Payroll

Application for Cancer Indemnity Insurance (A-75000 Series)
Application to: American Family Life Assurance Company of Columbus (AFLAC)
Worldwide Headquarters: Columbus, Georgia 31999

❑ New
❑ Conversion
Policy Number:

To Be Completed by Applicant: Please Print in Black Ink

Applicant's Name _____ DOB _____ Sex _____
Last First MI Month/Day/Year

Applicant's SSN _____ - _____ - _____ Dependent Children ❑ Yes ❑ No

(Write spouse's name below if you are applying for Two-Parent Family coverage; if no spouse or spouse is not to be covered, write "N/A" or "None" 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 Code _____

Home Telephone ( ) _____

Policyowner's Name _____ Relationship to Applicant _____
(if other than applicant)

Address _____ Owner's SSN _____ - _____ - _____
Street or Post Office Box Apt. No.

City _____ State _____ ZIP Code _____

Payroll Account Name _____ Payroll Account Number _____

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.

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.

TO BE COMPLETED BY AFLAC ASSOCIATE/AGENT

Check Coverage Desired:	❑ Individual ❑ Two-Parent Family	❑ One-Parent Family	
Level 1: Policy (Series A-75100)	❑ CCAIPA	❑ CCAIPD	❑ Pre-tax
Level 2: Policy (Series A-75200)	❑ CCAIPB	❑ CCAIPE	❑ After-tax
Level 3: Policy (Series A-75300)	❑ CCAIPC	❑ CCAIPF	
Optional Rider:			
Building Benefit Rider (Series A-75050) Units ____	❑ CCAIPG	❑ CCAIPK	
Return of Premium Rider (Series A-75051) ❑ New rider ❑ Retain current rider (Factor amt. ____)	❑ CCAIPH	❑ CCAIPL	
Specified-Disease Rider (Series A-75052) ❑ New rider ❑ Retain current rider	❑ CCAIPJ	❑ CCAIPM	

Billing Method:	**Mode:**		
☒ Payroll Deduction	❑ 01 Weekly	❑ 01 Semimonthly	❑ 06 Semiannual
	❑ 01 14-Day Biweekly	❑ 01 Monthly	❑ 12 Annual
	❑ 01 28-Day Biweekly	❑ 03 Quarterly	

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

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

PLEASE COMPLETE THE FOLLOWING QUESTIONS:

1. Have you or has anyone to be covered under this policy ever been diagnosed with or treated for Cancer of any type or form? ❑ Yes ❑ No
   If no, skip to number 7 or number 5 if this is a conversion. If yes, please complete numbers 2 and 3.

2. Was any Cancer referred to in number 1 an internal Cancer (which includes melanoma of Clark's Level III or higher, or a Breslow level greater than 1.5 mm):
   (a) diagnosed or treated within the last five years or for which preventive Hormonal Therapy has been received within the last 12 months? ❑ Yes ❑ No
   If yes, was it the ❑ Named Insured ❑ Spouse ❑ Child? Name of the child(ren):

   _____

   Any individual(s) indicated above will not be covered under the policy.

   (b) last diagnosed or treated over five years ago? ❑ Yes ❑ No
   If yes, was it the ❑ Named Insured ❑ Spouse ❑ Child? Name of the child(ren):

   _____

   Please complete a Cancer History Form provided by your associate/agent on any individual(s) listed.

3. Was any Cancer referred to in number 1 a Skin Cancer (which includes melanoma of Clark's Level I or II, or a Breslow level less than or equal to 1.5 mm):
   (a) diagnosed or treated within the last five years? ❑ Yes ❑ No
   If yes, was it the ❑ Named Insured ❑ Spouse ❑ Child? Name of the child(ren):

   _____

   Any individual(s) indicated above 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.

   (b) last diagnosed or treated over five years ago? ❑ Yes ❑ No
   If yes, was it the ❑ Named Insured ❑ Spouse ❑ Child? Name of the child(ren):

   _____

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

If you answered yes to number 1 and this is a conversion, please complete the conversion section below.

YOU MUST COMPLETE THIS SECTION IF THIS IS A CONVERSION.

IF your answer to number 1 above was "yes," complete number 4 below. If no, skip to number 5.

4. Have you or any person to be covered under this policy received benefits, other than Wellness Benefits, under your existing AFLAC Cancer policy in the last five years? ❑ Yes ❑ No
   If yes, was it ❑ Named Insured ❑ Spouse ❑ Child? Name of the child(ren):

   _____

   Any individual(s) indicated above will not be covered under the policy.
5. If this is an application for a conversion, the following conditions apply: (a) If Cancer 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 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.
6. I acknowledge that I was offered the Building Benefit Rider and declined it. I understand that by not applying for the Building Benefit Rider that I will lose the building benefit amount accrued in my previous policy, if any.
   ❑ Yes
   Applicant's Initials _____
   ❑ N/A
7. 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 diagnosed before coverage has been in force 30 days from the Effective Date of coverage shown in the Policy Schedule, benefits for treatment of that Cancer 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.
8. I acknowledge receipt of, if applicable:
   ❑ Fair Credit Reporting Notice ❑ *Guide to Health Insurance for People with Medicare*
   ❑ Replacement Notice ❑ Outline of Coverage
9. 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.

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.

Complete this section if applicant is applying for Specified-Disease Rider Series A-75052.

American Family Life Assurance Company of Columbus (AFLAC)
Worldwide Headquarters: 1932 Wynnton Road, Columbus, Georgia 31999

SUPPLEMENTAL MEDICAL INFORMATION QUESTIONNAIRE FOR SPECIFIED-DISEASE RIDER

Have you or has anyone to be covered under this policy ever been diagnosed or treated for 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, Legionnaires' disease, malaria, meningitis (bacterial), multiple sclerosis, muscular dystrophy, myasthenia gravis, necrotizing fasciitis, osteomyelitis, polio, rabies, Reye's syndrome, scarlet fever, 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?
If "child," please list the name of the child(ren) _____.
Any person(s) named will not be covered under Specified-Disease Rider Form Series A-75052.

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.

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 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.

Applicant'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).

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).