Payroll

SPECIFIED HEALTH EVENT INSURANCE POLICY
(Series A74000)
Supplemental Health Insurance Coverage
Application to: American Family Life Assurance Company of Columbus
(herein referred to as 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 _____ Sex _____ SSN _____ - _____ - _____
Month/Day/Year

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 as of the Effective Date of coverage.

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

Account Name _____ Account No. _____

Name of Employer _____

PLEASE COMPLETE THE FOLLOWING ELIGIBILITY QUESTIONS

1. Are you, the Proposed Insured, actively at work with the employer listed above? ❑ Yes ❑ No
   If no, a policy will not be issued; therefore, do not submit this application.
2. (a) Is your Spouse, if applying for coverage, actively at work? ❑ Yes ❑ No ❑ N/A
   (b) If no, is your Spouse now hospitalized or unable to perform his or her normal duties and activities? *If yes to 2(b), your Spouse is not eligible for coverage.* ❑ Yes ❑ No ❑ N/A

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 agent, and provide the policy number, company name, and Effective Date of the policy being replaced here: _____

_____

Do you have any other critical illness coverage (Specified Health Event, Critical Care and Recovery, or Lump Sum Critical Illness) with Aflac (not including a critical illness rider)? ❑ Yes ❑ No

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

Policy Number: _____

Do you have a hospital intensive care policy or rider with Aflac? ❑ Yes ❑ No

If yes, and you are applying for Option 2 or Option 3, and you have both a hospital intensive care policy and a critical illness policy, the oldest policy will be converted. The newest policy will be cancelled.
If yes, and you are applying for Option 2 or Option 3, and you only have a hospital intensive care policy, it will be converted.
If yes, and you are applying for Option 2 or Option 3, and you only have either a hospital intensive care rider or specified health event rider, it will be cancelled.

Please give current policy number and see Applicant's Statements and Agreements concerning conversions and replacement of coverage.
Policy Number: _____

PLEASE NOTE: If anyone other than the Proposed Insured is to be covered and has any other Specified Health Event, Critical Care and Recovery, or Lump Sum Critical Illness coverage with Aflac, or if applying for policy Option 2 or Option 3, any other hospital intensive care policy or rider with Aflac, the existing coverage must be cancelled in order to be covered under this policy. Please submit a request to cancel the existing coverage.

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

Policy (Select one):
❑ Pre-Tax or ❑ After-Tax

❑ **Option 1: Specified Health Event (Policy Form A74100FL)**
❑ **Option 2: Specified Health Event with Intensive Care Unit Benefits (Policy Form A74200FL)**
❑ **Option 3: Specified Health Event with ICU and Heart Surgery Benefits (Policy Form A74300FL)**

Optional Riders:
❑ **First-Occurrence Building Benefit Rider (Rider Form A74050FL)**
Options: ❑ **No rider** ❑ **New rider** ❑**Retain current rider**
❑ **Specified Health Event Recovery Benefit Rider (Rider Form A74051FL)**
Options: ❑ **No rider** ❑ **New rider** ❑**Retain current rider**

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

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

PLEASE NOTE: If the 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. _____ Agent's No. _____

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

IF YOU ARE APPLYING FOR OPTION 1, OPTION 2, OR OPTION 3, PLEASE COMPLETE QUESTIONS 1 THROUGH 3.

1. Within the last five years, has anyone to be covered been diagnosed with or treated by a licensed member of the medical profession at a health facility for any of the following? ❑ Yes ❑ No

   Heart Attack
   Stroke or transient ischemic attack (TIA)
   Kidney disease or disorder (excluding stones)

2. Within the last five years, has anyone to be covered had or been advised by a licensed member of the medical profession of the need to have any of the following? ❑ Yes ❑ No

   Major organ transplant
   Coronary artery bypass surgery
   Angioplasty or stent placement

3. **If either of Questions 1 or 2 is answered yes, was it the:**

❑ Proposed Insured? ❑ Spouse? ❑ Child? If "Child," please list the name(s) of the child(ren).

_____ .

Any person(s) indicated above will not be covered under the policy. If the named person is the Proposed Insured, a policy will not be issued; therefore, do not submit this application.

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

IF YOU ARE APPLYING FOR OPTION 2 OR OPTION 3, PLEASE ALSO COMPLETE QUESTIONS 4 THROUGH 11.

4. Is anyone to be covered the mother or father of a child currently conceived but as yet unborn, or within the last 12 months, has anyone to be covered been diagnosed with or treated by a licensed member of the medical profession for infertility? ❑ Yes ❑ No

5. Does anyone to be covered currently have or in the last ten years has anyone to be covered been diagnosed with or received medical treatment for any of the following by a licensed member of the medical profession? ❑ Yes ❑ No

Cerebral vascular insufficiency
Congenital heart disease (excluding surgically corrected atrial septal defect)
Heart-related chest pain (including angina or acute coronary syndrome)
Congestive heart failure
Cystic fibrosis
Systemic lupus

6. Within the last five years, has anyone to be covered tested positive for exposure to the human immunodeficiency virus (HIV), or has anyone to be covered been diagnosed with or treated by a licensed member of the medical profession for acquired immune deficiency syndrome (AIDS) or AIDS-related complex (ARC) caused by the HIV infection or other sickness or condition derived from such infection? ❑ Yes ❑ No

7. Does anyone to be covered currently have or in the last ten years has anyone to be covered been diagnosed with or received medical treatment by a licensed member of the medical profession for diabetes:

requiring the use of insulin within the last five years;
with complications to include retinopathy, neuropathy, or nephropathy;
with continued tobacco use; or
diagnosed prior to age 30 (excluding gestational)? ❑ Yes ❑ No

8. Is anyone to be covered currently confined in a hospital or nursing home, or within the last 12 months, has hospitalization been recommended by a Physician? ❑ Yes ❑ No

9. Does anyone to be covered currently have or in the last ten years has anyone to be covered been diagnosed with or medically treated by a licensed member of the medical profession for sickle cell anemia or 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

10. In the last 12 months, has anyone to be covered received treatment for more than 24 hours in a Hospital Intensive Care Unit (not including treatment as a result of an accident)? ❑ Yes ❑ No

11. **If any one of Questions 4 through 10 is answered yes, was it the:**

❑ Proposed Insured? ❑ Spouse? ❑ Child? If "Child," please list the name(s) of the child(ren).

_____ .

Any person(s) indicated above will not be covered under the policy. If the named person is the Proposed Insured, a policy will not be issued; therefore, do not submit this application.

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

IF YOU ARE APPLYING FOR OPTION 3, PLEASE ALSO COMPLETE QUESTIONS 12 – 15.

12. In the last ten years, has anyone to be covered had or been advised to have, or consulted with or been evaluated by a licensed member of the medical profession of the need to have, any of the following? ❑ Yes ❑ No
Defibrillator placement
Pacemaker placement
Heart valve surgery

13. Within the last 12 months, has anyone to be covered been prescribed medication for irregular heartbeat, heart palpitation, or tachycardia (not including preventive treatment with antibiotics prior to dental appointment); received medical treatment 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, by a licensed member of the medical profession? ❑ Yes ❑ No

14. Does anyone to be covered currently have or in the last ten years has anyone to be covered been diagnosed with or received medical treatment for any of the following by a licensed member of the medical profession? ❑ Yes ❑ No

Heart Attack (two or more)
Coronary artery disease
Bypass surgery
Atrial fibrillation
Cardiomyopathy
Arterial blockage
Peripheral vascular disease
Stroke or TIA (two or more)

15. **If any one of Questions 12 through 14 is answered yes, was it the:**

❑ Proposed Insured? ❑ Spouse? ❑ Child? If "Child," please list the name(s) of the child(ren).

_____ .

Any person(s) indicated above will not be covered under the policy. If the named person is the Proposed Insured, a policy will not be issued; therefore, do not submit this application.

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

APPLICANT'S STATEMENTS AND AGREEMENTS:

- 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.
- I understand that the policy I am applying for will not cover any person who has reached his or her 71st birthday before the Effective Date of coverage. **The Benefits for Hospital Intensive Care Unit Confinements in the Option 2 (Form A74200FL) and Option 3 (Form A74300FL) policies reduce to half at age 70.**
- I understand that coverage is not provided for an illness, disease, infection, disorder, or Injury for which, within the 12-month period before the Effective Date of coverage, prescription medication was taken or medical testing, medical advice, consultation, or treatment was recommended or received, or for which conditions existed that would ordinarily cause a prudent person to seek diagnosis, care, or treatment. Benefits will not be payable for any Loss that is caused

by a Pre-existing Condition unless the Loss occurs more than 12 months after the Effective Date of coverage. If this coverage is a replacement of similar coverage, we will give credit for the time the person was covered under previous coverage when determining the Pre-existing Conditions Limitations, exclusive of any applicable waiting periods under the new coverage.

Proposed Insured's Initials _____

- If applicable, I understand that Dependent Children, if any, must be under age 26 as of the Effective Date of coverage. Once covered, Dependent Children will continue to be covered until their 26th birthday. When coverage on all Dependent Children terminates, you must notify Aflac, in writing, and elect whether to continue the coverage on an Individual or Named Insured/Spouse Only basis. After such notice, Aflac will arrange for the payment of the appropriate premium due, including returning any unearned premium.
- I acknowledge receipt of, if applicable:
  - ❑ Replacement Notice
  - ❑ Outline of Coverage
  - ❑ *Guide to Health Insurance for People with Medicare*
- I understand that (1) the policy, together with the applications, 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 agent of Aflac, unless written herein and (2) the 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.
- I have read, or had read to me, the statements and answers I have provided on this application. I understand that the 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 to the best of my knowledge and belief. 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 the policy.
- I understand that the purchase of the 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.
- If I am applying to replace existing Aflac coverage with this policy, I acknowledge that the policies and/or rider 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 Aflac policy and/or rider and its/their benefits for the benefits provided in this Aflac policy.

Proposed Insured's Initials _____

- If this is an application for a conversion of coverage, the following conditions will apply: (1) If any one of Questions 1 or 2, 4 through 9, or 11 through 13 is answered yes, the policy for which this application is made for the person(s) identified in Item 3, Item 10, or Item 14 will be void, and coverage will continue for such person(s) only under the terms of the previous policy, if such policy remains in force; (2) The Time Limit on Certain Defenses provision will run from the Effective Date of the new policy, and the original policy will be terminated as of the Effective Date of the new policy; and (3) The Pre-existing Condition Limitations provision in the new policy will run from the original policy's Effective Date for the benefits provided under the original policy. For any increased benefit amount, the Pre-existing Condition Limitations provision in the new policy will run from the new policy's Effective Date.

Proposed Insured's Initials _____

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.

Any person who knowingly and with intent to injure, defraud or deceive any insurer, files a statement of claim or an application containing any false, incomplete or misleading information, is guilty of a felony of the third degree.

Signed and Dated at _____ on _____
City and State Date

Proposed Insured's Signature _____

Agent's Signature _____ Date _____
Licensed Agent

Typed or Printed Name of Agent: _____

Agent Telephone Number: _____

Agent Florida License Number: _____

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).