Payroll

Application for Short-Term Disability Insurance (A-57400 Series)
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. _____ - _____ - _____

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)

Are you covered under California's Temporary Disability Insurance (TDI) or an equivalent state-mandated disability insurance plan? ❑ Yes ❑ No
If "NO", then you are not eligible for the Continuing Disability Benefit Rider (Series A-57451).

TO BE COMPLETED BY AFLAC ASSOCIATE/AGENT

PAYROLL MODE:
☐ 01 Weekly
☐ 01 Biweekly
☐ 01 Semimonthly
☐ 01 Monthly
☐ 01 28-day
☐ 03 Quarterly
☐ 06 Semiannual
☐ 12 Annual
☐ Pre-Tax
☐ After-Tax

Employee No. _____
Dept. No. _____
Billable Premium $ _____
Premium Collected $ _____
Associate/Agent No. _____
Sit. Code _____

CHECK COVERAGE DESIRED:	Class: ☐ A ☐ B ☐ C ☐ E

Benefit Periods:	☐ 6 Months ☐ 12 Months ☐ 24 Months **(maximum of 30 units)**
Elimination Periods: Injury/Sickness	☐ 0/7 Days ☐ 0/14 Days ☐ 7/14 Days ☐ 0/30 Days ☐ 30/30 Days ☐ 60/60 Days** ☐ 90/90 Days** **(**not available with a 6-month Benefit Period)** ☐ 180/180 Days*** **(***not available with a 6-month or a 12-month Benefit Period)**

	Total No. of Units	**Premium**
☐ Base Policy Series A-57400		
☐ On-the-Job Injury Rider Series A-57450		
☐ Continuing Disability Benefit Rider Series A-57451 Not available with a 6-month Benefit Period, a 12-month Benefit Period or a 180-day Elimination Period.		
NOTE: Each unit is equal to a $100 monthly benefit.	Total Premium	

TO BE COMPLETED BY APPLICANT

1. Do you have any of AFLAC's accident policies with disability benefits? If yes, please complete the Supplemental Notification section at the end of this application and be aware that you cannot have this policy without canceling those disability benefits with AFLAC. ❑ Yes ❑ No
2. Is the purchase of this coverage intended to replace any other disability insurance now in force? ❑ Yes ❑ No
   If yes, please read and sign the Replacement Notice provided by our associate/agent and provide the policy number here _____ ❑ Not applicable
3. 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 [$12,000 or $21,000 if covered under a state disability plan] or greater for coverage to be issued.

3a. 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
   If yes, a policy will not be issued; therefore, do not submit this application.

4. Do you have disability coverage, that you purchased, that will remain in force, which combined with this applied for coverage, will exceed 70% of your gross annual income? ❑ Yes ❑ No
   If yes, a policy will not be issued; therefore, do not submit this application.

PLEASE COMPLETE QUESTION 5 IF APPLYING FOR THE ON-THE-JOB DISABILITY RIDER

5. 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 ALL OF THE FOLLOWING QUESTIONS:

6. Do you 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
7. Have you 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
8. Are you currently on leave or not working because of Sickness, maternity, or Injury? ❑ Yes ❑ No
9. Are there any material or substantial duties of your job that you are unable to perform because of Sickness, maternity, or Injury? ❑ Yes ❑ No
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
    - Muscular dystrophy
    - Ulcerative colitis
    - 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 for 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
    - Drug or alcohol abuse
    - Kidney disease (not including kidney stones)
    - Atrial fibrillation

15. Within the last six weeks, have you taken prescribed medication for the treatment of Injury, disease, or disorder of the back, neck, or joints? ❑ Yes ❑ No

16. 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

- Diverticulitis
- Type II diabetes
- Chronic bronchitis
- Pancreatitis
- Seizures
- Blood disorders
- Hypertension (high blood pressure)
- Joint replacement
- Gastric bypass
- Asthma

17. 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 Question 6, additional underwriting may be required. If you answered yes to any one of Questions 7 through 17, a policy will not be issued; therefore, do not submit this application.

18. Have you received disability benefits or claimed workers' compensation in the last five years? ❑ Yes ❑ No
19. 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
20. In the past 12 months, have you been confined in a Hospital as an inpatient (not including confinement because of routine childbirth)? ❑ 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
22. 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

If you answered yes to any one of Questions 18 through 22, you must complete Items 25 and 26 and provide details in Item 27.

PLEASE COMPLETE QUESTIONS 23 THROUGH 25 IF APPLYING FOR THE 24-MONTH BENEFIT PERIOD OR FOR MORE THAN 20 UNITS OF ANY ONE MONTHLY DISABILITY BENEFIT

23. During the past 24 months, excluding routine checkups, have you been treated for any other illness/Injury or have you had any medical/surgical treatment other than those listed above? ❑ Yes ❑ No
24. a. Do you have any individual disability income coverage in force? ❑ Yes ❑ No
    b. Do you have any group disability income coverage in force? ❑ Yes ❑ No
    If yes to 24a or 24b, please list your monthly benefit amounts/percentages: _____,
    your Benefit Period: _____, and your Elimination Period: _____ .

If you answered yes to Question 23, you must complete Item 26 and provide details in Item 27.

25. 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

26.

Your Physician's Name _____ Phone Number _____
(if no regular Physician, Physician last seen)

Address _____

Date Last Seen by Physician _____ Reason for Last Visit _____

27. Details to Questions 18-23

	Medical Conditions	Onset (mo/yr)	Surgery Performed? (If yes, provide the type of procedure and date)	Name and Address of Physician and Hospital
Question 18				
Question 19				
Question 20				
Question 21				
Question 22				
Question 23				

APPLICANT'S STATEMENTS AND AGREEMENTS

28. I understand that the Effective Date of the policy will be the date recorded in the Policy Schedule by AFLAC Worldwide Headquarters.

29. I acknowledge receipt of, if applicable:
- ❑ Replacement Notice
- ❑ Outline of Coverage
- ❑ *Guide to Health Insurance for People With Medicare*
- ❑ Fair Credit Reporting Notice

30. 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.
I understand that coverage is not provided for a Sickness or an Injury for which, within the 12-month period before the Effective Date of coverage, medical advice, consultation, or treatment was recommended or received, or symptoms existed that would ordinarily cause a prudent person to seek diagnosis, care, or treatment, unless the loss begins more than 12 months after the Effective Date of coverage.

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 short-term disability policy. I currently have disability benefits under AFLAC accident/disability Policy Number _____. I understand that I must cancel existing AFLAC disability coverage to purchase this short-term disability policy.

Please cancel:

- ❑ The disability riders attached to my accident policy, but keep my accident policy in force.
- ❑ Cancel my entire accident policy (with Disability Benefits) number _____. I understand that I will be terminating benefits provided for in my current accident policy that are not provided for in the new short-term disability policy.

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) _____

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).