Payroll

Application for Cancer Indemnity Insurance (A78000 Series)
Application to: American Family Life Assurance Company of Columbus
(herein referred to as Aflac)
Worldwide Headquarters • Columbus, Georgia 31999

❑ Payroll
❑ New
❑ Conversion

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 (Optional)

Address _____
Street or Post Office Box Apt. No.

City _____ State _____ ZIP _____

Telephone ( ) _____
❑ Home ❑ Work ❑ Cell

Email Address (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

Employee's Name _____ Relationship to Proposed Insured _____
(For Billing, If Employee Is Medically Ineligible for Coverage)

Account Name _____ Account No. _____

Name of Employer _____

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 Cancer coverage with Aflac, other than a Lump Sum Cancer Benefit Rider? ❑ **Yes** ❑ **No**

If yes, this must be a conversion of that coverage. Please indicate the current policy number below and see Applicant's Statements and Agreements concerning conversions.

Policy Number: _____

Does anyone to be covered have an Aflac Lump Sum Critical Illness policy **with a Lump Sum Cancer Benefit Rider**? ❑ **Yes** ❑ **No**

If yes, please complete the Supplemental Notification section at the end of this application and be aware that you cannot have this policy without canceling the Aflac Lump Sum Cancer Benefit Rider.

Are you (or Employee listed above if Employee is medically ineligible for coverage) actively working with the employer listed on the first page of this application? If no, a policy will not be issued; therefore, do not submit this application. ❑ **Yes** ❑ **No**

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

❑ **Preferred: Policy (Series A78100)**	❑ Pre-Tax ❑ After-Tax
❑ **Select: Policy (Series A78200)**	
❑ **Classic: Policy (Series A78300)**	
❑ **Premier: Policy (Series A78400)**	

Optional Riders:	
Initial Diagnosis Building Benefit Rider (Series A78050) Units _____ Options: ❑ No rider ❑ New rider ❑ Retain current rider	
Dependent Child Rider (Series A78051) **(only available with One-Parent Family or Two-Parent Family coverage)** Options: ❑ No rider ❑ New rider ❑ Retain current rider	
Specified-Disease Benefit Rider (Series A78052) Options: ❑ No rider ❑ New rider ❑ Retain current rider	
Return of Premium Benefit Rider (Series A78053) Options: ❑ No rider ❑ New rider ❑ Retain current rider (Factor amt. _____)	❑ After-Tax Only

Billing Method:
❑ Payroll Deduction
❑ Bank Draft (B/D)
❑ Credit Card (C/C)

Mode:
❑ 01 Weekly
❑ 01 14-Day Biweekly
❑ 01 Semimonthly
❑ 01 28-Day Biweekly
❑ 01 Monthly
❑ 03 Quarterly
❑ 06 Semiannual
❑ 12 Annual

PLEASE NOTE: If 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 _____

ASSOCIATED CANCEROUS CONDITION: a myelodysplastic blood disorder, myeloproliferative blood disorder, or internal 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: all Cancers other than Nonmelanoma Skin Cancer.

PLEASE COMPLETE THE FOLLOWING UNDERWRITING QUESTIONS.

1. Have you or has anyone to be covered under this policy ever been diagnosed with or treated for Cancer or an Associated Cancerous Condition of any type or form? ❑ **Yes** ❑ **No**
If yes, please complete Questions 2, 3, and 4.

2. 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, a policy will not be issued.

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

3. 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. Additional underwriting may be required.

4. 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 Initials _____

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

5. Have you or has anyone to be covered under this policy ever had adrenal hypofunction (Addison's disease), amyotrophic lateral sclerosis (ALS or Lou Gehrig's disease), botulism, bubonic plague, cerebral palsy, cholera, cystic fibrosis, diphtheria, encephalitis (including encephalitis contracted from West Nile virus), Huntington's disease, Lyme disease, 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 A78052.

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

APPLICANT'S STATEMENTS AND AGREEMENTS

- I acknowledge that I was offered the optional riders, and I have personally determined which, if any, are best for me.

  Proposed Insured's Initials _____

- I understand that the Effective Date of the policy will be the date recorded in the Policy Schedule by Aflac Worldwide Headquarters. It is not the date I signed this application. 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 my option, I may elect to void the policy from its beginning and receive a full refund of premium.

  Proposed Insured's Initials _____

- I understand that the policy I am applying for will not cover any person who has attained age 76 before the Effective Date of the policy.
- I understand that Dependent Children, if any, must be under age 26 at the time of application. Once covered, Dependent Children will continue to be covered until their 26th birthday.
- I acknowledge receipt of, if applicable:
  - ❑ Replacement Notice
  - ❑ Outline of Coverage
  - ❑ *Guide to Health Insurance for People with Medicare*
- If this is an application for a conversion, the following conditions apply: (a) If Cancer or an 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.

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 Aflac 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.

Proposed Insured's Initials _____

- I have reviewed the statements and answers I have provided on this application. I understand that this policy is 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. 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 this 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.

NOTICE OF INFORMATION PRACTICES

To issue an insurance policy, Aflac may need to obtain additional information about you 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, Kansas, Maine, Massachusetts, Minnesota, Montana, Nevada, New Jersey, North Carolina, Ohio, Oregon, Virginia, and Wisconsin.

SUPPLEMENTAL NOTIFICATION
COMPLETE IF YOU ARE REPLACING/TERMINATING EXISTING AFLAC COVERAGE THAT CONTAINS CANCER BENEFITS.

_____ is applying for Aflac's Cancer policy and currently has cancer benefits under a Lump Sum Cancer Benefit Rider on Aflac's Lump Sum Critical Illness policy number _____.

Existing Aflac Cancer coverage must be cancelled to purchase this Cancer policy.

- ❑ Please cancel the existing Lump Sum Cancer Benefit Rider attached to Lump Sum Critical Illness policy number _____, but keep the Lump Sum Critical Illness policy in force. Existing benefits provided for in the current Lump Sum Cancer Rider will not be provided for in the new Cancer policy.
- ❑ Please cancel the entire Lump Sum Critical Illness policy (with Lump Sum Cancer Benefit Rider) number _____. Existing benefits provided for in the current Lump Sum Critical Illness policy and Lump Sum Cancer Benefit Rider are not provided for in the new Cancer policy.

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

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 WEBSITE 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).