Non-Payroll

SPECIFIED HEALTH EVENT PROTECTION INSURANCE POLICY
(A71000 Series)
Supplemental Health Insurance Coverage
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

Proposed Insured's Name _____ (Last) _____ (First) _____ (MI)

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

State of Birth: _____ Are you applying for Dependent Child(ren) coverage? ❑Yes ❑No
If yes, Dependent Children must be under age 25 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 _____ (Last) _____ (First) _____ (MI) DOB _____ (Month/Day/Year) Sex _____

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

City _____ State _____ ZIP _____

Home Telephone ( ) _____

**Spouse includes domestic partner (when applicable).*

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

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 coverage with Aflac? ❑ Yes ❑ No
If yes, this must be a conversion of that coverage. If yes, give current policy number and see Item 26.
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 Series A71200) 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 Specified Health Event policy without canceling your existing Hospital Intensive Care policy with Aflac.

Are you covered by Medi-Cal? ❑ Yes ❑ No If "YES", then a policy will not be issued.

Are you 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 covered by a comprehensive health care policy or a comprehensive health maintenance organization (HMO) plan? ☐ Yes ☐ No
If the answer is "NO", then a policy cannot be issued.

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

_____
_____
_____

TO BE COMPLETED BY AFLAC ASSOCIATE/AGENT

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

❑ Plan 1: Specified Health Event Only (Policy Series A71100)
❑ Plan 2: Specified Health Event with Hospital Intensive Care Unit Benefits (Policy Series A71200)
❑ First Occurrence Building Benefit Rider (Rider Series A71050) ($500)
❑ Primary Specified Health Event Recovery Rider (Rider Series A71051)

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

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 _____

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

PLEASE COMPLETE QUESTIONS 1 THROUGH 10 IF APPLYING FOR PLAN 1 OR PLAN 2.

1. Has anyone to be covered ever 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. Has anyone to be covered ever been diagnosed with or received medical 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. Has anyone to be covered ever had or been advised to have 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. Has anyone to be covered ever been diagnosed with or medically treated for acquired immune deficiency syndrome (AIDS) or ARC by a member of the medical profession? ❑ 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 medical 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 symptoms? ❑ Yes ❑ No

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 of the child(ren).

_____.

Any person(s) so designated will not be covered under the policy.
If the person named is the Proposed Insured named on the front of this application, a policy will not be issued.

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

Additional underwriting may be required.

PLEASE ONLY COMPLETE QUESTIONS 11 THROUGH 19
IF APPLYING FOR PLAN 2, POLICY SERIES A71200.

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. Has anyone to be covered ever 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. Has anyone to be covered ever been diagnosed with or medically 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

18. **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) so designated will not be covered under the policy.
If the person named is the Proposed Insured named on the front of this application, a policy will not be issued.

19. Is anyone to be covered the mother or father of a child currently conceived but as yet unborn? ❑ Yes ❑ No
Please note, children born within 10 months of the Effective Date of this policy, as shown in the Policy Schedule, will not be covered for any losses or confinements that occur or begin within the first 28 days of life.
PLEASE INITIAL:_____
Proposed Insured

APPLICANT'S STATEMENTS AND AGREEMENTS:

20. I understand that the Effective Date of the policy will be the date recorded in the Policy Schedule by Aflac Worldwide Headquarters.
21. 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 (Series A71200) reduce to half at age 70.**
22. I understand that coverage is not provided for Specified Health Events for which medical advice, consultation, 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.
23. I understand that unmarried Dependent Children, if any, must be under age 25 at the time of application. Once covered, Dependent Children will continue to be covered until the anniversary date of the policy following their 25th birthday.
24. I acknowledge receipt of, if applicable:
    - ❑ Replacement Notice
    - ❑ Outline of Coverage
    - ❑ *Guide to Health Insurance for People with Medicare*
25. I understand that the insurance I am applying for will be issued based solely upon the written answers to questions and information asked for in this application and 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.
26. If this is an application for a conversion of coverage, the following conditions will apply: (a) If any one of Questions 1 through 8 or 11 through 17 is answered yes, the policy for which this application is made for the person(s) identified in Item 9 or Item 18 will be void, and coverage will continue for this person under the terms of the previous policy, if such policy remains in force. (b) 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. (c) 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. 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, Nevada, New Jersey, North Carolina, Ohio, Oregon, and Virginia.

SUPPLEMENTAL NOTIFICATION

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

I, _____, am applying for Aflac's 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 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 Specified Health Event 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.

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

If I am applying to replace existing coverage with this policy, I acknowledge that the policies may have different benefits and that I should compare them to determine which is best for me. I understand and agree that I am terminating my current policy and its benefits for the benefits provided in the 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 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).