



**SPECIFIED HEALTH EVENT INSURANCE POLICY  
(Series A74000)**

New  
 Conversion

**Supplemental Health Insurance Coverage**

Application to: American Family Life Assurance Company of Columbus  
(herein referred to as Aflac)  
Worldwide Headquarters • Columbus, Georgia 31999

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**

- 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.
- (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.**

<b>Check Coverage Desired:</b>	<input type="checkbox"/> Individual	<input type="checkbox"/> Named Insured/ Spouse Only	<input type="checkbox"/> One-Parent Family	<input type="checkbox"/> Two-Parent Family
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**Policy (Select one):**

<input type="checkbox"/> <b>Option 1: Specified Health Event (Policy Form A74100FL)</b>	<input type="checkbox"/> Pre-Tax or <input type="checkbox"/> After-Tax
<input type="checkbox"/> <b>Option 2: Specified Health Event with Intensive Care Unit Benefits (Policy Form A74200FL)</b>	
<input type="checkbox"/> <b>Option 3: Specified Health Event with ICU and Heart Surgery Benefits (Policy Form A74300FL)</b>	

**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:**

<input type="checkbox"/> Payroll Deduction	<input type="checkbox"/> 01 Semimonthly	<input type="checkbox"/> 01 28-Day Biweekly	<input type="checkbox"/> 06 Semiannual
<input type="checkbox"/> Bank Draft (B/D, ACH)	<input type="checkbox"/> 01 Weekly	<input type="checkbox"/> 01 Monthly	<input type="checkbox"/> 12 Annual
<input type="checkbox"/> Credit Card (C/C)	<input type="checkbox"/> 01 14-Day Biweekly	<input type="checkbox"/> 03 Quarterly	

**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 \_\_\_\_\_

**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** \_\_\_\_\_



**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).