Payroll

Application for 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
Policy Number:

Please Print in Black Ink – To Be Completed by Proposed Insured/Employee

Proposed Insured's/Employee's Name _____
Last First MI

DOB _____ Sex _____ SSN _____ - _____ - _____
Month/Day/Year (Optional)

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 (optional) _____

Payroll Account Name _____ Payroll Account No. _____

Name of Employer _____ Type of Business _____

Job Duties _____

Job Title _____

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

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 agent and provide the policy number, company name, and Effective Date of the policy being replaced here:

_____

_____

Do you have any other Short-Term Disability coverage with Aflac? ❑ 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 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.

ELIGIBILITY QUESTIONS
TO BE COMPLETED BY PROPOSED INSURED/EMPLOYEE

1. Are you actively working with the employer listed on the first page of this application? ❑ Yes ❑ No

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

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2. Do you work fewer than 19 hours per week with the employer listed on the first page of 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 the first page of 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.**

TO BE COMPLETED BY AFLAC 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. _____ Agent No. _____

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

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

Total Disability Benefit Periods:	☐ 3 Months ☐ 6 Months ☐ 12 Months ☐ 18 Months **(maximum of 30 units)** ☐ 24 Months **(maximum of 30 units)**
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)** ☐ 60/60 Days** ☐ 90/90 Days** ☐ 180/180 Days** **(**not available with 3- or 6-month Total Disability Benefit Period)**

	No. of Units Purchased for this Application	**Premium**	❑ Pre-Tax or ❑ After-Tax
☐ Base Policy Series A57600			
☐ On-the-Job Injury Rider Series A57650 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 the first page of 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			
☐ Additional Units of Disability Benefit Rider Series A57651 (applies to base policy only) **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.	**Total Premium**		

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PLEASE COMPLETE THE FOLLOWING UNDERWRITING QUESTIONS 1–6 IF YOUR INDUSTRY CLASS IS E OR IF YOU ARE APPLYING FOR A BENEFIT PERIOD GREATER THAN SIX MONTHS, MORE THAN 40 TOTAL UNITS OF COVERAGE, OR UPGRADING YOUR EXISTING AFLAC DISABILITY POLICY.

1. Are you currently disabled (diagnosed or treated by a licensed member of the medical profession) due to sickness or injury; or have you been out of work or disabled (diagnosed or treated by a licensed member of the medical profession) due to sickness or injury more than five consecutive days within the last 12 months, excluding colds, influenza, routine childbirth, appendectomy, tonsillectomy, cholecystectomy (gall bladder removal), or hysterectomy? ❑Yes ❑No

2. Do you have any condition for which any medical procedure (including but not limited to surgery, child delivery, or organ or bone marrow transplant) has been planned or the possibility of which has been discussed with a licensed member of the medical profession? ❑Yes ❑No

3. Within the last five years, have you been convicted of a felony, convicted one or more times with operating a vehicle while under the influence of alcohol or drugs, convicted two or more times with a moving violation, or are you currently on parole or incarcerated in a correctional institution? ❑Yes ❑No

For new policies:
- **If you answered Yes to any of Questions 1–3 and your Industry Class is E, a policy will not be issued; therefore, do not submit this application.**
- **If you answered Yes to any of Questions 1–3 and you belong to another Industry Class, you may only apply for the guaranteed-issue limit.**

For upgrades to existing policies, if you answered Yes to any of Questions 1–3, an upgrade will not be issued; therefore, do not submit this application.

4. Within the last six months, have you been diagnosed by a licensed member of the medical profession with any medical condition; received any medical treatment by a licensed member of the medical profession, including injections or chiropractic adjustments; or been prescribed or taken prescription medications (other than prescription contraceptives)? ❑Yes ❑No
   If Yes, please provide descriptive information below.

Height _____ (ft) _____ (in) Current Weight _____ (lbs)

Medical Condition			
Onset (mo/yr)			
Method of Treatment (prescription medications, injections, surgery, physical therapy, etc.)			
Date First Prescribed/Onset of Treatment			
For Hypertension and Diabetes, List the Average Reading (for the last three months)			

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If more medical conditions exist, please use the additional chart provided:

Medical Condition			
Onset (mo/yr)			
Method of Treatment (prescription medications, injections, surgery, physical therapy, etc.)			
Date First Prescribed/Onset of Treatment			
For Hypertension and Diabetes, List the Average Reading (for the last three months)			

5. Within the last 12 months, have you used tobacco products or any other products containing nicotine? ❑ Yes ❑ No

6. a. Do you have any individual disability income coverage in force other than Aflac? ❑ Yes ❑ No
   b. Do you have any group disability income coverage in force other than Aflac? ❑ Yes ❑ No

   If you answered Yes to 6a or 6b, please list your monthly benefit amounts/percentages:_____, your Benefit Period:_____, and your Elimination Period:_____.

ADDITIONAL UNDERWRITING MAY BE REQUIRED.

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 this application was signed by me.
- I understand that (1) Aflac is not bound by any statement made by me, or any agent of Aflac, unless written herein, and (2) the agent cannot change the provisions of the policy or waive any of its provisions, either orally or in writing.
- I understand that (1) the policy, together with this application, and the endorsements, benefit agreements, riders, and attached papers, if any, constitutes the entire contract of insurance; and (2) no change to the policy will be valid until approved by Aflac's president and secretary, and noted in or attached to the policy.
- 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 conditions 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. Routine follow-up care to determine whether a breast cancer has recurred in a person who has been previously determined to be free of breast cancer does not constitute medical advice, diagnosis, care, or treatment for purposes of determining pre-existing conditions, unless evidence of breast cancer is found during or as a result of the follow-up care;
  - Coverage is not provided for an illness, disease, infection, or any other physical condition, independent of Injury, that is diagnosed or treated by a Physician within the first 30 days after the Effective Date of coverage, unless the resulting disability 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 _____

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- If this is an application for a conversion of coverage, I understand that: (1) 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; and (2) 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.

  Proposed Insured's Initials _____

- If I am applying to replace existing Aflac coverage with this policy, I acknowledge that the policies may have different benefits and that I should make a comparison to personally determine which is best for me. I understand and agree that I am terminating my current Aflac policy and its benefits for the benefits provided in this Aflac policy.

  Proposed Insured's Initials _____

- I have reviewed the statements and answers I have provided on this application. I understand that this policy is 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 to the best of my knowledge and belief. 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 this policy.
- I acknowledge receipt of, if applicable:
  - ❑ Replacement Notice
  - ❑ Outline of Coverage
  - ❑ *Guide to Health Insurance for People With Medicare*
  - ❑ Fair Credit Reporting Notice

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.

INFORMATION REGARDING THE MEDICAL INFORMATION BUREAU (MIB)
PRENOTICE

Information regarding your insurability will be treated as confidential. Aflac may, however, make a brief report thereon to MIB Inc. (formerly known as the Medical Information Bureau), a not-for-profit membership organization of insurance companies that operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or submit a claim for benefits to such a company, MIB, upon request, will supply such company with the information in its file. Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB toll-free at 1-866-692-6901 (TTY 1-866-346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

Aflac may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its Web site at mib.com.

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AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

I authorize the following to give information (as defined below) to Aflac or any person or entity acting on its part: 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" 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 nonmedical 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 MIB, Inc.

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 if coverage is 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 to contest the policy itself. My revocation must be submitted in writing to Aflac, Attn: 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.

I would prefer to receive an electronic copy of my policy instead of a paper copy. ❑ Yes ❑ No

Any person who knowingly and with intent to injure, defraud or deceive any insurer, files a statement of claim or an application containing any false, incomplete or misleading information, is guilty of a felony of the third degree.

Signed and Dated at _____ on _____
City and State Date

Proposed Insured's/Employee's Signature _____

I certify that I personally saw the Proposed Insured/Employee when the application was written, and each question was asked of the Proposed Insured/Employee and answered as recorded. All answers recorded are correct to the best of my knowledge.

Agent's Signature _____ Date _____
Licensed Resident Agent

Typed or Printed Name of Agent: _____

Agent Telephone Number: _____

Agent Address: _____

Agent Florida License Number: _____

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 AFLAC.COM.

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