Payroll

SHORT-TERM DISABILITY INSURANCE (A57600 Series)
Application to: American Family Life Assurance Company of Columbus
(herein referred to as Aflac)
Worldwide Headquarters • Columbus, Georgia 31999

- ❑ New
- ❑ Conversion
- ❑ Additional Units
- ❑ Add Aflac Value Rider Only
- ❑ Add CI Rider Only
- ❑ Convert CI Rider Only

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

Driver's License Number_____ State of Issue_____ State of Birth_____

Address _____
Street or Post Office Box Apt. No.

City _____ State _____ ZIP _____

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

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

E-Mail Address _____

Account Name_____ Account No._____

Name of Employer _____ Type of Business _____

Job Duties _____

Job Title _____

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

PLEASE COMPLETE THE FOLLOWING ELIGIBILITY QUESTIONS

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? ❑ Yes ❑ No

If you answered No to Question 1, a policy will not be issued; therefore, do not submit this application.

2. Do you work fewer than 19 hours per week with the employer listed on this application? ❑ Yes ❑ No

3. Do you have disability coverage that you purchased that will remain in force which, combined with this applied-for coverage, will exceed 72 percent of your gross monthly income? ❑ Yes ❑ No

If you answered Yes to Question 2 or 3, a policy will not be issued; therefore, do not submit this application.

4. I certify that my taxable (gross) annual income from my job with the employer listed on this application is $_____ (If you are self-employed, please use an average of the **net earnings** for the past two years from the business listed on this application.) I understand that this information may require verification, to include tax records, at the time of claim. **Annual income must be $9,000 or greater for coverage to be issued.**

Is the purchase of this coverage intended to replace any other disability insurance with another carrier? ❑ Yes ❑ No ❑ N/A

If Yes, please read and sign the Replacement Notice provided by your associate/agent, if applicable, and provide the policy number here: _____

Do you currently have any other Short-Term Disability coverage with Aflac or have you, the Proposed Insured, had any other Short-Term Disability coverage with Aflac that terminated within the last 12 months? ❑ Yes ❑ No

If Yes, or we determine that other Short-Term Disability coverage was in force within the last 12 months, this application will be processed as a conversion of that coverage. Please give current policy number and see the Applicant's Statements and Agreements concerning conversions and replacement of coverage.

Policy Number: _____

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 _____

If this is an application for a conversion of coverage, I understand that: (1) 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; and (2) the Pre-existing Conditions and pregnancy exclusion provision in the new policy will run from the original policy's Effective Date for the benefits provided under the original policy. For all increased benefit amounts (i.e., amounts due to additional units, increased benefit period, or reduced elimination period), the Pre-existing Conditions and pregnancy exclusion provisions in the new policy will run from the new policy's Effective Date.

Proposed Insured's Initials _____

Do you have any Aflac accident policies with disability benefits? ❑ Yes ❑ No

If Yes, please complete the Supplemental Notification section at the end of this application, and be aware that you cannot have this policy without canceling those disability benefits with Aflac.

If applying for an optional lump sum critical illness benefit rider, please answer the following questions:

Is the lump sum critical illness benefit rider (Aflac Plus Rider) intended to replace any other health insurance now in force? ❑ Yes ❑ No
If Yes, please read and sign the Replacement Notice provided by your associate/agent, if applicable.

Is anyone to be covered also covered under any other Aflac Plus Rider? ❑ Yes ❑ No
If Yes, anyone covered under an existing Aflac Plus Rider cannot be covered under the new rider; therefore, the new rider will not be issued.

Are you applying to convert your current HSA-compatible Aflac Plus Rider (Series CIRIDERH) to the Aflac Plus Rider (Series CIRIDER) that is not HSA-compatible? ❑ Yes ❑ No
If Yes, please complete the Notice and Acknowledgment Regarding Conversion form provided by your associate/agent.

TO BE COMPLETED BY AFLAC ASSOCIATE/AGENT

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 B/D, ACH, or C/C billing method is checked, only the following modes of payment are available: Monthly, Quarterly, Semiannual, or Annual.

Employee No. _____ Dept. No. _____ Assoc./Agent's No. _____

Billable Premium $ _____ Premium Collected $ _____ Sit. Code _____

CHECK COVERAGE DESIRED:	Class: ☐ A ☐ B ☐ C

Total Disability Benefit Periods:	☐ 3 Months ☐ 6 Months
Partial Disability Benefit Period:	3 Months
Elimination Periods: Injury/Sickness	☐ 0/7 Days ☐ 0/14 Days ☐ 7/7 Days ☐ 7/14 Days ☐ 14/14 Days ☐ 0/30 Days* ☐ 30/30 Days* **(*not available with 3-month Total Disability Benefit Period)**

	No. of Units Purchased for this Application	❑ Pre-Tax or ❑ After-Tax
☐ Base Policy Series A57600 (Issue Ages 18-74)		
☐ Optional On-the-Job Injury Rider Series A57650 (Issue Ages 18-74) Are you currently covered by on-the-job disability income replacement under a collective bargaining agreement, workers' compensation or a similar law in your job with the employer listed on this application? ❑ Yes ❑ No **Similar laws include but are not limited to the following:** Railroad Retirement Act; Jones Act; Maritime Doctrine of Maintenance, Wages, or Cure; Longshore and Harbor Workers' Compensation Act **If you answered Yes, the maximum number of units for the On-the-Job Injury Rider coverage will be based on half of the unit amount allowed for your salary.**		
☐ Optional Additional Units of Disability Benefit Rider Series A57651 (applies to base policy only) (Issue Ages 18-74) **Current Units:**_____ (includes any additional units previously purchased) **(must match policy Elimination and Benefit periods)**		
NOTE: Each unit is equal to a $100 monthly benefit.		

Optional Aflac Value Rider (Issue Ages 18-69):	
❑ Aflac Value Rider Series A57653 Options: ❑ New rider ❑ Retain current rider	☒After-Tax Only

Optional Lump Sum Critical Illness Benefit Riders (Issue Ages 18-70):	
Select One Rider: ❑ Aflac Plus Rider (Series CIRIDER) ❑ Aflac Plus Rider (Series CIRIDERH) Options: ❑ Retain current rider ❑ Convert current rider	❑ Pre-Tax or ❑ After-Tax

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 acknowledge receipt of, if applicable:
  - ❑ Replacement Notice
  - ❑ Outline of Coverage
  - ❑ Electronic Delivery Notice
  - ❑ Aflac Plus Rider Replacement Notice
  - ❑ *Guide to Health Insurance for People With Medicare*
  - ❑ Fair Credit Reporting Notice
  - ❑ Aflac Plus Rider Conversion Notice
  - ❑ Aflac Plus Rider Outline of Coverage

- I understand that the policy, together with the applications, endorsements, benefit agreements, riders, and attached papers, if any, constitutes the entire contract of insurance.

- I understand that (1) I will be informed whether or not this application has been accepted within 60 days or be given the reason for any further delay, and (2) the associate/agent cannot change the provisions of the policy or waive any of its provisions.

- 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.

- I understand that the following conditions apply:
  - 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, medical advice, consultation, or treatment was recommended or received, or for which symptoms existed that would ordinarily cause a prudent person to seek diagnosis, care, or treatment. Disability caused by a Pre-existing Condition or reinjuries to a Pre-existing Condition will not be covered unless it begins more than 12 months after the Effective Date of coverage; and
  - Aflac will not pay benefits for a Disability that is caused by or occurs as a result of pregnancy or childbirth within the first ten months of the Effective Date of coverage (Complications of Pregnancy will be covered to the same extent as a Sickness).

  Proposed Insured's Initials _____

- If this is an application for a conversion of coverage, I understand that the Pre-existing Conditions and pregnancy exclusion provisions will run from the original policy's Effective Date for the benefits provided under the original policy. I further understand that for all increased benefit amounts (i.e., amounts due to additional units, increased benefit period, or reduced elimination period), the following conditions apply:
  - 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, medical advice, consultation, or treatment was recommended or received, or for which symptoms existed that would ordinarily cause a prudent person to seek diagnosis, care, or treatment. Disability caused by a Pre-existing Condition or reinjuries to a Pre-existing Condition will not be covered unless it begins more than 12 months after the Effective Date of coverage; and
  - Aflac will not pay benefits for a Disability that is caused by or occurs as a result of pregnancy or childbirth within the first ten months of the Effective Date of coverage (Complications of Pregnancy will be covered to the same extent as a Sickness).

  Proposed Insured's Initials _____

- 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. 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), subject to the conditions/provisions of the policy.

ADDITIONAL APPLICANT'S STATEMENTS AND AGREEMENTS FOR LUMP SUM CRITICAL ILLNESS BENEFIT RIDER:

- I understand that coverage is not provided for any 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 symptoms existed that would ordinarily cause a prudent person to seek diagnosis, care, or treatment. Benefits for a loss that is caused by a Pre-existing Condition will not be covered unless the Onset Date is more than 12 months after the Effective Date of coverage.

  Proposed Insured's Initials _____

- If this is an application for a conversion of coverage, I understand that: (1) 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.
- I understand the impact that the premium for this coverage has on my paycheck.
- I further understand the impact that the total monthly Aflac premium for this coverage and any other Aflac coverage has on my paycheck and believe it to be appropriate for me.

SUPPLEMENTAL NOTIFICATION
COMPLETE IF YOU ARE REPLACING OR TERMINATING EXISTING AFLAC DISABILITY COVERAGE.

I, _____, am applying for Aflac's Short-Term Disability policy. I currently have disability benefits under Aflac Accident/Disability policy number _____. I understand that I must cancel existing Aflac disability coverage to purchase this Short-Term Disability policy.

- ❑ Please cancel the disability riders attached to my accident policy, but keep my accident policy in force.
- ❑ I wish to retain my spouse disability rider. I may retain the spouse disability rider **ONLY** if the accident policy remains in force.
- ❑ Please cancel my entire accident policy (with disability benefits) number _____. I understand that I will be terminating benefits provided for in my current accident policy that are not provided for in the new Short-Term Disability policy.

NOTICE OF INFORMATION PRACTICES

To issue an insurance policy, Aflac may need to obtain additional information about you 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, Montana, Nevada, New Jersey, North Carolina, Ohio, Oregon, and Virginia.

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

I authorize the following to give information (as defined below) to American Family Life Assurance Company of Columbus, American Family Life Assurance Company of New York, and Continental American Insurance Company (collectively, "Aflac"): any medical professional, medical care institution, pharmacy-related service organizations, insurer (including Aflac, with respect to other Aflac coverages), reinsurer, government agency (including departments of public safety and motor vehicle departments), MIB, Inc. (formerly known as the Medical Information Bureau), consumer reporting agency, or employer.

"Information" includes facts or opinions relating to my past, present, or future physical or mental health or condition (excluding psychotherapy notes), employment, other insurance coverage, driving record, or any other medical or nonmedical facts that are required as part of the underwriting process in order to determine eligibility for insurance or to evaluate a claim for benefits during the time this authorization is valid. I also authorize Aflac to give information to MIB, Inc.

I also authorize Aflac to make a brief report of my personal health information to MIB, Inc. (formerly known as the Medical Information Bureau). I understand that any disclosure of health information to Aflac for the purpose of determining eligibility for coverage other than health plan coverage means the information may no longer be protected by federal privacy regulations. I further understand, however, that such information may be redisclosed only in accordance with other applicable laws or regulations.

I understand that this information will be used by Aflac for enrollment or to determine eligibility for insurance or for underwriting or risk rating (where applicable) purposes and, should coverage be issued, the information may be used to contest a claim for benefits or the issuance of the policy itself during the contestability period provided in the policy.

I understand that Aflac is conditioning the issuance of coverage on the provision of this authorization, and that, while I may refuse to sign this authorization, my refusal to do so could result in coverage not being issued.

I understand that I may revoke this authorization at any time, except to the extent that (1) Aflac has taken action in reliance on this authorization or (2) other law provides Aflac with the right to contest a claim under the policy or the policy itself. My revocation must be submitted in writing to Aflac, Policy Service, 1932 Wynnton Road, Columbus, Georgia 31999.

Unless otherwise revoked, I agree that this authorization will expire on the earlier of the date Aflac notifies me of its declination of my application for coverage or, if a policy is issued, two years from the date this application is signed.

I agree that a copy of this authorization is as valid as the original.

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

Proposed Insured's Signature _____

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.

I certify that I have advised the applicant to consider the impact that this Aflac coverage has on his or her paycheck, and I agree with the applicant's decision that it is appropriate for purchase.

Associate's/Agent's Signature _____ Date _____
Licensed Associate/Agent

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 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).