Payroll

Application for Cancer Indemnity Insurance (A76000 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 Proposed Insured/Employee

Proposed Insured's/Employee's Name _____ _____ _____
Last First MI

DOB _____ Sex _____ SSN _____ - _____ - _____
Month/Day/Year (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

Address _____
Street or Post Office Box Apt. No.

City _____ State _____ ZIP _____

Home Telephone ( ) _____ E-Mail Address (optional) _____

Billing Name (if different from Proposed Insured/Employee): _____

Payroll Account Name _____ Payroll Account 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.
Do you currently have an active Aflac Cancer Policy Form Series A76100? ❑ Yes ❑ No
If yes, then you may not use this application. **Please use Application Form Series A76004.**
You may be eligible to apply for additional coverage.
If no, do you currently have an active Aflac cancer policy that has been in force for 12 months or more? ❑ Yes ❑ No

TO BE COMPLETED BY AFLAC ASSOCIATE/AGENT

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

❑ Policy (Series A76100) ❑ Policy (Series A761ES) ❑ Pre-Tax ❑ After-Tax

Optional Riders:

Initial Diagnosis Benefit Rider (Series A76050)
Options: **❑ No rider ❑$2,500 ❑$5,000 ❑$7,500 ❑$10,000**

Cancer Screening
and Annual Care Benefit Rider (Series A76051)

Options: **❑ No rider ❑$50 ❑$75 ❑$100 ❑$125**

Specified-Disease Benefit Rider (Series A76052)
Options: **❑ No rider ❑ New rider ❑Retain current rider**

❑ After-Tax Only

Return of Premium Benefit Rider (Series A76053)
Options: ❑ No rider ❑ New rider ❑ Retain current rider
(Factor amt. _____)

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

Employee No. _____ Dept. No. _____ Assoc./Agent's No. _____

Billable Premium $ _____ Premium Collected $ _____ Sit. Code _____

ASSOCIATED CANCEROUS CONDITION: a myelodysplastic blood disorder, myeloproliferative blood disorder, or carcinoma in situ (in the natural or normal place, confined to the site of origin without having invaded neighboring tissue). An Associated Cancerous Condition is limited to only the conditions listed above.

CANCER: a disease manifested by the presence of a malignant tumor characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue. "Cancer" also includes, but is not limited to, leukemia, Hodgkin's disease, and melanoma.

INTERNAL CANCER means all Cancers other than Nonmelanoma Skin Cancer.

PLEASE COMPLETE THE FOLLOWING QUESTIONS

1. Have you or has anyone to be covered had Internal Cancer or an Associated Cancerous Condition that was diagnosed or last treated **within the last five years** or received preventive hormonal therapy within the last 12 months?

❑Yes ❑ No

If yes, was it the ❑ Named Insured ❑ Spouse ❑ Child? Name of the child(ren):

_____

Any person(s) so designated will not be covered under the policy. If the named person is the Proposed Insured/Employee, a policy will not be issued.

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

2. Have you or has anyone to be covered had Internal Cancer or an Associated Cancerous Condition that was diagnosed or last treated **over five years ago**? **❑Yes ❑ No**

If yes, was it the ❑ Named Insured ❑ Spouse ❑ Child? Name of the child(ren):

_____

If yes, please complete a Cancer History Form provided by your associate/agent on any individual(s) listed. You are eligible for a maximum of $5,000 of the Initial Diagnosis Benefit Rider and you are eligible for a maximum of $75 of the Cancer Screening and Annual Care Benefit Rider. No additional amounts will be issued.

3. Have you or has anyone to be covered had Nonmelanoma Skin Cancer that was diagnosed or last treated within the last five years? **❑Yes ❑ No**

If yes, was it the ❑ Named Insured ❑ Spouse ❑ Child? Name of the child(ren)

_____

Any person(s) so designated will be issued a Skin Cancer Exclusion Rider. Benefits will not be payable under this policy for the indicated individual for the treatment of Skin Cancer.

If yes, and this is a conversion, the person(s) so designated is not eligible for coverage under the converted policy.

Proposed Insured's/Employee's Initials _____

ANSWER THE FOLLOWING QUESTIONS ONLY IF YOU WISH TO PURCHASE MORE THAN $5,000 OF THE INITIAL DIAGNOSIS BENEFIT RIDER OR MORE THAN $75 OF THE CANCER SCREENING AND ANNUAL CARE BENEFIT RIDER.

4. Have you or has anyone to be covered received abnormal test results from a Cancer or Associated Cancerous Condition screening within the past 90 days, or are you or anyone to be covered waiting on the results of medical tests for an undiagnosed condition? **❑Yes ❑ No**

5. Have you or has anyone to be covered used tobacco products or products containing nicotine of any type in the last 12 months? **❑Yes ❑ No**

If the answer to either Question 2, 4, or 5 is yes, you are eligible for a maximum of $5,000 of the Initial Diagnosis Benefit Rider and you are eligible for a maximum of $75 of the Cancer Screening and Annual Care Benefit Rider. No additional amounts will be issued.

PLEASE READ NUMBER 6 IF THIS IS A CONVERSION AND YOU DID NOT SELECT ANY OF THE OPTIONAL RIDERS.

6. I acknowledge that I was offered the Optional Riders and declined one or more of them.

Proposed Insured's/Employee's Initials _____

PLEASE ANSWER THE FOLLOWING QUESTION IF APPLYING FOR THE SPECIFIED-DISEASE RIDER

7. Have you or has anyone to be covered under this policy ever had adrenal hypofunction (Addison's disease), ALS (amyotrophic lateral sclerosis) or Lou Gehrig's disease, botulism, bubonic plague, cerebral palsy, cholera, cystic fibrosis, diphtheria, encephalitis (including encephalitis contracted from West Nile virus), Huntington's chorea, malaria, meningitis (bacterial), multiple sclerosis, muscular dystrophy, myasthenia gravis, necrotizing fasciitis, osteomyelitis, polio, rabies, Reye's syndrome, scleroderma, sickle-cell anemia, systemic lupus, tetanus, toxic shock syndrome, tuberculosis, tularemia, typhoid fever, variant Creutzfeldt-Jakob disease (mad cow disease), or yellow fever in any form? **❑Yes ❑ No**

If yes, was it the ❑ Named Insured ❑ Spouse ❑ Child? Name of the child(ren):

_____

Any person(s) so designated above will not be covered under Specified-Disease Rider Form Series A76052.

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

APPLICANT'S STATEMENTS AND AGREEMENTS

8. I understand that the Effective Date of this policy will be the date recorded on the Policy Schedule by Aflac**. It is not the date the application is signed.** This policy contains a 30-day waiting period. If a Covered Person has Cancer or an Associated Cancerous Condition diagnosed before coverage has been in force 30 days, benefits for treatment of that Cancer or Associated Cancerous Condition will apply only to treatment occurring after two years from the Effective Date of the policy or, at your option, you may elect to void the policy from its beginning and receive a full refund of premium.

9. I acknowledge receipt of, if applicable:
- ❑ *Guide to Health Insurance for People with Medicare*
- ❑ Replacement Notice
- ❑ Outline of Coverage

10. I understand that: (a) the policy of insurance I am now applying for will be issued based upon the written answers to questions and information asked for in this application and any other pertinent information Aflac may require for proper underwriting; (b) Aflac is not bound by any statement made by me, or any associate/agent of Aflac, unless written herein; (c) the associate/agent cannot change the provisions of the policy or waive any of its provisions either orally or in writing; (d) the policy, together with this application, endorsements, benefit agreements, riders, and attached papers, if any, constitutes the entire contract of insurance; and (e) no change to the policy will be valid until approved by Aflac's secretary and president and noted in or attached to the policy.

11. If this is an application for a conversion, the following conditions apply: (a) If Cancer or Associated Cancerous Condition is diagnosed between the date this application is signed and the Effective Date of the policy shown in the Policy Schedule, the policy for which this application is made will be void, and coverage will continue under the terms of the previous policy, which may remain in force. Any benefits that may be due will be paid under the previous policy. (b) The waiting period provision of the new policy 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. Any premium paid on the original policy that is unearned as of the Effective Date of the new policy will be applied to the new 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.

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 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. I also understand that if I am receiving any Medicaid benefits, the purchase of this supplemental coverage is not necessary.

If I am applying to convert my current policy to another Aflac policy, I acknowledge that I have been advised that the policies have different benefits and that I should compare them to determine which is best for me. I understand and agree that I am giving up my current policy and its benefits for the benefits provided in the new 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. I further realize that any fraudulent material misrepresentation therein may result in loss of coverage under the policy.

Proposed Insured's/Employee's Signature _____ Date _____

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).