

Nonpayroll

APPLICATION FOR HOSPITAL CONFINEMENT SICKNESS
INDEMNITY LIMITED BENEFIT INSURANCE (A-45000 Series)
Application to: American Family Life Assurance Company of Columbus (AFLAC)
Worldwide Headquarters: Columbus, Georgia 31999

Policy Number
New
Conversion

Please Print in Black Ink — To Be Completed by Applicant

Applicant's Name, DOB, Sex, SSN, Spouse's Name, DOB, Sex, Address, City, State, ZIP, Home Telephone, Policyowner's Name, Relationship to Applicant, Address, City, State, ZIP

Name of Employer/Association:

Is anyone to be covered under this policy covered by Medicaid or any Title XIX program?
If yes, that person cannot be covered under this policy. Name of person covered by Medicaid or Title XIX program:

Do you have any other hospital confinement sickness indemnity coverage with AFLAC?
If yes, this must be a conversion of that coverage. Provide current policy number and see Item 18.

Do you have any hospital confinement indemnity coverage with AFLAC?
If yes, do you intend to terminate your existing coverage?
If yes, please provide current policy number and complete the Supplemental Notification section at the end of this application.

Is this insurance intended to replace any other health insurance now in force?
If yes, please read and sign the Replacement Notice provided by your associate/agent, if applicable.

TO BE COMPLETED BY AFLAC ASSOCIATE/AGENT

Check Coverage Desired:

Individual, Two-Parent Family, One-Parent Family, Named Insured/Spouse Only

Table with 4 columns: Policy Series, DHIPSA, DHIPSB, DHIPSC, DHIPSD, DHIPSE, DHIPSF, DHIPSG, DHIPSH, DHIPSI

Optional Rider:

Additional Initial Hospitalization Series A-45050: UNITS: DHIPS1, DHIPS2, DHIPS3

Billing Method:

Direct, Bank Draft (B/D, ACH), Association List Bill, Credit Card (C/C)

Modes:

01 Monthly (B/D & C/C Only), 03 Quarterly, 06 Semiannual, 12 Annual

Card Name \_\_\_\_\_ Card No. \_\_\_\_\_

Expiration Date \_\_\_\_\_

I authorize American Family Life Assurance Company of Columbus (AFLAC) to charge my VISA/MASTERCARD/AMERICAN EXPRESS account in accordance with the premium rate that I have chosen. Premiums will be advanced by my bank until I cancel authorization in writing to AFLAC. Cancellation will be effective on the first day of the month following AFLAC's receipt of notice to cancel.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Associate/Agent No. \_\_\_\_\_ Sit. Code \_\_\_\_\_ Billable Premium \$ \_\_\_\_\_ Premium Collected \$ \_\_\_\_\_

**PLEASE COMPLETE ALL OF THE FOLLOWING:**

1. Is anyone to be covered the mother or father of a child currently conceived but as yet unborn?  Yes  No

**Please note, children born within 10 months of the Effective Date of this policy, as shown in the Policy Schedule, will not be covered for any losses or confinements that occur or begin within the first 28 days of life. PLEASE INITIAL:** \_\_\_\_\_

**Applicant**

2. Is anyone to be covered currently confined in a hospital or nursing home, or has a physician recommended hospitalization?  Yes  No

3. Has anyone to be covered ever been diagnosed or treated by a member of the medical profession as having any of the following?  Yes  No

- |   |   |
|---|---|
| * Alzheimer's disease   | * Systemic lupus                                |
| * Senile dementia   | * End-stage renal disease                       |
| * Emphysema   | * Kidney failure                                |
| * Cerebral vascular insufficiency                                       | * Kidney disease or disorder (excluding stones) |
| * Transient ischemic attack (TIA)                                       | * Liver disease or disorder                     |
| * Heart bypass surgery (involving four or more vessels)                 | * Cirrhosis                                     |
| * Uncorrected congenital heart defect (excluding mitral valve prolapse) | * Hepatitis (excluding Type A)                  |
| * Stroke  | * Muscular dystrophy                            |
| * Cardiomyopathy  | * Crohn's disease                               |
| * Type I diabetes   | * Sickle cell anemia                            |
| * Psoriatic arthritis   | * Cystic fibrosis                               |

4. Has anyone to be covered ever been diagnosed with or received treatment by a member of the medical profession for Type II diabetes diagnosed prior to age 30; Type II diabetes with complications to include retinopathy, neuropathy, or nephropathy; Type II diabetes that required insulin use within the last 12 months; or Type II diabetes with continued tobacco use?  Yes  No

5. Has anyone to be covered ever been diagnosed or treated by a member of the medical profession as having AIDS, or has anyone to be covered ever tested positive for the human immunodeficiency virus (HIV) or HTLV-III (antibodies to human T-lymphotropic virus Type III)?  Yes  No

6. Has anyone to be covered ever had or been advised to have an organ transplant, or consulted with or been evaluated by a member of the medical profession of the need to have an organ transplant?  Yes  No

7. During the past 36 months has anyone to be covered been diagnosed or received treatment by a member of the medical profession for any of the following?  Yes  No
- |  |   |
|--|---|
| * Angina (chest pains)                               | * Pancreatitis                                |
| * Congestive heart failure                           | * Ulcerative colitis                          |
| * Heart attack                                       | * Alcohol or drug abuse                       |
| * Heart bypass surgery (involving 3 or less vessels) | * Parkinson's disease                         |
| * Angioplasty or stent placement                     | * Multiple sclerosis                          |
| * Chronic obstructive pulmonary disease (COPD)       | * Cancer (excluding non-melanoma skin cancer) |
| * Peripheral vascular disease (circulatory problems) |   |
| * Arrhythmia (with pacemaker or defibrillator)       |   |
8. During the past 12 months, has anyone to be covered been hospitalized two or more times; hospitalized five or more days; or missed more than seven consecutive days of work due to injury or sickness (excluding a normal pregnancy)?  Yes  No
9. During the past 12 months has anyone to be covered been treated in a hospital or hospital emergency room for any respiratory disorders or psoriasis?  Yes  No
10. During the past six months, has anyone to be covered had any surgical procedure or been advised by a physician to have tests, treatment, or surgery that has not yet been done or are they undergoing evaluation following an abnormal test result?  Yes  No

11. **If any one of Questions 2 through 10 is answered yes, was it the:**  
 Named Insured  Spouse  Child? If "Child," please list the name of the child(ren) \_\_\_\_\_  
**Any person(s) so designated will not be covered under the policy.**

12. List all hospital indemnity policies you currently have in force and provide the daily benefit amount. \_\_\_\_\_

**APPLICANT'S STATEMENTS AND AGREEMENTS:**

13. I understand that the effective date of the policy will be the date recorded in the Policy Schedule by AFLAC Worldwide Headquarters. The policy has a 30-day waiting period for sickness that begins on the effective date of the policy.
14. I understand that the policy I am applying for will not cover any person who has attained age 65 prior to the effective date of the policy.
15. I acknowledge receipt of, if applicable:  
 Fair Credit Reporting Notice  Replacement Notice  
 Outline of Coverage  *Guide to Health Insurance for People with Medicare*
16. **I understand that coverage is not provided for health conditions for which symptoms were evident or for which medical advice or treatment was recommended or received within the 12-month period before the effective date of coverage unless the loss begins more than six months after the effective date of coverage.**
17. I understand that: (a) The insurance I am applying for will be issued based solely upon the written answers to questions and information asked for in this application. (b) AFLAC is not bound by any statement made by me, the applicant, or any associate/agent of AFLAC unless written herein. (c) The associate/agent cannot change the provisions of the policy or waive any of its provisions either orally or in writing. (d) The policy, together with this application, endorsements, benefit agreements, riders and attached papers, if any, is the entire contract of insurance. (e) No change to the policy will be valid until approved by AFLAC's secretary and president, and noted in or attached to the policy.

18. If this is an application for a conversion of coverage, the following conditions will apply: (a) If any one of questions 2 through 10 are answered yes, the policy for which this application is made for the person(s) identified in Item 11 will be void, and coverage will continue under the terms of the previous policy, which may remain in force. Benefits that may be due any person(s) listed in Item 11 will be paid under the previous policy. (b) Any person(s) not listed in Item 11, if eligible, will be covered under the new policy. (c) The waiting period and the Time Limit on Certain Defenses provision will run from the effective date of the original policy, and the original policy will be terminated as of the effective date of the new policy. (d) The Pre-existing Conditions provision in the new policy will run from the original policy's effective date for the benefits provided under the original policy. For the increased benefit amount, the Pre-existing Conditions provision in the new policy will run from the new policy's effective date.

**NOTICE OF INFORMATION PRACTICES**

To issue an insurance policy, AFLAC may need to obtain additional information about you and any other persons proposed for insurance. Some information will come from you and some may come from other sources. That information and any other subsequent information collected by AFLAC may in some circumstances be disclosed to third parties without your specific consent. You have the right to access and correct the information collected about you except information that relates to a claim or to a civil or criminal proceeding. If you wish to have a more detailed explanation of our information practices, please submit a written request to our worldwide headquarters. This notice applies only in Arizona, California, Connecticut, Georgia, Illinois, Maine, Massachusetts, Minnesota, Nevada, New Jersey, North Carolina, Ohio, Oregon and Virginia.

**SUPPLEMENTAL NOTIFICATION**

**COMPLETE THIS SECTION IF YOU ARE REPLACING/TERMINATING EXISTING COVERAGE.**

I, \_\_\_\_\_, am applying for AFLAC's Hospital Confinement Sickness Indemnity Limited Benefit Policy that pays benefits for a covered sickness only. I currently have hospital confinement benefits under AFLAC Hospital Confinement Indemnity Policy Number \_\_\_\_\_.

**Please cancel my existing hospital confinement indemnity policy and issue this new policy.** \_\_\_\_\_  
(Please Initial)

**I understand that this new policy pays benefits for a covered sickness only. Other than the Physician Visits Benefit, this policy does not pay for injuries.**

**I understand that the purchase of this 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 convert my current policy to another AFLAC policy, I acknowledge that I have been advised that the policies have different benefits and that I should compare them to determine which is best for me. I understand and agree that I am giving up my current policy and its benefits for the benefits provided in the new policy. I also understand that the new policy only pays benefits for a covered sickness. Other than the Physician Visits Benefit, this policy does not pay for injuries. I have read, or had read to me, the completed application, and I realize policy issuance is based upon statements and answers provided herein, and they are complete and true.

Signed and Dated at \_\_\_\_\_ on \_\_\_\_\_  
City and State Date

Applicant's Signature \_\_\_\_\_

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.

Associate/Agent's Signature \_\_\_\_\_  
Licensed Resident Associate/Agent Date

**MAKE CHECK OR MONEY ORDER PAYABLE TO AFLAC.  
FOR INFORMATION, CALL TOLL-FREE 1-800-99-AFLAC (1-800-992-3522).  
VISIT OUR WEB SITE AT [www.aflac.com](http://www.aflac.com).**

For indemnity policies and other policies that pay a fixed dollar amount per day, excluding long-term care policies.

**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).



## Payment Authorization Agreement

### Policyholder/Applicant Information

	Policy Numbers	Premium \$	Policy Numbers	Premium \$
Name: _____	_____	_____	_____	_____
Address: _____	_____	_____	_____	_____
City, State, ZIP: _____	_____	_____	_____	_____
Phone: _____	No. of policies <input type="checkbox"/>		Total: \$ _____	

### Deduction Information

When would you like your premiums deducted? \_\_\_\_\_  
Please choose any day 1–28.

How often?  Monthly  
 Quarterly  
 Semiannually  
 Annually

For newly issued policies only: For ease of your policy administration, we will make the effective date of coverage the same as your selected draft date following the receipt of your application in worldwide headquarters.

#### I choose to pay by electronic draft.

Draftee Name: \_\_\_\_\_  
 Depository Name/Branch: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_  
 Transit/ABA Number: \_\_\_\_\_  
 Account Number: \_\_\_\_\_  Checking  Savings

#### I choose to pay by credit or debit card.

Visa  Credit card  
 MasterCard  Debit card  
 American Express

Card Number: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

### Confirmation

I authorize Aflac to initiate debit entries electronically to my account indicated above and I authorize the depository institution named above to debit same to such account. This authorization remains effective and in full force until Aflac and the depository/institution have received written notification from me of its termination in such time and in such manner to afford Aflac and the depository/institution a reasonable opportunity to act on it.

Policyholder's/Applicant's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Associate's/Agent's Signature: \_\_\_\_\_ Writing Number: \_\_\_\_\_ Date: \_\_\_\_\_  
(Required for SNG Only)

American Family Life Assurance Company of Columbus (Aflac)  
 Worldwide Headquarters • 1932 Wynnton Road • Columbus, GA 31999-0001  
 1.800.99.AFLAC (1.800.992.3522) • aflac.com