AUTHORIZATION TO DISCLOSE INFORMATION

MAIL TO: American Family Life Assurance Company of Columbus
1932 Wynnton Road
Columbus, Georgia 31999-0001

I authorize American Family Life Assurance Company of Columbus, American Family Life Assurance Company of New York, and Continental American Insurance Company (collectively, "Aflac") to disclose information to the Medical Information Bureau (MIB). I understand that this information will be used by MIB for the purpose of assisting the insurance industry in the accurate underwriting of insurance products as well as assisting the insurance industry in facilitating the fair pricing of insurance products through more accurate risk assessment. "Information" includes information in Aflac's possession relating to my physical or mental health or condition (excluding psychotherapy notes, but including, for example, medical diagnosis/treatment information related to underwriting), and nonmedical financial information (including, for example, policy status).

I understand that any disclosure of health information to MIB 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 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 Aflac has taken action in reliance on this authorization. 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, two years from the policy effective date.

I agree that a copy of this authorization is as valid as the original and that I or an authorized representative may request a copy of this authorization.

_____
Printed Name of Individual Subject to Disclosure

_____ _____
Signature Date

If this authorization has been signed by a personal representative on behalf of an individual, his/her authority to act on behalf of the individual must be set forth here:

_____ _____
Printed Name of Legal/Personal Representative Legal Relationship
(e.g. Power of Attorney, Estate Executor)