Payroll

Application for Hospital Confinement Indemnity Insurance
(B40000 Series)
Application to: American Family Life Assurance Company of Columbus
(herein referred to as Aflac)

Worldwide Headquarters • Columbus, Georgia 31999

❑ New
❑ Conversion
❑ Downgrade
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 ( ) _____

Email Address _____

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
(NOT REQUIRED FOR A DECREASE IN HOSPITAL CONFINEMENT BENEFIT AMOUNT ONLY)

1. **Are you, the Proposed Insured, currently reporting to work (not out on leave, FML, disability, hiatus, or layoff) with the employer listed on this application? If no, a policy will not be issued; therefore, do not submit this application.** **❑ Yes ❑ No**
2. **(a) Is your Spouse, if applying for coverage, currently reporting to work (not out on leave, FML, disability, hiatus, or layoff)?** **❑ 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 hospital confinement indemnity or hospital confinement **sickness** indemnity coverage with Aflac? **❑ Yes ❑ No**
If yes, or we determine that other hospital confinement indemnity or hospital confinement **sickness** indemnity coverage was in force within the last 6 months, this application will be processed as a conversion of that coverage.
If you are applying to change your Hospital Confinement Benefit amount or add any additional rider(s), this application will be processed as a conversion of your coverage.

If you have both hospital confinement indemnity and hospital confinement **sickness** indemnity coverage, you must convert both policies to this one new hospital confinement indemnity policy. Please give current policy number(s) and see the Applicant's Statements and Agreements concerning conversions and replacement of coverage.

Policy Number(s) to Be Converted: _____

PLEASE NOTE: If anyone to be covered, other than the Proposed Insured, has any other hospital confinement indemnity or hospital confinement sickness indemnity coverage with Aflac, such person(s) must submit a request to cancel the existing coverage in order to be eligible for coverage under this policy. If at any time Aflac discovers that someone, other than the Proposed Insured, is covered under any other hospital confinement indemnity or hospital confinement sickness indemnity coverage with Aflac, then such individual(s) will be removed from this policy as of the date of duplication. Any premiums paid for such individual(s) will be refunded, less any benefits previously paid for such individual(s) under this policy, from such date.

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

Hospital Confinement Indemnity Policy (Issue Ages 18-75):

❑ **Option 1 (Series B40100)**
❑ **Option H (Series B4010H)**

Hospital Confinement Benefit Amount:
❑ **Retain Current Amount**

❑ **$500** ❑ **$1,000** ❑ **$1,500** ❑ **$2,000**
❑ **$3,000** ❑ **$4,000** ❑ **$5,000**

❑ Pre-Tax
❑ After-Tax

Optional Riders (Issue Ages 18-75)

❑ **Extended Benefits Rider (Series B40050)***
Options: ❑ No rider ❑ New rider ❑ Retain current rider

❑ **Hospital Stay and Surgical Care Rider (Series B40051)***
Options: ❑ No rider ❑ New rider ❑ Retain current rider
***Not available with Option H**

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 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 _____

I am applying for Guaranteed-Issue; therefore, the underwriting questions are not required to be answered.
❑ Yes ❑ No

PLEASE COMPLETE THE FOLLOWING UNDERWRITING QUESTIONS IF YOU ARE APPLYING FOR OPTION H, AN INCREASE IN THE HOSPITAL CONFINEMENT BENEFIT AMOUNT, A CONVERSION FROM ANOTHER POLICY SERIES, OR THE HOSPITAL STAY AND SURGICAL CARE RIDER.
(NOT REQUIRED FOR A DECREASE IN HOSPITAL CONFINEMENT BENEFIT AMOUNT ONLY):

1. 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**

2. Is anyone to be covered currently confined in a Hospital or nursing home, or has a licensed member of the medical profession recommended hospitalization or nursing home confinement? ❑ **Yes** ❑ **No**

3. Does anyone to be covered have a condition for which a medical procedure (including but not limited to surgery, organ or bone marrow transplant, or joint replacement) has been planned or the possibility of which has been discussed with a licensed member of the medical profession within the past 12 months? ❑ **Yes** ❑ **No**

4. Within the last six months, has anyone to be covered been advised by a licensed member of the medical profession to have tests or treatment that has not yet been done or is anyone undergoing evaluation following an abnormal test result? ❑ **Yes** ❑ **No**

5. Has anyone to be covered been diagnosed by a licensed member of the medical profession with diabetes before the age of 30 (except for gestational diabetes)? ❑ **Yes** ❑ **No**

6. Within the last five years, (two years for breast cancer), has anyone to be covered been medically treated or diagnosed by a licensed member of the medical profession as having any of the following? ❑ **Yes** ❑ **No**

- Chronic obstructive lung disease, including chronic obstructive pulmonary disease (COPD)
- Cerebral vascular disease
- Heart attack
- Uncorrected congenital heart defect
- Congestive heart failure
- Sickle cell anemia
- Systemic lupus
- Multiple sclerosis
- Diabetes treated with insulin or other injectable medication
- Diabetes and used tobacco after the diagnosis
- Organ or bone marrow transplant
- Alcohol or drug abuse
- Pulmonary fibrosis
- Cystic fibrosis
- Stroke or transient ischemic attack (TIA)
- Heart bypass surgery, stent placement, or angioplasty
- Cardiomyopathy
- Cancer,other than nonmelanoma skin cancer
- Muscular dystrophy
- Psoriatic arthritis
- Liver disease or disorder
- Diabetes with complications, including but not limited to nephropathy, neuropathy, or retinopathy
- Kidney disease or disorder (except kidney stones)

7. 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**

8. Within the last three years, has anyone to be covered been medically treated or diagnosed by a licensed member of the medical profession for any of the following? ❑ **Yes** ❑ **No**

- Heart-related chest pain (including angina or acute coronary syndrome)
- Atrial fibrillation
- Pancreatitis
- Crohn's disease
- Alzheimer's disease
- Heart disease or disorder with pacemaker or defibrillator implant
- Peripheral vascular disease (circulatory problems)
- Ulcerative colitis or proctitis
- Parkinson's disease
- Senile dementia

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(s) of the child(ren).

_____

Any person(s) indicated above will not be covered under the policy and/or rider(s). If the named person is the Proposed Insured, a policy and/or rider(s) 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 and/or riders 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 following conditions apply:
  - Coverage is not provided for any illness, disease, infection, disorder, condition, or injury for which, within the 12-month period before the Effective Date of coverage, prescription medication was taken or medical testing, 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. Care or treatment caused by a Pre-existing Condition will not be covered unless it begins 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 period of time the person was covered under the previous coverage, if the previous coverage was continuously in force to a date not more than 62 days before the Effective Date of the new coverage, when determining the Pre-existing Condition Limitations, exclusive of any applicable waiting periods under the new coverage; and
  - Aflac will not pay benefits for a loss that is caused by or occurs as a result of giving birth within the first ten months of the Effective Date of coverage; or pregnancy in existence prior to the Effective Date of coverage, including any resulting Complications of Pregnancy or maternal-fetal intervention procedure. For pregnancy beginning on or after the Effective Date of coverage, Complications of Pregnancy are covered to the same extent as a Sickness.

Proposed Insured's Initials _____

- This policy contains a 30-day waiting period for Sickness that begins on the Effective Date of the policy. **Benefits are not payable for any illness, disease, infection, disorder, or condition that is medically evaluated, diagnosed, or treated by a Physician before coverage has been in force 30 days, unless the loss begins more than 12 months after the Effective Date of coverage.**

Proposed Insured's Initials _____

- I understand that the policy and/or rider(s) I am applying for will not cover any person who has reached his or her 76th birthday before the Effective Date of coverage.
- 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
  - ❑ *Guide to Health Insurance for People with Medicare*
  - ❑ Outline of Coverage
  - ❑ Electronic Delivery Notice
- If this is an application for a conversion, I understand that: (1) if any one of Questions 1 through 8 is answered yes, the coverage for which this application is made for the person(s) identified in Question 9 will be void, and coverage will continue under the terms of the existing policy(ies). Benefits that may be due any person(s) listed in Question 9 will be paid under the previous policy. Any person(s) not listed in Question 9, if eligible, will be covered under the new policy. Also, the waiting period and the Time Limit on Certain Defenses provision will run from the Effective Date of the new coverage; (2) the original coverage(s) will be terminated as of the Effective Date of the new coverage; and (3) the Pre-existing Conditions provision in the new coverage will run from the original coverage's Effective Date for the benefits provided under the original policy. For any increased benefit amount, the Pre-existing Conditions provision in the new policy will run from the new policy's Effective Date.

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 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.

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

  Proposed Insured's Initials _____

- I acknowledge that I have been informed whether there are any optional rider(s) available. If any optional rider(s) are available, then I acknowledge that I have personally determined which, if any, are best for me.

  Proposed Insured's Initials _____

- I have read, or had read to me, the statements and answers I have provided on this application. I understand that the policy and/or rider(s) is/are 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 the policy and/or rider(s).
- I understand that the purchase of this policy and/or rider(s) 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 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

THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES.

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.

Proposed Insured's Signature _____

WAS THE AGENT PRESENT AT THE TIME THE APPLICATION WAS COMPLETED? ❑Yes ❑ No

If yes, 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.

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.

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 dollar amount, regardless of your expenses, for each day you meet the policy conditions. 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).