REQUEST FOR ADDITION/APPLICATION FOR REINSTATEMENT

American Family Life Assurance Company of Columbus (AFLAC), Worldwide Headquarters: Columbus, GA 31999
For information, call toll-free 1-800-99-AFLAC (1-800-992-3522).
Fax Number: 1-800-448-8922

Name of Policyholder: _____ SS#: _____

Policy Number (s): _____

Date of Birth: _____ Telephone #: _____ Best time to call: _____

Current Address of Policyholder: _____

City: _____ State: _____ Zip: _____

Name of Employer/Payroll Account: _____

Associate/Agent's Signature: _____ Writing Number: _____
(If applicable) Licensed Resident Associate/Agent

PLEASE MAKE THE FOLLOWING ADDITION TO MY POLICY:

NOTE: ADDITIONS CAN NOT BE MADE TO SHORT TERM DISABILITY POLICIES.

❑ **ADDITION**

Person(s) to be added: _____

Date(s) of birth: _____ Relationship: _____

Reason(s) for addition(s): _____

Effective date of addition(s): _____

Type of coverage now desired: ❑ Two-Parent Family ❑ One-Parent Family ❑ Husband-Wife

❑ **REINSTATEMENT**

Attached is $ _____ to cover _____ months premium. I hereby apply for reinstatement of my coverage as indicated above.

PLEASE READ THE FOLLOWING

The applicant does not have to disclose an HIV (AIDS Virus) test which was administered: (1) to a criminal offender or crime victim as a result of a crime that was reported to the police; (2) to a patient who received the services of emergency medical services personnel at a hospital or medical care facility; (3) to emergency medical personnel who were tested as a result of performing emergency medical services. The term "emergency medical personnel" includes individuals employed to provide pre-hospital emergency services; licensed police officers, firefighters, paramedics, emergency medical technicians, licensed nurses, rescue squad personnel, or other individuals who serve as volunteers of an ambulance service who provide emergency medical services; crime lab personnel, correctional guards, including security guards at the Minnesota security hospital, who experience a significant exposure to an inmate who is transported to a facility for emergency medical care; and other persons who render emergency care or assistance at the scene of an emergency, or while an injured person is being transported to receive medical care and who would qualify for immunity under the good Samaritan law.

All portions of this form applicable to your type of coverage must be completed before your application can be processed; therefore, please be sure to indicate the name of any person who has a history of the medical conditions listed, if applicable, in the spaces provided. **If none, please write the word "none".**

PLEASE COMPLETE THE SECTION THAT APPLIES TO YOU

❑ **DENTAL REINSTATEMENT**

❑ **CANCER**

1. Have you or anyone to be covered under this policy ever been diagnosed or treated for cancer of any type or form? ❑ Yes ❑ No If yes, was it the ❑ Named Insured ❑ Spouse ❑ Child?
   If "child," please list the name of the child(ren) _____.
   If yes, please complete Question 2 below.
2. Has the person(s) designated above:
   (a) received treatment for cancer in the last five years (10 years for nonpayroll)? ❑ Yes ❑ No
   (b) received hormonal therapy for cancer within the last 12 months? ❑ Yes ❑ No
   If no to (a) and (b), please complete Internal Malignancy Form provided by your associate/agent.
   If yes to (a), what type of cancer was it:
   - ❑ Skin cancer or Melanomas of Clark's Level I or II? (Policy may be issued with a Skin Cancer Exclusion Rider.)
   - ❑ Internal cancer or Melanomas of Clark's Level III or higher? (These individuals will not be covered under this policy.)

   If yes to (b), the individual(s) will not be covered under this policy.

Please complete question 3 below only if requesting reinstatement of Specified (Dread) Disease Rider.

3. Have you or anyone to be covered under this policy ever had adrenal hypofunction (Addison's disease), ALS (amyotrophic lateral sclerosis), cerebral palsy, cystic fibrosis, diphtheria, encephalitis, Huntington's chorea, Legionnaires' disease, malaria, meningitis (bacterial), multiple sclerosis, muscular dystrophy, myasthenia gravis, necrotizing fasciitis, osteomyelitis, polio, rabies, scleroderma, sickle-cell anemia, systemic lupus, tetanus or tuberculosis in any form? ❑ Yes ❑ No If yes, was it the: ❑ Named Insured ❑ Spouse ❑ Child?

If "child," please list the name of the child(ren) _____.
Any person(s) named will not be covered under Specified Disease Rider, Form Series A-59052.

❑ **INTENSIVE CARE**

Complete questions 1 through 6 for additions or reinstatements on payroll sales only.

1. Has anyone to be covered been diagnosed with or treated by a member of the medical profession in the last five years for: angina, congestive heart failure, heart attack or stroke? ☐ Yes ☐ No
2. Has anyone to be covered had or been advised of the need to have coronary angioplasty, coronary atherectomy, coronary bypass surgery, heart valve surgery or surgery for congenital heart defects within the last five years? ☐ Yes ☐ No
3. Has anyone to be covered ever been treated or diagnosed by a member of the medical profession with chronic liver disease, chronic kidney disease or impaired kidney function (not including kidney stones) or been treated with dialysis by a member of the medical profession? ☐ Yes ☐ No
4. Has anyone to be covered ever been treated or diagnosed by a member of the medical profession as having AIDS or has anyone to be covered ever tested positive for HIV (human immunodeficiency virus)? ☐ Yes ☐ No
5. Within the last five years, has anyone to be covered ever had or been advised to have an organ transplant or consulted with a member of the medical profession about the need to have an organ transplant? ☐ Yes ☐ No

6. If any one of Questions 1 through 5 is answered "yes," the name and the relationship of the person(s) must be shown in the following space. Any person(s) so named will not be covered under the policy. _____

_____

Complete questions 7 through 13 for additions and reinstatements on nonpayroll sales only.

7. Is anyone to be covered currently confined in a hospital or nursing home, or has hospitalization been recommended by a Physician? ☐ Yes ☐ No
8. Has anyone to be covered been diagnosed with or treated in the last five years for: angina, congestive heart failure, heart attack or stroke; or has anyone to be covered had coronary angioplasty, coronary atherectomy, coronary bypass surgery, heart valve surgery or surgery for congenital heart defects within the last five years? ☐ Yes ☐ No
9. Has anyone to be covered ever been treated with dialysis or diagnosed with AIDS or tested positive for HIV (human immunodeficiency virus)? ☐ Yes ☐ No
10. Within the last five years, has anyone to be covered ever had or been advised to have an organ transplant or consulted with a member of the medical profession about the need to have an organ transplant? ☐ Yes ☐ No
11. Has anyone to be covered been hospitalized three or more times in the last two years? ☐ Yes ☐ No
12. Has anyone to be covered ever been treated for or diagnosed by a member of the medical profession with: chronic liver disease, sickle-cell anemia, emphysema, glomerulonephritis, nephrotic syndrome, polycystic kidney disease, chronic kidney disease, impaired kidney function (not including kidney stones), alcohol or drug abuse, pancreatitis or insulin-dependent diabetes? ☐ Yes ☐ No
13. If any one of Questions 7 through 12 is answered "yes," the name and the relationship of the person(s) must be shown in the following space. Any person(s) so named will not be covered under the policy. _____

_____

❑ **ACCIDENT**

Complete questions 1 through 17 for additions and reinstatements.

1. List your annual income (without overtime, unless contractual, bonuses or other incentives) for your full-time job. Annual Income $ _____. If you are self-employed, your gross annual income is your net earnings. I understand that this information will be verified at the time of claim.

PLEASE COMPLETE QUESTIONS 2 THROUGH 8 IF REINSTATING ANY DISABILITY RIDER:

2. Do you have a short-term disability policy with Aflac? If yes, please complete the Supplemental Notification section at the end of this application and be aware that you cannot have this policy with the disability riders without canceling your short-term disability policy with Aflac. ❑ Yes ❑ No
3. Have you been convicted with driving under the influence of alcohol or any narcotic within the last 12 months or been convicted two or more times within the last five years? ❑ Yes ❑ No
4. Are you currently on leave or not working due to Sickness, maternity or Injury? ❑ Yes ❑ No
5. Are there any material or substantial duties of your job that you are unable to perform due to Sickness, maternity or Injury? ❑ Yes ❑ No
6. Do you work fewer than [30] hours per week in your primary (full-time) occupation with the employer listed on the first page of the application? ❑ Yes ❑ No
7. Is your current annual income less than [$10,000], without overtime (unless contractual), for your primary occupation? ❑ Yes ❑ No
8. Within the last six weeks, have you taken prescribed pain medication for Injury, disease or disorder of the back, neck or joint(s)? ❑ Yes ❑ No

If you answered "yes," to any one of Questions 3 through 8, you are not eligible for any disability rider coverage and, therefore, no disability rider will be reinstated.

PLEASE COMPLETE QUESTION 9 IF REINSTATING THE ON-THE-JOB DISABILITY RIDER:

9. Are you covered by workers' compensation or similar law in your full-time job? ❑ Yes ❑ No

If you answered "yes," you are not eligible for On-The-Job rider coverage and, therefore, this rider will not be reinstated.

PLEASE COMPLETE QUESTIONS 10 THROUGH 17 IF REINSTATING THE SICKNESS DISABILITY RIDER:

10. Has a member of the medical profession ever diagnosed you with or ever treated you for any of the following: ❑ Yes ❑ No
    - stroke or TIA
    - heart valve replacement
    - vascular insufficiency (circulatory problems)
    - insulin-dependent diabetes
    - emphysema
    - chronic liver disease
    - chronic hepatitis (other than Type A)
    - fibromyalgia
    - systemic lupus
    - chronic fatigue syndrome
    - rheumatoid arthritis
    - multiple sclerosis
    - Crohn's disease
    - regional enteritis/ileitis
    - diverticulosis
    - ulcerative colitis
11. Have you ever been diagnosed with acquired immune deficiency syndrome (AIDS) by a member of the medical profession or have you ever tested positive for the human immunodeficiency virus (HIV)? ❑ Yes ❑ No
12. In the past five years, has a member of the medical profession diagnosed you with or treated you for cancer (other than non-melanoma skin cancers)? ❑ Yes ❑ No
13. In the past 24 months, has surgery been performed for any of the following or has a member of the medical profession diagnosed you with or treated you for any of the following: ❑ Yes ❑ No
    - heart attack
    - congestive heart failure
    - angina
    - coronary angioplasty
    - coronary bypass surgery
    - sciatica
    - carpal tunnel syndrome (unless surgically corrected)
    - drug or alcohol abuse
    - kidney disease (not including kidney stones)

If you answered "yes" to any one of Questions 10 through 13, you are not eligible for Sickness Disability rider coverage and, therefore, this rider will not be reinstated.

14. Have you received disability benefits or claimed workers' compensation in the last five years? ❑ Yes ❑ No
15. In the past 12 months, have you missed five consecutive days or 10 total days of work due to your Sickness or Injury (not related to pregnancy)? ❑ Yes ❑ No
16. In the past 12 months, have you been confined in a hospital as an inpatient (not including confinement due to pregnancy)? ❑ Yes ❑ No
17. In the past 12 months, has a member of the medical profession diagnosed you with or treated you for any of the following: ❑ Yes ❑ No
    - chronic bronchitis
    - asthma
    - back, neck or joint Injury or disorder
    - hypertension

If you answered "yes" to any one of Questions 14 through 17, you must complete Item 22 and provide details in Item 23.

In addition to completing questions 1 through 17, complete questions 18 through 21 for additions and reinstatements on nonpayroll sales only.

18. Have you or has anyone to be covered by this policy been convicted with driving under the influence of alcohol or any narcotic within the last 12 months or been convicted two or more times within the last five years? If yes, please list the name and the relationship of the person(s) in the following space. Any person(s) so named will not be covered under the policy. ❑ Yes ❑ No

    _____

    If the person so named is the primary insured, then a policy will not be issued; therefore, do not submit this application.
19. In the past 12 months, has a member of the medical profession diagnosed you with or treated you for back, neck or joint Injury, disease or disorder? If yes, please complete Item 22 and provide details in Item 23. ❑ Yes ❑ No

20. If you are self-employed, have you been self-employed for fewer than 24 consecutive months? ❑ Yes ❑ No

21. If you are not self-employed, have you been employed by the same employer for fewer than 12 consecutive months? ❑ Yes ❑ No

If you answered "yes" to any one of Questions 20 through 21, you are not eligible for any disability rider coverage and, therefore, no disability rider will be reinstated.

22. **Within the last six weeks, have you been prescribed any medication by a Physician or taken any prescription medication (not including prescription contraceptives)?** If yes, please provide complete information below. ❑ Yes ❑ No

Medication name	Dosage	Frequency	Date first prescribed	Reason

Your Physician's Name: _____ Phone Number: _____
If no regular Physician, Physician last seen

Address _____

Date last seen by Physician: _____ Reason for last visit: _____

23. **(Details to Questions 14 – 17 and Question 19)**

	Condition(s)	Onset (mo/yr)	Surgery Performed? (yes/no/date)	Name and Address of Physician and Hospital
Question 14				
Question 15				
Question 16				
Question 17				
Question 19				

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

I, _____ , am applying for reinstatement of Aflac's policy with disability benefits. I currently have disability benefits under Aflac short-term disability policy number _____.
I understand that I must cancel my existing Aflac short-term disability policy in order to reinstate this policy.

❑ Please cancel my short-term disability policy so that this accident policy with disability benefits can be reinstated.

❑ **SHORT TERM DISABILITY --- REINSTATEMENTS ONLY**

1. Do you have any of Aflac's accident policies with disability benefits? 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. ❑ Yes ❑ No
2. Is the purchase of this coverage intended to replace any other disability insurance now in force? If yes, please read and sign the Replacement Notice provided by your associate/agent and provide policy number here: _____ ❑ Yes ❑ No ❑ Not applicable
3. Do you have any other individual disability coverage in force with another company? If yes, please provide name of company, benefit amount and elimination period here: _____ ❑ Yes ❑ No

PLEASE COMPLETE QUESTION 4 IF REINSTATING MORE THAN $700 OF ANY ONE MONTHLY DISABILITY BENEFIT:

4. List your annual income (without overtime, unless contractual, bonuses or other incentives) for your full-time job. Annual Income $ _____. If you are self-employed, your gross annual income is your net earnings. I understand that this information will be verified at the time of claim.

PLEASE COMPLETE ALL OF THE FOLLOWING QUESTIONS:

5. Do you work fewer than [30] hours per week in your primary (full-time) occupation with the employer listed on the first page of the application? ❑ Yes ❑ No
6. Have you been convicted with driving under the influence of alcohol or any narcotic within the last 12 months or been convicted two or more times within the last five years? ❑ Yes ❑ No
7. Are you currently on leave or not working due to Sickness, maternity or Injury? ❑ Yes ❑ No
8. Are there any material or substantial duties of your job that you are unable to perform due to Sickness, maternity or Injury? ❑ Yes ❑ No
9. Is your current annual income less than [$12,000], without overtime (unless contractual), for your primary occupation? ❑ Yes ❑ No
10. Has a member of the medical profession ever diagnosed you with or ever treated you for any of the following: ❑ Yes ❑ No
    - stroke or TIA
    - heart valve replacement
    - vascular insufficiency (circulatory problems)
    - insulin-dependent diabetes
    - emphysema
    - chronic liver disease
    - chronic hepatitis (other than Type A)
    - fibromyalgia
    - systemic lupus
    - chronic fatigue syndrome
    - rheumatoid arthritis
    - multiple sclerosis
    - Crohn's disease
    - regional enteritis/ileitis
    - diverticulosis
    - ulcerative colitis
11. Have you ever been diagnosed with acquired immune deficiency syndrome (AIDS) by a member of the medical profession or have you tested positive for HIV (human immunodeficiency virus)? ❑ Yes ❑ No
12. In the past five years, has a member of the medical profession diagnosed you with or treated you for cancer (other than non-melanoma skin cancers)? ❑ Yes ❑ No
13. In the past 24 months, has surgery been performed for any of the following or has a member of the medical profession diagnosed you with or treated you for any of the following: ❑ Yes ❑ No
    - heart attack
    - congestive heart failure
    - angina
    - coronary angioplasty
    - coronary bypass surgery
    - sciatica
    - carpal tunnel syndrome (unless surgically corrected)
    - drug or alcohol abuse
    - kidney disease (not including kidney stones)
14. Within the last six weeks, have you taken prescribed pain medication for Injury, disease or disorder of the back, neck or joint(s)? ❑ Yes ❑ No

If you answered "yes" to Question 5, additional underwriting may be required. If you answered "yes" to any one of Questions 6 through 14, a policy will not be reinstated; therefore, do not submit this application.

15. Have you received disability benefits or claimed workers' compensation in the last five years? ❑ Yes ❑ No

16. In the past 12 months, have you missed five consecutive days or 10 total days of work due to your Sickness or Injury (not related to pregnancy)? ❑ Yes ❑ No
17. In the past 12 months, have you been confined in a hospital as an inpatient (not including confinement due to pregnancy)? ❑ Yes ❑ No
18. In the past 12 months, has a member of the medical profession diagnosed you with or treated you for any of the following: ❑ Yes ❑ No
    - chronic bronchitis
    - asthma
    - back, neck or joint Injury or disorder
    - hypertension

If you answered "yes" to any one of Questions 15 through 18, you must complete Item 22 and provide details in Item 23.

PLEASE COMPLETE QUESTIONS 19 THROUGH 22 IF REINSTATING MORE THAN 20 UNITS OF ANY ONE MONTHLY DISABILITY BENEFIT:

19. During the past 12 months, have you had any surgical procedure or have you been advised by a Physician to have tests, treatment or surgery that has not yet been done? ❑ Yes ❑ No
20. During the past 24 months, for other than routine checkups, have you been treated for any other illness/Injury or have you had any medical/surgical treatment other than those listed above? ❑ Yes ❑ No
21. Do you have any group disability income coverage in force? ❑ Yes ❑ No
    If yes, please list your monthly benefit amount(s)/percentage(s): _____ and your elimination period: _____.

If you answered "yes" to any one of Questions 19 through 21, additional underwriting may be required. If you answered "yes" to any one of Questions 19 or 20 you must provide details in Item 23.

22. **Within the last six weeks, have you been prescribed any medication by a Physician or taken any prescription medication (not including prescription contraceptives)?** ❑ Yes ❑ No
    If yes, please provide complete information below.

Medication name	Dosage	Frequency	Date first prescribed	Reason

Your Physician's Name: _____ Phone Number: _____
If no regular Physician, Physician last seen

Address _____

Date last seen by Physician: _____ Reason for last visit: _____

23. **(Details to Questions 15 - 20)**

	Condition(s)	Onset (mo/yr)	Surgery Performed? (yes/no/date)	Name and Address of Physician and Hospital
Question 15				
Question 16				
Question 17				

Question 18				
Question 19				
Question 20				

❑ **HOSPITAL INDEMNITY**

Complete questions 1 through 6 for additions or reinstatements on payroll sales only.

1. Is anyone to be covered currently confined in a hospital or nursing home, or has a Physician recommended hospitalization? ❑ Yes ❑ No
2. Has anyone to be covered been confined in a hospital for 14 or more hours within the last 36 months because of any of the following? (Check all that apply.) ❑ Yes ❑ No

   ❑ angina ❑ heart surgery ❑ transient ischemic attack (TIA)
   ❑ congestive heart failure ❑ stroke ❑ cerebral vascular insufficiency
   ❑ heart attack ❑ internal cancer ❑ peripheral vascular disease

3. Has anyone to be covered been confined in a hospital for 14 or more hours within the last 12 months because of any of the following? (Check all that apply.) ❑ Yes ❑ No

   ❑ emphysema ❑ Parkinson's disease
   ❑ sickle-cell anemia ❑ chronic liver disease
   ❑ asthma ❑ chronic obstructive pulmonary disease

4. Has anyone to be covered ever been treated or diagnosed by a member of the medical profession as having any of the following? (Check all that apply.) ❑ Yes ❑ No

   ❑ Alzheimer's disease ❑ end-stage renal disease
   ❑ senile dementia ❑ kidney failure
   ❑ systemic lupus ❑ insulin-dependent diabetes

5. Has anyone to be covered ever been treated or diagnosed 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. If Question 1, 2, 3, 4 or 5 is answered "yes," the name and the relationship of the person(s) must be shown in the following space. Any person(s) so named will not be covered under the policy. _____

   _____

Complete questions 7 through 13 for additions or reinstatements on nonpayroll sales only.

7. Is anyone to be covered currently confined in a hospital or nursing home, or has a Physician recommended hospitalization? ❑ Yes ❑ No
8. During the past 12 months, have you had any surgical procedure or have you been advised by a Physician to have tests, treatment or surgery that has not yet been done? ❑ Yes ❑ No

9. Has anyone to be covered been confined in a hospital for 14 or more hours within the last 36 months because of any of the following? (Check all that apply.) ❑ Yes ❑ No

- ❑ angina
- ❑ congestive heart failure
- ❑ heart attack
- ❑ heart surgery
- ❑ chronic obstructive pulmonary disease
- ❑ chronic liver disease
- ❑ alcohol or drug abuse
- ❑ peripheral vascular disease
- ❑ Parkinson's disease
- ❑ asthma
- ❑ internal cancer
- ❑ pancreatitis

10. Has anyone to be covered ever been treated or diagnosed by a member of the medical profession as having any of the following? (Check all that apply.) ❑ Yes ❑ No

- ❑ Alzheimer's disease
- ❑ cerebral vascular insufficiency
- ❑ emphysema
- ❑ senile dementia
- ❑ sickle-cell anemia
- ❑ stroke
- ❑ heart bypass surgery involving four or more vessels
- ❑ systemic lupus
- ❑ transient ischemic attack (TIA)
- ❑ end-stage renal disease
- ❑ kidney failure
- ❑ insulin-dependent diabetes
- ❑ Crohn's disease

11. Has anyone to be covered ever been treated or diagnosed 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
12. Has anyone to be covered ever had or been recommended to have an organ transplant? ❑ Yes ❑ No
13. If Question 7, 8, 9, 10, 11 or 12 is answered "yes," the name and the relationship of the person(s) must be shown in the following space. Any person(s) so named will not be covered under the policy. _____

_____

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.

THIS SECTION ONLY APPLIES TO ADDITIONS AND REINSTATEMENT OF SHORT TERM DISABILITY AND ACCIDENT WITH DISABILITY RIDERS

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

I authorize the following to give information (as defined below) to American Family Life Assurance Company of Columbus (Aflac) or any person or entity acting on its part: any medical professional, medical care institution, insurer (including Aflac, with respect to other Aflac coverages), reinsurer, government agency (including departments of public safety and motor vehicle departments), the Medical Information Bureau, consumer reporting agency or employer. "Information" means 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 non-medical facts that Aflac deems appropriate 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 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 re-disclosed 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, GA 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, 26 months from the date the authorization is signed.

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

I understand that the reinstated policy will cover only loss resulting from Injury that takes place after the date of reinstatement and loss resulting from Sickness that is diagnosed or treated more than 10 days after the date of reinstatement.

I have read, or had read to me, the completed application and realize policy reinstatement and/or additions to my policy are based upon statements and answers provided herein. They are complete and true to the best of my knowledge and belief, and I understand that Aflac and I shall have the same rights as provided under the policy(s) immediately before the due date of the defaulted premium, subject to any provisions endorsed on or attached to the policy(s) in connection with the reinstatement. I further understand that coverage under the reinstated policy is subject to the terms set forth in my policy(s) reinstatement provision.

Signature (X): _____ Date: _____

Cafeteria/Section 125 Plans

If premiums for your policy are deducted on a pre-tax basis, this section should be completed by your plan administrator.

Account Approval Signature: _____ Date: _____

Printed Name: _____

MAKE CHECKS PAYABLE TO AFLAC.
FOR INFORMATION, CALL TOLL-FREE 1-800-99-AFLAC (1-800-992-3522).
Fax Number: 1-800-448-8922