Non-Payroll

SUPPLEMENTAL SPECIFIED HEALTH EVENT PROTECTION INSURANCE POLICY (FORMS A71100PA AND A71200PA)

❑ New
❑ Conversion

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

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 (Optional)

Address _____
Street or Post Office Box Apt. No.

City _____ State _____ ZIP _____

Home Telephone ( ) _____ Business Telephone ( ) _____

State of Birth _____ 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

Name of Employer/Association _____ Account No. _____
(Optional)

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: _____

Does anyone to be covered have any Hospital Intensive Care coverage with Aflac? ❑ Yes ❑ No
If yes, you may not apply for Plan 2 (Policy Form A71200PA) unless the existing Hospital Intensive Care policy is terminated. If desired, please complete the Supplemental Notification section at the end of this application and be aware that you cannot have Plan 2 of the Supplemental Specified Health Event policy without canceling your existing Hospital Intensive Care policy with Aflac.

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)
❑ Plan 2: Critical Care and Recovery with Hospital Intensive Care Unit Benefits (Policy Form A71200PA)
❑ First-Occurrence Building Benefit Rider (Rider Form A71050) ($500)
Options: ❑ **No rider** ❑ **New rider** ❑**Retain current rider**
❑ Primary Specified Health Event Recovery Rider (Rider Form A71051PA)
Options: ❑ **No rider** ❑ **New rider** ❑**Retain current rider**

Billing Method:

❑ Direct
❑ Bank Draft (B/D, ACH)
❑ List Bill
❑ Emp. Nonpayroll/Assoc.
❑ Credit Card (C/C)

Modes:

❑ 01 Monthly (B/D & C/C Only)
❑ 03 Quarterly
❑ 06 Semiannual
❑ 12 Annual

Associate's/Agent's No. _____ Sit. Code _____ Billable Premium $ _____ Premium Collected $ _____

PLEASE COMPLETE QUESTIONS 1 THROUGH 9 IF APPLYING FOR PLAN 1 OR PLAN 2.

1. In the last five years, have you or anyone to be covered currently have or been diagnosed with or received treatment by a member of the medical profession for any of the following? ❑ Yes ❑ No

   Any disease, disorder, or abnormality of the heart including, but not limited to, cardiomyopathy, Heart Attack, congestive heart failure, or congenital heart disease (excluding surgically corrected atrial septal defect)
   Any disease, disorder or abnormality of the circulatory system, including, but not limited to, stroke, TIA, arterial blockage, or cerebral vascular insufficiency
   Chronic obstructive pulmonary disease (COPD)
   Cystic fibrosis
   Type I diabetes
   Impaired kidney function
   Kidney disease or disorder (excluding stones or acute infection) or kidney failure
   Liver disease or disorder (excluding hepatitis A)
   Systemic lupus
   Sickle cell anemia

2. In the last five years, have you or anyone to be covered currently have or been diagnosed with or received treatment by a member of the medical profession for diabetes (1) requiring the use of insulin within the last five years, or (2) with complications to include retinopathy, neuropathy, or nephropathy, or (3) with continued tobacco use, or (4) diagnosed prior to age 30 (excluding gestational)? ❑ Yes ❑ No

3. In the last five years, have you or anyone to be covered had or been advised to have a Major Organ Transplant, taking medication as the result of a Major Organ Transplant, or consulted with or been evaluated by a member of the medical profession of the need to have a Major Organ Transplant? ❑ Yes ❑ No

4. In the last five years, have you or anyone to be covered currently have or 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

5. Within the last two years, has anyone to be covered received chemotherapy treatment by a member of the medical profession for any medical condition, not to include hormonal treatment for cancer? ❑ Yes ❑ No

6. Within the last 12 months, has anyone to be covered been prescribed or received treatment with blood thinners, not including aspirin, by a member of the medical profession? ❑ Yes ❑ No

7. Within the last 12 months, has anyone to be covered received treatment by a member of the medical profession in an emergency room or hospital for hypertension/high blood pressure (not related to pregnancy), or had a medication change to improve blood pressure readings? ❑ Yes ❑ No

8. Within the last six months, has anyone to be covered had or received treatment by a member of the medical profession for chest pain, shortness of breath, blackouts, fainting, or dizziness, or been advised by a member of the medical profession to have diagnostic tests to evaluate these conditions? ❑ Yes ❑ No

If any one of Questions 1 through 8 is answered yes, was it the:

❑ Proposed Insured? ❑ 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, a policy will not be issued; therefore, do not submit this application.

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

9. Please list your height and weight: Height: ____ft. ____in. Weight: _____lbs.

Additional underwriting may be required.

PLEASE ONLY COMPLETE QUESTIONS 10 THROUGH 17
IF APPLYING FOR PLAN 2, POLICY FORM A71200PA.

10. Is anyone to be covered the mother or father of a child currently conceived but as yet unborn? ❑ Yes ❑ No
If yes, this policy will not be issued.

11. Is anyone to be covered currently confined in a hospital or nursing home, or has hospitalization been recommended by a Physician? ❑ Yes ❑ No

12. In the last five years, have you or anyone to be covered currently have or been treated with dialysis (not to include an acute event) or been diagnosed with or treated by a member of the medical profession for chronic kidney disease to include glomerulonephritis, nephrotic syndrome, or polycystic kidney disease? ❑ Yes ❑ No

13. In the last five years, have you or anyone to be covered currently have or been diagnosed with or treated by a member of the medical profession for emphysema, or has anyone to be covered required the use of oxygen for a chronic respiratory disease/disorder, excluding the use of a CPAP machine for the treatment of sleep apnea? ❑ Yes ❑ No

14. In the last five years, has anyone to be covered been diagnosed with or treated by a member of the medical profession for congestive heart failure or heart valve surgery? ❑ Yes ❑ No

15. Has anyone to be covered been hospitalized three or more times in the last two years? ❑ Yes ❑ No

16. In the last 12 months, has anyone to be covered received treatment in a Hospital Intensive Care Unit or Step-Down Intensive Care Unit (not including treatment as a result of an accident)? ❑ Yes ❑ No

17. In the last 12 months, has anyone to be covered been prescribed or taken any medication for the treatment of infertility? ❑ Yes ❑ No

If any one of Questions 11 through 17 is answered yes, was it the:

❑ Proposed Insured? ❑ 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, 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 65 before the Effective Date of the policy. **The Intensive Care Benefits A, B, and J of the Plan 2 policy (Form A71200PA) reduce to half at age 70.**
- 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.
- 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.

SUPPLEMENTAL NOTIFICATION
COMPLETE IF YOU ARE REPLACING/TERMINATING EXISTING AFLAC HOSPITAL INTENSIVE CARE COVERAGE.

I, _____, am applying for Aflac's Supplemental Specified Health Event Policy (Plan 2), which contains hospital intensive care benefits. I currently have hospital intensive care benefits under Aflac's Hospital Intensive Care Policy Number _____. I understand that I must cancel existing Aflac Hospital Intensive Care coverage to purchase this Supplemental Specified Health Event policy.

❑ Please cancel my Hospital Intensive Care Policy Number _____. I understand that I will be terminating benefits provided for in my current Hospital Intensive Care policy that may not be provided for in the new Supplemental Specified Health Event policy.

- 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 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 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).