Payroll

Application for Hospital Confinement Indemnity Insurance
(B40000 Series)
Application to: American Family Life Assurance Company of Columbus
(herein referred to as Aflac)

Worldwide Headquarters • Columbus, Georgia 31999

❑ New
❑ Conversion
❑ Downgrade

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

Address _____
Street or Post Office Box Apt. No.

City _____ State _____ ZIP _____

Telephone ( ) _____

Email Address _____

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

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

*Spouse includes domestic partner

Account Name _____ Account No. _____

Name of Employer _____

PLEASE COMPLETE THE FOLLOWING ELIGIBILITY QUESTIONS
(NOT REQUIRED FOR A DECREASE IN HOSPITAL CONFINEMENT BENEFIT AMOUNT ONLY)

1. **Are you, the Proposed Insured, currently reporting to work (not out on leave, FML, disability, hiatus, or layoff) with the employer listed on this application? If no, a policy will not be issued; therefore, do not submit this application.** **❑ Yes ❑ No**
2. **(a) Is your Spouse, if applying for coverage, currently reporting to work (not out on leave, FML, disability, hiatus, or layoff)?** **❑ Yes ❑ No ❑ N/A**
   (b) If no, is your Spouse now hospitalized or unable to work due to a physical or mental impairment? *If yes to 2(b), your Spouse is not eligible for coverage.* **❑ Yes ❑ No ❑ N/A**

Are you or anyone to be covered, currently covered by Medi-Cal? **❑ Yes ❑ No**
If yes, then a policy will not be issued.

Are you or anyone to be covered, currently covered by Medicare Parts A and B AND a Medicare Supplement policy or certificate, or contract and coverage for excess charges under Part B? **❑ Yes ❑ No**
If yes, then a policy will not be issued.

Are you or each person proposed for coverage, currently covered by a hospital or medical expense insurance, health care service plan, a health maintenance organization (HMO) contract, or major medical expense insurance? **❑ Yes ❑ No**
If no, then that person(s) without medical, hospital, and surgical coverage is not eligible for this hospital confinement indemnity coverage and a policy cannot be issued.

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.

Do you have any other hospital confinement indemnity or hospital confinement **sickness** indemnity coverage with Aflac? ❑ **Yes** ❑ **No**
If yes, or we determine that other hospital confinement indemnity or hospital confinement **sickness** indemnity coverage was in force within the last 6 months, this application will be processed as a conversion of that coverage.

If you are applying to change your Hospital Confinement Benefit amount, convert your optional specified disease lump sum benefit rider, or add any additional rider(s), this application will be processed as a conversion of your coverage.

If you have both hospital confinement indemnity and hospital confinement **sickness** indemnity coverage, you must convert both policies to this one new hospital confinement indemnity policy. Please give current policy number(s) and see the Applicant's Statements and Agreements concerning conversions and replacement of coverage.

Policy Number(s) to Be Converted: _____

PLEASE NOTE: If anyone to be covered, other than the Proposed Insured, has any other hospital confinement indemnity or hospital confinement sickness indemnity coverage with Aflac, such person(s) must submit a request to cancel the existing coverage in order to be eligible for coverage under this policy. Such person(s) may keep their existing coverage without undergoing underwriting again for issuance of this new policy, but must be removed from this application. If at any time Aflac discovers that someone, other than the Proposed Insured, is covered under any other hospital confinement indemnity or hospital confinement sickness indemnity coverage with Aflac, then such individual(s) will be removed from this policy as of the date of duplication. Any premiums paid for such individual(s) will be refunded, less any benefits previously paid for such individual(s) under this policy, from such date.

If applying for an optional specified disease lump sum benefit rider (Aflac Plus Rider), please answer the following questions:

Is the specified disease lump sum benefit rider 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.

Is anyone to be covered also covered under any other specified disease lump sum benefit rider on any other policy? ❑ **Yes** ❑ **No**
If yes, anyone covered under an existing specified disease lump sum benefit rider cannot be covered under the new rider; therefore, the new rider will not be issued.

Are you applying to convert your current HSA-compatible specified disease lump sum benefit rider (Series CIRIDERH) to the specified disease lump sum benefit rider (Series CIRIDER) that is not HSA-compatible? ❑ **Yes** ❑ **No**
If yes, please complete the Notice and Acknowledgment Regarding Conversion form provided by your associate/agent.

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

Hospital Confinement Indemnity Policy (Issue Ages 18-64):

❑ **Option 1 (Series B40100)**
❑ **Option H (Series B4010H)**

Hospital Confinement Benefit Amount:
❑ **Retain Current Amount**
❑ **$500** ❑ **$1,000** ❑ **$1,500** ❑ **$2,000**
❑ **$3,000** ❑ **$4,000** ❑ **$5,000**

❑ Pre-Tax
❑ After-Tax

Optional Riders (Issue Ages 18-64)

❑ **Extended Benefits Rider (Series B40050)***
Options: ❑ No rider ❑ New rider ❑ Retain current rider
❑ **Hospital Stay and Surgical Care Rider (Series B40051)***
Options: ❑ No rider ❑ New rider ❑ Retain current rider
***Not available with Option H**

Optional Specified Disease Lump Sum Benefit Riders (Issue Ages 18-64): **Select One Rider:** ❑ **Aflac Plus Rider (Series CIRIDER)* or ❑ Aflac Plus Rider (Series CIRIDERH)**** **Options: ❑ No rider ❑ New rider ❑ Retain current rider ❑ Convert current rider** ***Not available with Option H** ****Not available with Option 1**	❑ Pre-Tax ❑ After-Tax

Billing Method:	**Mode:**	
❑ Payroll Deduction	❑ 01 Weekly	❑ 01 Monthly
❑ Bank Draft (B/D)	❑ 01 14-Day Biweekly	❑ 03 Quarterly
❑ Credit Card (C/C)	❑ 01 Semimonthly	❑ 06 Semiannual
	❑ 01 28-Day Biweekly	❑ 12 Annual

PLEASE NOTE: If the B/D 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 _____

I am applying for Guaranteed-Issue; therefore, the underwriting questions are not required to be answered.
❑ Yes ❑ No

PLEASE COMPLETE THE FOLLOWING UNDERWRITING QUESTIONS IF YOU ARE APPLYING FOR OPTION H, AN INCREASE IN THE HOSPITAL CONFINEMENT BENEFIT AMOUNT, A CONVERSION FROM ANOTHER POLICY SERIES, OR THE HOSPITAL STAY AND SURGICAL CARE RIDER.
(NOT REQUIRED FOR A DECREASE IN HOSPITAL CONFINEMENT BENEFIT AMOUNT ONLY):

1. Is anyone to be covered the mother or father of a child currently conceived but as yet unborn, or within the last 12 months, has anyone to be covered been diagnosed with or treated by a member of the medical profession for infertility? **❑ Yes ❑ No**

2. Is anyone to be covered currently confined in a Hospital or nursing home, or within the last 12 months, has a member of the medical profession recommended hospitalization or nursing home confinement? **❑ Yes ❑ No**

3. Within the last 12 months, has anyone to be covered been diagnosed with a condition by a member of the medical profession for which treatment includes a medical procedure (including but not limited to surgery, organ or bone marrow transplant, or joint replacement)? **❑ Yes ❑ No**

4. Within the last six months, has anyone to be covered had any medical tests conducted for which results are pending or is anyone undergoing medical evaluation due to test results received? **❑ Yes ❑ No**

5. Has anyone to be covered been diagnosed by a member of the medical profession with diabetes before the age of 30 (except for gestational diabetes)? **❑ Yes ❑ No**

6. Within the last five years, has anyone to be covered been medically treated or diagnosed by a member of the medical profession as having any of the following? ❑ **Yes** ❑ **No**

- Chronic obstructive lung disease, including chronic obstructive pulmonary disease (COPD)
- Cerebral vascular disease
- Heart attack
- Uncorrected congenital heart defect
- Congestive heart failure
- Sickle cell anemia
- Systemic lupus
- Multiple sclerosis
- Diabetes treated with insulin or other injectable medication
- Diabetes and used tobacco after the diagnosis
- Organ or bone marrow transplant
- Alcohol or drug abuse
- Pulmonary fibrosis
- Cystic fibrosis
- Stroke or transient ischemic attack (TIA)
- Heart bypass surgery, stent placement, or angioplasty
- Cardiomyopathy
- Cancer, other than nonmelanoma skin cancer
- Muscular dystrophy
- Psoriatic arthritis
- Liver disease or disorder
- Diabetes with complications, including but not limited to nephropathy, neuropathy, or retinopathy
- Kidney disease or disorder (except kidney stones)

7. Within the last five years, has anyone to be covered been diagnosed with or treated for acquired immune deficiency syndrome (AIDS) or AIDS-related conditions (ARC) by a member of the medical profession? ❑ **Yes** ❑ **No**

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

8. Within the last three years, has anyone to be covered been medically treated or diagnosed by a member of the medical profession for any of the following? ❑ **Yes** ❑ **No**

- Heart-related chest pain (including angina or acute coronary syndrome)
- Atrial fibrillation
- Pancreatitis
- Crohn's disease
- Alzheimer's disease
- Heart disease or disorder with pacemaker or defibrillator implant
- Peripheral vascular disease (circulatory problems)
- Ulcerative colitis or proctitis
- Parkinson's disease
- Senile dementia

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

❑ Proposed Insured? ❑ Spouse? ❑ Child? If "Child," please list the name(s) of the child(ren).

_____

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

If a child, are any other children to be covered? ❑**Yes** ❑ **No**

APPLICANT'S STATEMENTS AND AGREEMENTS

- I understand that the Effective Date of the policy and/or riders 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 following conditions apply:
  - Coverage is not provided for any illness, disease, infection, condition, or injury for which, within the 12-month period before the Effective Date of coverage, prescription medication was taken or medical testing, advice, or treatment was recommended or received from a Physician. Care or treatment caused by a Pre-existing Condition will not be covered unless it begins more than 12 months after the Effective Date of coverage; and
  - Aflac will not pay benefits for a loss that is caused by or occurs as a result of giving birth within the first ten months of the Effective Date of coverage; or pregnancy in existence prior to the Effective Date of coverage, including any resulting Complications of Pregnancy or maternal-fetal intervention procedure.

For pregnancy beginning on or after the Effective Date of coverage, Complications of Pregnancy are covered to the same extent as a Sickness.

Proposed Insured's Initials _____

- I understand that the policy and/or rider(s) I am applying for will not cover any person who has reached his or her 65th birthday before the Effective Date of coverage.
- I understand that Dependent Children, if any, must be under age 26 as of the Effective Date of coverage. Once covered, Dependent Children will continue to be covered until their 26th birthday. When coverage on all Dependent Children terminates, you must notify Aflac, in writing, and elect whether to continue the coverage on an Individual or Named Insured/Spouse Only basis. After such notice, Aflac will arrange for the payment of the appropriate premium due, including returning any unearned premium.
- I acknowledge receipt of, if applicable:
  - ❑ Replacement Notice
  - ❑ *Guide to Health Insurance for People with Medicare*
  - ❑ Aflac Plus Rider Conversion Notice
  - ❑ Aflac Plus Rider Outline of Coverage
  - ❑ Outline of Coverage
  - ❑ Electronic Delivery Notice
  - ❑ Aflac Plus Rider Replacement Notice
- If this is an application for a conversion, I understand that: (1) if any one of Questions 1 through 8 is answered yes, the coverage for which this application is made for the person(s) identified in Question 9 will be void, and coverage will continue under the terms of the existing policy(ies). Benefits that may be due any person(s) listed in Question 9 will be paid under the previous policy. Any person(s) not listed in Question 9, if eligible, will be covered under the new policy. Also, the Time Limit on Certain Defenses provision will run from the Effective Date of the new coverage; (2) the original coverage(s) will be terminated as of the Effective Date of the new coverage; and (3) the Pre-existing Conditions provision in the new coverage will run from the original coverage's Effective Date for the benefits provided under the original policy. For any increased benefit amount, the Pre-existing Conditions provision in the new policy will run from the new policy's Effective Date.

Proposed Insured's Initials _____

- I understand that (1) the policy, together with this application, endorsements, benefit agreements, riders, and attached papers, if any, constitutes the entire contract of insurance, and (2) 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 coverage with this policy and/or rider(s), I acknowledge that the policies and/or rider(s) may have different benefits and that I should compare them to determine which is/are best for me. I understand and agree that I am terminating my current policy(ies) and/or rider(s) and its/their benefits for the benefits provided in this Aflac policy and/or rider(s).

Proposed Insured's Initials _____

- I acknowledge that I have been informed whether there are any optional rider(s) available. If any optional rider(s) are available, then I acknowledge that I have personally determined which, if any, are best for me.

Proposed Insured's Initials _____

- I have read, or had read to me, the statements and answers I have provided on this application. I understand that the policy and/or rider(s) is/are 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 to the best of my knowledge and belief. 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 the policy and/or rider(s).
- I understand that the purchase of this policy and/or rider(s) is intended to supplement my existing comprehensive health care coverage. It is not intended to replace or be issued in lieu of that coverage.

ADDITIONAL APPLICANT'S STATEMENTS AND AGREEMENTS FOR SPECIFIED DISEASE LUMP SUM BENEFIT RIDER:

- I understand that the specified disease lump sum rider I am applying for will not cover any person who has reached his or her 65th birthday before the Effective Date of the rider.
- I understand that coverage is not provided for any illness, disease, infection, or injury for which, within the 12-month period before the Effective Date of coverage, prescription medication was taken or medical testing, medical advice, or treatment was recommended or received from a Physician. Benefits for a loss that is caused by a Pre-existing Condition will not be covered unless the Onset Date is more than 12 months after the Effective Date of coverage.

  Proposed Insured's Initials _____

- If this is an application for a conversion of the specified disease lump sum benefit rider, I understand that: (1) the Time Limit on Certain Defenses provision will run from the Effective Date of the new coverage, (2) the original coverage(s) will be terminated as of the Effective Date of the new coverage, and (3) the Pre-existing Conditions provision in the new coverage will run from the original coverage'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. Information relating to HIV, AIDS, or ARC status will not be disclosed. 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, Montana, Nevada, New Jersey, North Carolina, Ohio, Oregon, and Virginia.

I prefer to receive an electronic copy of my policy instead of a paper copy. ❑ Yes ❑ No
If yes, please enter your email address on Page 1.

Signed and Dated At _____ on _____
City and State Date

THIS IS A SUPPLEMENT TO HEALTH INSURANCE. IT IS NOT A SUBSTITUTE FOR ESSENTIAL HEALTH BENEFITS OR MINIMUM ESSENTIAL COVERAGE AS DEFINED IN FEDERAL LAW. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES.

Proposed Insured's Signature _____

WAS THE ASSOCIATE/AGENT PRESENT AT THE TIME THE APPLICATION WAS COMPLETED? ❑Yes ❑ No

If yes, 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 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 WEBSITE AT AFLAC.COM.

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).

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).

AUTHORIZATION TO OBTAIN INFORMATION

MAIL TO: American Family Life Assurance Company of Columbus
1932 Wynnton Road
Columbus, Georgia 31999-0001

Primary Policyholder's Name:	**SSN**(optional):	**Date of Birth:**
Policy Number(s):		
Address:		
Name of Individual Subject to Disclosure (if not the primary policyholder):		**Date of Birth:**
Relationship to Primary Policyholder: □ Self □ Spouse □ Domestic Partner		

I authorize the following to give information (as defined below) to American Family Life Assurance Company of Columbus, American Family Life Assurance Company of New York, and Continental American Insurance Company (collectively, "Aflac"): any medical professional, medical care institution, pharmacy-related service organizations, insurer (including Aflac, with respect to other Aflac coverages), reinsurer, government agency (including departments of public safety and motor vehicle departments), MIB, Inc. (formerly known as the Medical Information Bureau), consumer reporting agency, or employer.

"Information" includes facts or opinions relating to my past, or present physical or mental health or condition (excluding psychotherapy notes), employment, other insurance coverage or driving record that is required as part of the underwriting process in order to determine eligibility for insurance. It also includes any health information that may become part of my health record, during the time this authorization is valid and may be used for the purpose of evaluating a claim for benefits.

I understand that I may request an interview in connection with the preparation of the investigative consumer report and that upon request, receive a copy. 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 redisclosed 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 while processing a claim for benefits or to contest the issuance of the policy itself during the two-year 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, Georgia 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, thirty months from the date this authorization is signed.

I agree that a copy of this authorization is as valid as the original and that I or an authorized representative may request a copy of this authorization.

Signature of Individual Subject to Disclosure _____ Date Signed _____

If this authorization has been signed by a personal representative on behalf of an individual, his/her authority to act on behalf of the individual must be set forth here:

Printed Name of Legal/Personal Representative _____ Legal Relationship *(e.g. Power of Attorney)* _____

AUTHORIZATION TO DISCLOSE INFORMATION

MAIL TO: American Family Life Assurance Company of Columbus
1932 Wynnton Road
Columbus, Georgia 31999-0001

Primary Policyholder's Name:	**SSN**(optional):	**Date of Birth:**
Policy Number(s):		
Address:		
Name of Individual Subject to Disclosure (if not the primary policyholder):		**Date of Birth:**
Relationship to Primary Policyholder: □ Self □ Spouse □ Domestic Partner		

I authorize American Family Life Assurance Company of Columbus, American Family Life Assurance Company of New York, and Continental American Insurance Company (collectively, "Aflac") to make a brief report of my personal health information to MIB, Inc. (formerly known as the Medical Information Bureau).

I understand that this information will be used by MIB, Inc. for the purpose of assisting the insurance industry in the accurate underwriting of insurance products as well as assisting the insurance industry in facilitating the fair pricing of insurance products through more accurate risk assessment.

"Information" includes information in Aflac's possession relating to my physical or mental health or condition (excluding psychotherapy notes, but including, for example, medical diagnosis/treatment information related to underwriting), and nonmedical financial information (including, for example, policy status).

I understand that any disclosure of health information to MIB, Inc. means the information may no longer be protected by federal privacy regulations. I further understand, however, that such information may be redisclosed only in accordance with other applicable laws or regulations.

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 Aflac has taken action in reliance on this authorization. My revocation must be submitted in writing to Aflac, Policy Service, 1932 Wynnton Road, Columbus, Georgia 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, thirty months from the date this authorization is signed.

I agree that a copy of this authorization is as valid as the original and that I or an authorized representative may request a copy of this authorization.

Signature of Individual Subject to Disclosure _____ Date Signed _____

If this authorization has been signed by a personal representative on behalf of an individual, his/her authority to act on behalf of the individual must be set forth here:

Printed Name of Legal/Personal Representative _____ Legal Relationship *(e.g. Power of Attorney)* _____

DISCLOSURE STATEMENT

AMERICAN FAMILY LIFE ASSURANCE COMPANY OF COLUMBUS
(herein referred to as Aflac)
Worldwide Headquarters • Columbus, Georgia 31999
A Stock Company

Applicant's Name: _____

Policy Number: _____

THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES.

MINIMUM ESSENTIAL COVERAGE DEFINITION

The type of coverage an individual needs to have to meet the individual responsibility requirement under the Affordable Care Act. This includes individual market policies, job-based coverage, Medicare, Medicaid, CHIP, TRICARE and certain other coverage.

I certify, by signing below, that I am covered by a major medical policy or other coverage that satisfies the minimum essential coverage under the Affordable Care Act.

_____ _____

Applicant's Signature Date

American Family Life Assurance Company of Columbus
(herein referred to as Aflac)
Worldwide Headquarters • Columbus, GA 31999
For information, call toll-free 1.800.99.AFLAC (1.800.992.3522).

Suitability Notice

I, _____, have reviewed the benefits and premium of the insurance
Proposed Insured's Name

policy(ies) and/or riders that I am applying for and agree to the following.

- I understand the impact that the premium for this coverage has on my paycheck/income;
- I understand the impact that the total Aflac premium for this coverage and any other Aflac coverage has on my paycheck/income and believe it to be appropriate for me; and
- I have considered all of my existing health insurance coverage, with Aflac and/or with other carriers, and believe this additional coverage is appropriate for my insurance needs. I further understand that I can contact Aflac and/or other insurance carriers to assist in evaluating the suitability of insurance coverage for me.

Proposed Insured's Signature _____ Date _____

I certify that I have advised the applicant to consider the impact that this Aflac coverage has on his or her paycheck/income, and I agree with the applicant's decision that it is appropriate for purchase.

Associate's/Agent's Signature _____ Date _____
Licensed Associate/Agent