VISION INSURANCE POLICY (VSN100 Series)
Application to: American Family Life Assurance Company of Columbus (Aflac)
Worldwide Headquarters • Columbus, Georgia 31999

❑ New

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 SSN ________ - _____ - ________ Will dependent children be covered? ❑ Yes ❑ No

(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 space below.)

Spouse's Name ______________________________ DOB __________ Sex ________
Last First MI Month/Day/Year

Address ____
Street or Post Office Box Apt. No.

City ____________________ State __________ ZIP__________

Home Telephone ( ) ________________

Policy Owner's Name ____________________ Relationship to Applicant ____________________
(If Other Than Applicant)

Address ____________________ Policy Owner's SSN ______________
Street or Post Office Box Apt. No.

City ____________________ State __________ ZIP __________

Name of Vision Care Provider (optional) ______________________________

Name of Spouse's Employer (optional) ______________________________

Payroll Account Name ____________________ Payroll Account Number ______________
(optional)

Is this insurance intended to replace any other vision insurance other than eye exams and materials 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: ______________________________

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TO BE COMPLETED BY AFLAC AGENT

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

❑ Option 1: Policy with Vision Correction Benefit; Materials; No waiting period - $80 every year
❑ Option 2: Policy with Vision Correction Benefit; Materials; 12-mo. waiting period - $195 every 2 years
❑ Option 3: Policy with Vision Correction Benefit; Materials; 24-mo. waiting period - $340 every 3 years

❑ Pre-Tax
or
❑ After-Tax

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 _______________________

ALL OF THE FOLLOWING MUST BE COMPLETED:

1. Has anyone to be covered ever been diagnosed with or treated by a member of the medical profession for any of the following? ❑ Yes ❑ No

   Glaucoma, preglaucoma, and/or borderline glaucoma
   Macular degeneration
   Diabetic retinopathy
   Type I diabetes
   Cataract
   Legal blindness
   Ocular hypertension
   Tumor of the eye or brain
   Detached retina
   Multiple sclerosis
   Retinitis pigmentosa
   Optic neuritis or optic neuropathy
   Total blindness
   Cancer of the eye or brain

2. Has anyone to be covered ever been diagnosed by a member of the medical profession with an ongoing visual impairment/condition that cannot be corrected by eyeglasses, contact lenses, or surgery? ❑ Yes ❑ No

3. In the last 24 months, has anyone to be covered had or been advised by a member of the medical profession to have eye surgery (other than any type of Refractive Error Correction Surgery) or diagnosed with amblyopia (lazy eye) or treated with any eye patch regimen? ❑ Yes ❑ No

If any one of Questions 1 through 3 is answered yes, was it the:

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

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Any person(s) so designated will not be covered under the policy. If this is the Named Insured, the Applicant's Name on the first page of this application must be different.

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. a. I understand that if I selected Vision Correction Benefit option 2 there will be a 12-month waiting period for the Vision Correction Benefit and if I selected Vision Correction Benefit option 3, there will be a 24-month waiting period for the Vision Correction Benefit.
   b. **The policy contains a 30-day waiting period**. If a covered person has an eye disease or disorder, other than one caused by an Injury, 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 eye disease or disorder 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. **The 30-day waiting period for the policy does not apply to the Eye Examination Benefit or the Vision Correction Benefit.**
3. I understand that the policy I am applying for will not cover any person who has attained age 71 before the Effective Date of the policy.
4. I understand that dependent children, if any, will be covered until age 25.
5. I acknowledge receipt of, if applicable:
   ❑ Replacement Notice ❑ Outline of Coverage ❑ Guide to Health Insurance for People with Medicare

6. I understand that: (a) Aflac is not bound by any statement made by me, the applicant, or any agent of Aflac unless written herein. (b) The agent cannot change the provisions of the policy or waive any of its provisions either orally or in writing. (c) The policy, together with this application, endorsements, benefit agreements, riders, and attached papers, if any, is the entire contract of insurance. (d) No change to the policy will be valid until approved by Aflac's president and secretary, and noted in or attached to the policy. (e) All statements in this application are representations and not warranties.

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 agent.

I also understand that if I or anyone to be covered is receiving any Medicaid benefits, the purchase of this coverage is not necessary.

If I am applying to replace existing coverage with this policy, I acknowledge that the policies may have different benefits and that I should make a comparison to personally determine which is best for me. I understand and agree that I am terminating my current policy and its benefits for the benefits provided in the Aflac 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 to the best of my knowledge and belief. I realize that any false statement or misrepresentation hereon may result in loss of coverage under the policy.

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

Applicant's Signature ____

Policy Owner's Signature: ____
(If Different From Applicant)

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.

Agent's Signature ______________________________ Date ____________________
Licensed Resident Agent

Typed or Printed Name of Agent: ____

Agent Telephone Number: ____

Agent Address: ____

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 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).