 12 months, have you been confined in a Hospital as an inpatient (not including confinement because of routine childbirth)? ❑ Yes ❑ No
20. In the past 12 months, has a member of the medical profession diagnosed you with or treated you for any heart disease or disorder excluding insignificant heart murmurs? ❑ Yes ❑ No
21. In the past 12 months, has a member of the medical profession diagnosed you with or treated you for an Injury, disease, or disorder of the back, the neck, or a joint? ❑ Yes ❑ No

If you answered yes to any one of Questions 17 through 21, you must complete Items 22 and 23 and provide details in Item 24.

22. **Within the last six weeks, have you been prescribed any medication by a Physician or taken any prescription medication (not including prescription contraceptives)?** If yes, please provide complete information below. ❑ Yes ❑ No

Medication Name	Dosage	Frequency	Date First Prescribed	Reason

23.

Your Physician's Name ______________________ Phone Number ______________________
(If no regular Physician, Physician last seen)
Address ____
Date Last Seen by Physician ______________________ Reason for Last Visit ______________________

24. **Details to Questions 17–21**

	Medical Conditions	Onset (mo/yr)	Surgery Performed? (If yes, provide the type of procedure and date)
Question 17			
Question 18			
Question 19			
Question 20			
Question 21			

APPLICANT'S STATEMENTS AND AGREEMENTS

25. I understand that the Effective Date of the policy will be the date recorded in the Policy Schedule by AFLAC Worldwide Headquarters.
26. I acknowledge receipt of, if applicable:
    - ❑ Replacement Notice
    - ❑ Outline of Coverage
    - ❑ *Guide to Health Insurance for People With Medicare*
    - ❑ Fair Credit Reporting Notice
27. 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) AFLAC is not bound by any statement made by me, or any associate/agent of AFLAC, unless written herein; (3) the associate/agent cannot change the provisions of the policy or waive any of its provisions either orally or in writing; (4) the policy, together with this application, endorsements, benefit agreements, riders, and attached papers, if any, constitutes the entire contract of insurance; and (5) no change to the policy will be valid until approved by AFLAC's secretary and president and noted in or attached to the policy.

NOTICE OF INFORMATION PRACTICES

To issue an insurance policy, AFLAC may need to obtain additional information about you and any other persons proposed for insurance. Some information will come from you and some may come from other sources. That information and any other subsequent information collected by AFLAC may in some circumstances be disclosed to third parties without your specific consent. You have the right to access and correct the information collected about you except information that relates to a claim or to a civil or criminal proceeding. If you wish to have a more detailed explanation of our information practices, please submit a written request to our worldwide headquarters. This notice applies only in Arizona, California, Connecticut, Georgia, Illinois, Maine, Massachusetts, Minnesota, Nevada, New Jersey, North Carolina, Ohio, Oregon, and Virginia.

SUPPLEMENTAL NOTIFICATION
COMPLETE IF YOU ARE REPLACING/TERMINATING EXISTING AFLAC DISABILITY COVERAGE.

I, ______________________________________ , am applying for AFLAC's policy with disability benefits. I currently have disability benefits under AFLAC short-term disability policy number _____________________. I understand that I must cancel my existing AFLAC short-term disability policy to purchase this policy.

❑ Please cancel my short-term disability policy so that this accident policy with disability benefits can be issued.

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

I authorize the following to give information (as defined below) to American Family Life Assurance Company of Columbus (AFLAC) or any person or entity acting on its part: any medical professional, medical care institution, insurer (including AFLAC, with respect to other AFLAC coverages), reinsurer, government agency (including departments of public safety and motor vehicle departments), the Medical Information Bureau, consumer reporting agency or employer. “Information” means facts or opinions relating to my past, present, or future physical or mental health or condition (excluding psychotherapy notes), employment, other insurance coverage or driving record to determine eligibility for insurance or to evaluate a claim for benefits during the time this authorization is valid. I also authorize AFLAC to give information to the Medical Information Bureau. I understand that any disclosure of health information to AFLAC for the purpose of determining eligibility for coverage other than health plan coverage means the information may no longer be protected by federal privacy regulations. I further understand, however, that such information may be re-disclosed only in accordance with other applicable laws or regulations.

I understand that this information will be used by AFLAC for enrollment or to determine eligibility for insurance or for underwriting or risk rating (where applicable) purposes and, should coverage be issued, the information may be used to contest a claim for benefits or the issuance of the policy itself during the contestability period provided in the policy.

I understand that AFLAC is conditioning the issuance of coverage on the provision of this authorization, and that, while I may refuse to sign this authorization, my refusal to do so could result in coverage not being issued.

I understand that I may revoke this authorization at any time, except to the extent that (1) AFLAC has taken action in reliance on this authorization, or (2) other law provides AFLAC with the right to contest a claim under the policy or the policy itself. My revocation must be submitted in writing to AFLAC, Policy Service, 1932 Wynnton Road, Columbus, GA 31999.

Unless otherwise revoked, I agree that this authorization will expire on the earlier of the date AFLAC notifies me of its declination of my application for coverage or, if a policy is issued, two years from the policy effective date.

I agree that a copy of this authorization is as valid as the original.

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 by my associate/agent.

I have read, or had read to me, the completed application and realize that policy issuance is based upon statements and answers provided herein and any other pertinent information AFLAC may require for proper underwriting. The answers are complete and true to the best of my knowledge and belief.

CALIFORNIA LAW PROHIBITS AN HIV TEST FROM BEING REQUIRED OR USED BY HEALTH INSURANCE COMPANIES AS A CONDITION OF OBTAINING HEALTH INSURANCE COVERAGE.

Signed and Dated at ______________________________________ on ____________________
City and State Date

Applicant's Signature (X)____

Beneficiary (your estate unless otherwise indicated) ____________________________________
Relationship

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

Associate/Agent Signature ______________________________________ ____________________
Licensed Associate/Agent Date

MAKE CHECK OR MONEY ORDER PAYABLE TO AFLAC.
FOR INFORMATION, CALL TOLL-FREE 1-800-99-AFLAC (1-800-992-3522).

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 provides limited benefits if you meet the conditions listed in the policy. 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).