

Nonpayroll

**HOSPITAL CONFINEMENT INDEMNITY INSURANCE POLICY
(A46000 Series)**

- New
- Conversion

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

Policy Number: _____

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

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

SSN _____ - _____ - _____ 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

Address _____ Apt. No. _____
 Street or Post Office Box

City _____ State _____ ZIP _____

Home Telephone () _____

Name of Employer/Association _____ Account No. _____

Do you have any other hospital indemnity coverage other than a hospital confinement sickness indemnity policy with Aflac? Yes No
 If yes, this must be a conversion of that coverage. Provide current policy number and see Item 20.
 Policy Number _____

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

TO BE COMPLETED BY AFLAC ASSOCIATE/AGENT

Check Coverage Individual Named Insured/ Spouse Only One-Parent Family Two-Parent Family
Desired:
 Plan 1: (Policy Series A46100) **Optional Rider**
 Plan 2: (Policy Series A46200) Initial Hospitalization Benefit Rider (Rider Series A46050)
 Plan 3: (Policy Series A46300) \$250 per unit: **UNITS:** _____

TO BE COMPLETED BY AFLAC ASSOCIATE/AGENT

Billing Method: Direct Emp. Nonpayroll/Assoc. Bank Draft (B/D, ACH) Credit Card (C/C)
Modes: 01 Monthly (B/D & C/C Only) 06 Semiannual 03 Quarterly 12 Annual

Card Name _____
 Card No. _____ Expiration Date _____

I authorize American Family Life Assurance Company of Columbus (Aflac) to charge my VISA/MASTERCARD/AMERICAN EXPRESS account in accordance with the premium rate that I have chosen. Premiums will be advanced by my bank until I cancel authorization in writing to Aflac. Cancellation will be effective on the first day of the month following Aflac's receipt of notice to cancel.

Signature _____ Date _____

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

ALL OF THE FOLLOWING MUST BE COMPLETED:

1. 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
2. Has anyone to be covered ever been medically treated or diagnosed by a member of the medical profession as having any of the following? Yes No
- * Alzheimer's disease
 - * senile dementia
 - * emphysema
 - * cerebral vascular insufficiency
 - * transient ischemic attack (TIA)
 - * heart bypass surgery (involving four or more vessels)
 - * uncorrected congenital heart defect (excluding mitral valve prolapse)
 - * stroke
 - * cardiomyopathy
 - * Type I diabetes
 - * psoriatic arthritis
 - * systemic lupus
 - * end-stage renal disease
 - * kidney failure
 - * kidney disease or disorder (excluding stones)
 - * liver disease or disorder
 - * cirrhosis
 - * hepatitis (excluding Type A)
 - * muscular dystrophy
 - * Crohn's disease
 - * sickle cell anemia
 - * cystic fibrosis
3. Has anyone to be covered ever been medically treated or diagnosed by a member of the medical profession as having Type II diabetes diagnosed prior to age 30; Type II diabetes with complications to include retinopathy, neuropathy, or nephropathy; Type II diabetes that required insulin use within the last 12 months; or Type II diabetes with continued tobacco use? Yes No
4. Has anyone to be covered ever been medically treated or diagnosed by a member of the medical profession for acquired immune deficiency syndrome (AIDS) or has anyone to be covered tested positive for human immunodeficiency virus (HIV)? Yes No
5. Has anyone to be covered ever had or been advised to have an organ transplant, or consulted with or been evaluated by a member of the medical profession of the need to have an organ transplant? Yes No
6. Has anyone to be covered been medically treated or diagnosed by a member of the medical profession for an internal cancer (which includes melanoma of Clark's Level III or higher, or a Breslow level greater than 1.5 mm) within the last five years? Yes No
7. During the past 36 months 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 (chest pains)
 - * congestive heart failure
 - * heart attack
 - * heart bypass surgery (involving 3 or less vessels)
 - * angioplasty or stent placement
 - * chronic obstructive pulmonary disease (COPD)
 - * peripheral vascular disease (circulatory problems)
 - * arrhythmia (with pacemaker or defibrillator)
 - * pancreatitis
 - * ulcerative colitis
 - * alcohol or drug abuse
 - * parkinson's disease
 - * multiple sclerosis
8. During the past 12 months, has anyone to be covered missed more than seven consecutive days of work due to Injury or Sickness (excluding a normal pregnancy)? Yes No
9. During the past 12 months has anyone to be covered been treated in a Hospital or Hospital emergency room for any respiratory disorders or psoriasis? Yes No

10. During the past six months, has anyone to be covered been advised by a member of the medical profession to have tests, treatment, or surgery that has not yet been done or are they undergoing evaluation following an abnormal test result? Yes No

11. **If any one of Questions 1 through 10 is answered yes, was it the:**
 Named Insured? Spouse? Child? If "Child," please list the name of the child(ren).

Any person(s) so designated will not be covered under the policy.

12. Has anyone to be covered been treated or had surgery at a Hospital as an outpatient or inpatient (not including treatment or surgery for elective procedures, childbirth, tonsils, appendix or gallbladder) in the last five years? Yes No

If you answered "yes", please provide details about the nature of the illness, Injury or need for medical attention below.

Name of individual(s):	Details:

13. Has anyone to be covered taken any medication recommended or prescribed by a member of the medical profession within the last six weeks (not including prescription contraceptives)? Yes No

If yes, please provide complete information below:

Name of Individual(s)	Name of Medication	Frequency	Date first Prescribed	Reason/medical condition

14. List all hospital indemnity policies you currently have in force, other than Aflac hospital indemnity policies, and provide the daily benefit amount. _____

APPLICANT'S STATEMENTS AND AGREEMENTS:

15. I understand that the Effective Date of the policy will be the date recorded in the Policy Schedule by Aflac Worldwide Headquarters. The policy has a 30-day waiting period for Sickness that begins on the Effective Date of the policy. **Benefits are not payable for any illness, disease, or disorder that is diagnosed by a Physician or medically treated before coverage has been in force 30 days from the Effective Date as shown in the Policy Schedule unless the loss begins more than six months after the Effective Date of coverage.**
16. 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.
17. I understand that dependent children, if any, must be under age 26 at the time of application. Once covered, coverage will be extended until the anniversary date of the policy following their 26th birthday.

18. I acknowledge receipt of, if applicable:

Replacement Notice Outline of Coverage Guide to Health Insurance for People with Medicare

19. I understand that: (a) Aflac is not bound by any statement made by me, the Proposed Insured, or any associate/agent of Aflac unless written herein. (b) The associate/agent cannot change the provisions of the policy or waive any of its provisions either orally or in writing. (c) The policy, together with this application, endorsements, benefit agreements, riders, and attached papers, if any, is the entire contract of insurance. (d) No change to the policy will be valid until approved by Aflac's president and secretary, and noted in or attached to the policy.

20. If this is an application for a conversion of coverage, the following conditions will apply: (a) If any one of Questions 1 through 10 are answered yes, the policy for which this application is made for the person(s) identified in Item 11 will be void, and coverage will continue under the terms of the previous policy, which may remain in force. Benefits that may be due any person(s) listed in Item 11 will be paid under the previous policy. (b) Any person(s) not listed in Item 11, if eligible, will be covered under the new policy. (c) The waiting period and the Time Limit on Certain Defenses provision will run from the Effective Date of the original policy, and the original policy will be terminated as of the Effective Date of the new policy. (d) The Pre-existing Conditions provision 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 Conditions provision in the new policy will run from the new policy's Effective Date.

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.

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.

If I am applying to replace existing Aflac hospital indemnity 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. I have read, or had read to me, the completed application, and I realize that policy issuance is based upon statements and answers provided herein, and they are complete and true. All statements made in this application are deemed representations and not warranties. I realize that any material misrepresentation therein may result in loss of coverage under the policy.

Signed and Dated at _____ on _____
City and State Date

Proposed Insured's Signature _____

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'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 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).



Payment Authorization Agreement

Policyholder/Applicant Information

	Policy Numbers	Premium \$	Policy Numbers	Premium \$
Name: _____	_____	_____	_____	_____
Address: _____	_____	_____	_____	_____
City, State, ZIP: _____	_____	_____	_____	_____
Phone: _____	No. of policies <input type="text"/>		Total: \$ _____	

Deduction Information

When would you like your premiums deducted? _____
Please choose any day 1–28.

How often? Monthly
 Quarterly
 Semiannually
 Annually

For newly issued policies only: For ease of your policy administration, we will make the effective date of coverage the same as your selected draft date following the receipt of your application in worldwide headquarters.

I choose to pay by electronic draft.

Draftee Name: _____
 Depository Name/Branch: _____
 City: _____ State: _____ ZIP: _____
 Transit/ABA Number: _____
 Account Number: _____ Checking Savings

I choose to pay by credit or debit card.

Visa Credit card
 MasterCard Debit card
 American Express

Card Number: _____ Expiration Date: _____

Confirmation

I authorize Aflac to initiate debit entries electronically to my account indicated above and I authorize the depository institution named above to debit same to such account. This authorization remains effective and in full force until Aflac and the depository/institution have received written notification from me of its termination in such time and in such manner to afford Aflac and the depository/institution a reasonable opportunity to act on it.

Policyholder's/Applicant's Signature: _____ Date: _____

Associate's/Agent's Signature: _____ Writing Number: _____ Date: _____
(Required for SNG Only)

American Family Life Assurance Company of Columbus (Aflac)
 Worldwide Headquarters • 1932 Wynnton Road • Columbus, GA 31999-0001
 1.800.99.AFLAC (1.800.992.3522) • aflac.com