Application for Accident Insurance (A-34000 Series) – base plan
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 APPLICANT

Applicant's Name ______________________ DOB ____________ Sex ________
Last First MI Month/Day/Year

Applicant's SS No. ________ - ________ - ____________ Dependent Children ❑ Yes ❑ No

(Write spouse's name below if you are applying for family coverage; if no spouse or if spouse is not to be covered, put N/A in space below.)

Spouse's Name ______________________ DOB ____________ Sex ________
Last First MI Month/Day/Year

Applicant's Address ______________________
Street or Post Office Box Apt. No.

City ______________________ State ____________ ZIP______________

Home Telephone ( ) ______________ Business Telephone ( ) ____________ Best Time to Call ________

Name of Employer ______________________ Type of Business ______________________

Job Duties ______________________

Job Title ______________________

Occupation Class ______________________ Industry Code ______________________
(Completed by associate/agent) (Completed by associate/agent)

Do you have another accident policy with AFLAC? ❑ Yes ❑ No
If yes, is this a change of that coverage? ❑ Yes ❑ No If yes, give current policy number: ______________

Is the purchase of this coverage intended to replace any other health insurance now in force? ❑ Yes ❑ No
If yes, please read and sign the Replacement Notice, if applicable, provided by your associate/agent and provide the policy number here ______________

TO BE COMPLETED BY AFLAC ASSOCIATE/AGENT

Billing Method:
☒ Payroll Deduction

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

Employee No. ______________ Dept. No. ______________ Assoc./Agent No. ______________

Billable Premium $ ______________ Premium Collected $ ____________ Sit. Code ______________

CHECK COVERAGE DESIRED: ❑ Individual ❑ Two-Parent Family
❑ One-Parent Family ❑ Named Insured/Spouse Only

Class: ☐ A ☐ B ☐ C ☐ D ☐ E	**Total No. of Units**	**Premium**	
❑ Level 1 Policy Series A-34100			❑ Pre-Tax or ❑ After-Tax
❑ Level 2 Policy Series A-34200			❑ Pre-Tax or ❑ After-Tax
	Total Premium		

PLEASE COMPLETE

Do you or anyone to be covered by this policy drive a taxi for wage, compensation or profit? If yes, please list the name and the relationship of the person(s) in the following space. Any person(s) so named will not be covered under the policy. ❑ Yes ❑ No

____

If the person so named is the primary insured, then a policy will not be issued; therefore, do not submit this application.

APPLICANT'S STATEMENTS AND AGREEMENTS

1. I understand that the Effective Date of the policy will be the date recorded in the Policy Schedule by AFLAC Worldwide Headquarters.
2. I acknowledge receipt of, if applicable:
   - ❑ Replacement Notice
   - ❑ Outline of Coverage
   - ❑ *Guide to Health Insurance for People With Medicare*
   - ❑ Fair Credit Reporting Notice
3. 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, riders, 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 secretary and president and noted in or attached to the 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 have read, or had read to me, the completed application and realize that policy issuance is based upon statements and answers provided herein 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.

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

Signed and Dated at ______________________________ on ____________
City and State Date

Applicant's Signature (X)______________________________

Beneficiary (your estate unless otherwise indicated) ______________________________
Relationship

I certify that I personally saw the applicant when the application was written, and each question was asked of the applicant and answered as recorded. All answers above are correct to the best of my knowledge.

Associate/Agent Signature ______________________________ ____________
Licensed Associate/Agent Date

MAKE CHECK OR MONEY ORDER PAYABLE TO AFLAC.
FOR INFORMATION, CALL TOLL-FREE 1-800-99-AFLAC (1-800-992-3522).

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 provides limited benefits if you meet the conditions listed in the policy. 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).