Nonpayroll

Aflac's Application for Nonpayroll Life Insurance (A64000 Series) Application to American Family Life Assurance Company of Columbus (Aflac) Worldwide Headquarters • Columbus, Georgia 31999	Policy Number ❑ New

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

Proposed Insured's Name _____
Last First MI

DOB _____ Sex ____ Height _____ _____ Current Weight _____ SSN _____ - _____ - _____
Month/Day/Year ft. in. lbs. (optional)

Driver's License Number _____ State of Issue _____ State of Birth _____

Proposed Insured's Address _____
Street or Post Office Box Apt. No.

City _____ State _____ ZIP Code _____

Primary Telephone ( ) _____ Best Time to Call _____
❑ Home ❑ Work ❑ Cell

Secondary Telephone ( ) _____ Best Time to Call _____
❑ Home ❑ Work ❑ Cell

E-mail Address (optional) _____

Name of Proposed Insured's Employer _____ Department No. (if required) _____

Occupation _____ Employee ID No. (if required) _____

Owner's Name _____ Relationship to Proposed Insured _____
(if other than Proposed Insured)

Address _____
Street or Post Office Box Apt. No.

City _____ State _____ ZIP Code _____

Do you have any other life coverage, not to include group guaranteed-issue life, with Aflac? ❑ Yes ❑ No
If yes, give current policy number: _____

Will the purchase of this life insurance policy give you more than $250,000 total face value ($100,000 if over age 50) of life insurance coverage with Aflac? ❑ Yes ❑ No

Is the purchase of this policy intended to replace any life insurance or annuity now in force? ❑ Yes ❑ No
If yes, please read and sign the Replacement Notice provided by your associate/agent, if applicable.

If the applicant is age 65, list all health and disability policies that are still in force (by type and company):

_____
_____
_____

Within the last 12 months, have you used tobacco products, products containing nicotine, and/or any nicotine delivery system? ❑ Yes ❑ No

TO BE COMPLETED BY AFLAC ASSOCIATE/AGENT

Billing Method
- ❑ Direct
- ❑ List Bill
- ❑ Bank Draft (B/D, ACH)
- ❑ Credit Card (C/C)

Mode
- ❑ 01 Monthly
- ❑ 03 Quarterly
- ❑ 06 Semiannual
- ❑ 12 Annual

For Bank Draft / ACH or Credit Card billing method, an Authorization Form must accompany this application.

Billable Premium $ _____ Premium Collected $_____

Assoc./Agent's No._____ Sit. Code_____

***If a check or money order is collected, please leave a temporary life insurance agreement form with the applicant and submit a copy to Aflac Worldwide Headquarters.**

Total life coverage with Aflac for the Proposed Insured cannot exceed $250,000 ($100,000 if over age 50).

Total number of units for the Proposed Insured are limited as follows:
- 2 to 50 units at $5,000 per unit if age 50 or younger
- 2 to 20 units at $5,000 per unit if age 51 or older

CHECK COVERAGE DESIRED:	**Issue Ages**	**Total Number of Units**	**Face Amount of Insurance**
☐ Whole Life Policy (Series A64100) ☐ **Automatic Premium Loan**	18–70		
☐ 10-Year Term Policy (Series A64200)	18–68		
☐ 20-Year Term Policy (Series A64300)	18–60		
☐ 30-Year Term Policy (Series A64500)	18–50		

Optional Rider for the Proposed Insured Only
☐ Accidental-Death Benefit Rider (Series A64054)

Optional Child Rider **PLEASE NOTE: $1,250 per unit (total number of units must match the Proposed Insured, not to exceed 12 units.)**	**Issue Ages**	**Total Number of Units**	**Face Amount of Insurance**
☐ Child Term Life Insurance Rider (Series A64053)	14 days* to 17 years		

*The Effective Date of coverage for any eligible newborn child will not begin until the later of (1) the date any eligible newborn child attains the age of 14 days or (2) the date any eligible newborn child is first released from the hospital after birth.

BENEFICIARY INFORMATION

PLEASE NOTE: We recommend that you do not name a minor child as your Beneficiary. If you name a minor child as your Beneficiary, any benefits due your minor Beneficiary will not be payable until a guardian for the financial estate of the minor is appointed by the court or such Beneficiary reaches the age of majority as defined by your state. If there is no Beneficiary, Aflac will pay any applicable benefit to your estate.

PRIMARY BENEFICIARY

FULL NAME (Last, First, MI)	RELATIONSHIP	CITY/STATE	DATE OF BIRTH	% OF PROCEEDS

CONTINGENT BENEFICIARY

FULL NAME (Last, First, MI)	RELATIONSHIP	CITY/STATE	DATE OF BIRTH	% OF PROCEEDS

COMPLETE QUESTIONS 1–17

1. Within the last five years, has anyone to be covered been convicted of a felony, been charged two or more times with operating a vehicle while under the influence of alcohol or drugs, been charged five or more times with a moving violation, or is currently on parole or incarcerated in a correctional institution? ❑Yes ❑ No

2. Within the last 12 months, has anyone to be covered been charged with operating a vehicle while under the influence of alcohol or drugs or does anyone to be covered currently have a suspended or revoked driver's license? ❑ Yes ❑ No

3. Within the last seven years, has anyone to be covered had an organ transplant, been placed on a transplant list, or been diagnosed with or received treatment by a member of the medical profession for the need to have an organ transplant? ❑Yes ❑ No

4. Within the last five years, has anyone to be covered been diagnosed with or treated by a member of the medical profession for major depression, bipolar disorder; schizophrenia; or a suicide attempt, or been admitted in a hospital or a mental or psychiatric facility within the last 12 months for any depressive, adjustment, anxiety, panic, emotional, psychotic, personality, compulsive, conduct, dissociative or manic disorder? ❑ Yes ❑ No

5. Within the last five years, has anyone to be covered been diagnosed with or treated by a member of the medical profession for: ❑ Yes ❑ No

heart attack
stroke/TIA
atrial fibrillation
heart surgery
pulmonary fibrosis
emphysema
diabetes treated with insulin
coronary artery disease and used tobacco after diagnosis
systemic lupus
implant of pacemaker/defibrillator
chronic lung disease (excluding asthma)
alcohol or drug abuse
multiple sclerosis
diabetes and used tobacco after diagnosis
diabetes with complications
diabetes with nephropathy
diabetes with neuropathy
diabetes with retinopathy
cancer (excluding skin cancer)
myelodysplastic blood disorder
myeloproliferative blood disorder
melanoma (Clark's Level III or higher, or a Breslow Level greater than 1.5 mm)
liver disease (excluding Hepatitis A), hepatomegaly, or liver damage/failure
kidney disease (not including stones), failure or abnormal kidney function

6. Within the last five years, has anyone to be covered been diagnosed with or treated by a member of the medical profession for: ❑ Yes ❑ No

AIDS
ARC
cystic fibrosis
chronic renal failure
renal hypertension
heart attack prior to age 40
coronary artery disease – more than two vessels
cardiomyopathy
heart valve replacement or correction
congestive heart failure
chronic or relapsing pancreatitis
cirrhosis of liver
Parkinson's disease
diabetes (Type II) diagnosed prior to age 30
end-stage renal failure
persistent vegetative state
ALS

7. Within the last two years, has anyone to be covered been diagnosed with or treated by a member of the medical profession for a condition in which life-expectancy is less than 12 months? ❑ Yes ❑ No

If you answered yes to any of Questions 1–7 was it the: ❑ Proposed Insured ❑ Child?
If child, please list the name(s) of the child(ren)

_____

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

If the person named is the Proposed Insured, a policy will not be issued; therefore, do not submit this application. If the person(s) named is the child, that person is not eligible to be covered under the policy or any rider(s).

8. Is anyone to be covered currently limited in the ability to work due to a physical or mental impairment, or in the last two years, has anyone to be covered been hospitalized two or more times, or been diagnosed by a member of the medical profession to have the need for surgery that has not yet been performed? ❑ Yes ❑No

9. In the last five years, has anyone to be covered missed five consecutive days of work due to sickness (not including days missed due to childbirth)? ❑ Yes ❑ No

10. In the last five years, has anyone to be covered been diagnosed with or treated by a member of the medical profession for a heart disease or defect (including congenital), high blood pressure (hypertension), lupus, Crohn's disease, ulcerative colitis, diabetes, kidney disease, respiratory or neurological deficit or disease, depression, anemia, leukemia, myelodysplastic or myeloproliferative blood disorders, blood clotting defects, or a tumor or cancer? ❑ Yes ❑ No

IF YOU ANSWERED YES TO ANY OF QUESTIONS 8–10, COMPLETE ITEM 10 BELOW.

11. **Details to Questions 8–10**

	Name of Individual(s)	Medical Condition(s)	Onset (mo/yr)	Surgery Performed or Recommended? (If yes, provide the type of procedure and date.)	For Hypertension and Diabetes, List the Average Reading (for the last three months).
Question 8					
Question 9					
Question 10					

12. **Within the last six weeks, has anyone to be covered been prescribed or taken any medication recommended by a Physician (not including prescription contraceptives)?** ❑ Yes ❑ No
If yes, please provide complete information below:

Name of Individual(s)	Name of Medication	Frequency of Intake	Date First Prescribed	Medical Condition Taken For

Your Physician's Name_____ Phone Number_____
(if no regular Physician, Physician last seen)

Address_____

Date Last Seen by Physician_____ Reason for Last Visit_____

13. Are you a citizen of the United States? ❑ Yes ❑ No
If no, copies of your permanent visa or proof of permanent residence must be submitted with application.

QUESTIONS 16–17 DO NOT APPLY TO THE CHILD RIDER.

14. In the last seven years, have you participated or do you currently participate in any of the following hazardous activities or avocations: sky diving, scuba diving, hang gliding, motorized vehicle racing, cave exploration, bungee jumping, parachuting, or mountain or rock climbing? ❑ Yes ❑ No

If yes, list the activity and frequency _____

15. In the last seven years, have you participated or do you currently participate in any of the following hazardous activities or avocations: flying as a passenger other than a fare-paying passenger in any aircraft, or acting as pilot or crew in any aircraft? ❑ Yes ❑ No

If yes, list the activity and frequency _____

16. Do you currently have plans to travel or reside outside the United States in the next 12 months? ❑ Yes ❑ No

If yes, where? _____ When? _____

Purpose/Why? _____

Mode of travel?_____

Length of stay?_____

17. Are you currently employed? ❑ Yes ❑ No
If yes, what is your annual income? _____

Additional Underwriting May Be Required.

PROPOSED INSURED'S STATEMENTS AND AGREEMENTS

I understand that the Policy Effective Date will be the date recorded in the Policy Schedule by Aflac Worldwide Headquarters. It is not the date this application was signed.

I acknowledge receipt of, if applicable: ❑ Replacement Notice ❑ Life Buyer's Guide

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, 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 president and secretary, and noted in or attached to the policy.

The statements and answers in the application are the basis for policy issuance by Aflac, and no information will be considered to have been given to Aflac unless it is stated in the application.

Aflac will have no liability until (1) a policy is issued on this application and delivered to and accepted by the Owner, and (2) the first premium due is paid in full while each proposed insured is alive.

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.

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, 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, present, or future physical or mental health or condition (excluding psychotherapy notes), employment, other insurance coverage, driving record, or any other medical or nonmedical facts that are required as part of the underwriting process in order 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 MIB, Inc.

California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

I also authorize Aflac to make a brief report of my personal health information to MIB, Inc. (formerly known as the Medical Information Bureau). 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 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, 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 application is signed.

I agree that a copy of this authorization is as valid as the original.

INFORMATION REGARDING THE MEDICAL INFORMATION BUREAU (MIB)
PRENOTICE

Information regarding your insurability will be treated as confidential. Aflac may, however, make a brief report thereon to MIB, Inc., formerly known as the Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file. Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB toll-free at 1-866-692-6901 (TTY 1-866-346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

Aflac may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its web site at www.mib.com.

I have read, or had read to me, the completed application. I realize that policy issuance is based upon statements and answers provided herein, and they are complete and true to the best of my knowledge and belief. All statements made in this application are deemed representations and not warranties. I realize that a false statement made in this application may result in the denial of claims or voiding of the policy if such statement was made with the intent to deceive or it affects the acceptance of the risk or hazard assumed by Aflac.

Signed and Dated at_____ on_____
City and State Date

Proposed Insured's Signature (X)_____

Owner, if Other Than Proposed Insured_____ on_____
Date

I certify that I personally saw the Proposed Insured when the application was completed, and each question was asked of the Proposed Insured and answered as recorded. All answers are correct to the best of my knowledge. To the best of my knowledge, this policy **will** ❑ **will not** ❑ replace or change any existing life insurance or annuity policy(ies).

Associate's/Agent's Signature_____

Date_____ Associate's/Agent's Writing Number_____ Sit. Code_____

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.