Payroll

ACCIDENT-ONLY INSURANCE (A36000 Series)

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 ( ) _____ Best Time to Call _____
❑ Home ❑ Work ❑ Cell

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 _____ Type of Business _____

Job Duties _____

Job Title _____

Occupation Class _____ Industry Code _____
(Completed by agent) (Completed by agent)

PLEASE COMPLETE THE FOLLOWING ELIGIBILITY QUESTION

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.

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: _____

_____

Does anyone to be covered currently have any other Accident coverage with Aflac or have you, the Proposed Insured, had any other Accident coverage with Aflac that terminated within the last six months? ❑ Yes ❑ No
If yes, or we determine that other Accident coverage was in force within the last six months, this application will be processed as a conversion of that coverage. Please give current policy number and see Applicant's Statements and Agreements concerning conversions and replacement of coverage.

Policy Number: _____

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

Class: ☐ A ☐ B ☐ C ☐ D ☐ E ❑ Pre-Tax or ❑ After-Tax

SELECT ONE TYPE OF COVERAGE: ❑ 24-Hour Accident-Only ❑ Off-the-Job Accident-Only (available on Option 3 only)

SELECT ONE PLAN OPTION (Issue Ages 18-75):	❑ Option 1	❑ Option 2	❑ Option 3	❑ Option 4

Optional Rider (Issue Ages 18-70):	
❑ Additional Accidental-Death Benefit Rider Series A36050	☒After-Tax Only

Billing Method:
- ❑ Payroll Deduction
- ❑ Bank Draft (B/D, ACH)
- ❑ 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 _____

BENEFICIARY INFORMATION

PLEASE NOTE: Your beneficiary will be your estate unless otherwise indicated.

If you name a trust as your beneficiary, please include full name of trust.

We do not recommend that you name a minor child as your beneficiary. If you name a minor child as your beneficiary, any benefits due your minor beneficiary will not be payable until a guardian for the financial estate of the minor is appointed by the court or such beneficiary reaches the age of majority as defined by your state. We suggest you obtain legal advice before naming a minor child as your beneficiary.

Primary beneficiary(ies): **NOTE: Total % of Proceeds must equal 100%**

(1) Name _____ % of Proceeds _____
Last Name First Name MI

Or Trustee(s) of _____
Name of Trust

Trust under trust agreement dated _____

Address _____
Street Address City State Zip

Telephone No. _____ SSN _____ - _____ - _____

Date of Birth _____ Relationship to Insured _____

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(2) Name _____ % of Proceeds _____
Last Name First Name MI

Or Trustee(s) of _____
Name of Trust

Trust under trust agreement dated _____

Address _____
Street Address City State Zip

Telephone No. _____ SSN _____ - _____ - _____

Date of Birth _____ Relationship to Insured _____

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Contingent beneficiary(ies): **NOTE: Total % of Proceeds must equal 100%**

(1) Name _____ % of Proceeds _____
Last Name First Name MI

Or Trustee(s) of _____
Name of Trust

Trust under trust agreement dated _____

Address _____
Street Address City State Zip

Telephone No. _____ SSN _____ - _____ - _____

Date of Birth _____ Relationship to Insured _____

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(2) Name _____ % of Proceeds _____
Last Name First Name MI

Or Trustee(s) of _____
Name of Trust

Trust under trust agreement dated _____

Address _____
Street Address City State Zip

Telephone No. _____ SSN _____ - _____ - _____

Date of Birth _____ Relationship to Insured _____

APPLICANT'S STATEMENTS AND AGREEMENTS:

- I understand that the Effective Date of the policy and/or rider(s) 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 76th birthday before the Effective Date of coverage. If I am applying for an optional rider, I understand that the rider I am applying for will not cover any person who has reached his or her 71st birthday before the Effective Date of coverage.
- 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*
  - ❑ Electronic Delivery Notice
- 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 purchase of the 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 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.

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- If I am applying to replace existing Aflac coverage with this policy, I acknowledge that the policies and/or rider(s) 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(s) and its/their benefits for the benefits provided in this Aflac policy.

  Proposed Insured's Initials _____

- I acknowledge that I was offered the optional rider(s), and 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) 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 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 and/or rider(s).

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.

The policy provides limited benefits. Review your policy carefully.

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.

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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).

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