APPLICATION FOR REINSTATEMENT
SHORT-TERM DISABILITY INSURANCE FOR A57600 SERIES
American Family Life Assurance Company of Columbus
(herein referred to as Aflac)

Worldwide Headquarters • Columbus, Georgia 31999
For information, call toll-free 1.800.99.AFLAC (1.800.992.3522).

Policy Number____________________________________

Name of Policyholder ____
Last First MI

DOB ______________________ Sex ________ SSN _________ - _____ - ____________
Month/Day/Year

Driver's License Number______________________ State of Issue_______________ State of Birth_____________

Current Address of Policyholder ____
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) ______________________________________

Former Address of Policyholder ____

City ________________________________ State ____________________ ZIP ____________________________

Name of Employer/Account Name____

Account No. (if applicable) ____

Associate/Agent's Signature and Writing Number ____
Licensed Associate/Agent

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.

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PLEASE COMPLETE THE FOLLOWING ELIGIBILITY QUESTIONS.

IF YOU ARE 70 YEARS OLD OR OLDER, YOU ARE NOT ELIGIBLE FOR REINSTATEMENT OF THE AFLAC VALUE RIDER.

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 reinstated; 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 reinstated; 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 reinstated.**

UNDERWRITING QUESTIONS REQUIRED
TO BE COMPLETED BY PROPOSED INSURED

1. Are you the mother of a child currently conceived but as yet unborn? ❑Yes ❑No ❑ N/A
2. Are you currently disabled due to sickness or injury, or have you been out of work or disabled 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
3. Within the last 12 months, have you been hospitalized more than 24 hours for reasons other than colds, influenza, routine childbirth, appendectomy, tonsillectomy, cholecystectomy (gall bladder removal), or hysterectomy? ❑Yes ❑No
4. Do you have any condition for which any medical procedure (including but not limited to surgery, or organ or bone marrow transplant) has been planned or the possibility of which has been discussed with medical personnel? ❑Yes ❑No
5. Have you been to see a member of the medical profession about a medical condition that has yet to be diagnosed? ❑Yes ❑No
6. Within the last five years, have you been convicted of a felony, charged two or more times with operating a vehicle while under the influence of alcohol or drugs, charged three or more times with a moving violation; or are you currently on parole or incarcerated in a correctional institution? ❑Yes ❑No
7. Do you currently have, or in the last 12 months have you been diagnosed with or treated by a member of the medical profession for any of the following conditions: ❑Yes ❑No

any sort of back, neck, or joint disorder
carpal tunnel syndrome
psoriatic arthritis
rheumatoid arthritis
sciatica
diabetes diagnosed prior to age 30 (excluding gestational diabetes)
AIDS
HIV-positive diagnosis
systemic lupus
muscular dystrophy
Parkinson's Disease
cystic fibrosis
pulmonary hypertension
renal hypertension
Crohn's disease
ileitis
regional enteritis
ulcerative colitis
ulcerative proctitis
vascular insufficiency (circulatory problems)

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8. Within the last five years, have you been diagnosed with or treated by a member of the medical profession for any of the following conditions or had any of the following procedures: ❑Yes ❑No

heart attack
cardiomyopathy
bypass/stents/angioplasty
atrial fibrillation
implant of pacemaker/defibrillator
heart surgery (including valve replacement or correction)
congestive heart failure
stroke/TIA
chronic obstructive pulmonary disease (COPD)
emphysema
pulmonary fibrosis
diabetes and used tobacco after diagnosis
diabetes treated with insulin or other injectable medication
diabetes with complications to include nephropathy, neuropathy, or retinopathy
kidney disease or disorder (not including stones)
liver disease or disorder (excluding Hepatitis A)
fibromyalgia
chronic fatigue syndrome
sarcoidosis
multiple sclerosis
alcohol or drug abuse
internal cancer (to include myelodysplastic blood disorder and myeloproliferative blood disorder)
melanoma (Clark's Level III or higher, or a Breslow Level greater than 1.5 mm)

If you answered Yes to any of Questions 1–8, a policy will not be reinstated; therefore, do not submit this application.

PLEASE COMPLETE THE FOLLOWING UNDERWRITING QUESTIONS 9–11 IF YOUR INDUSTRY CLASS IS E OR IF YOU ARE REINSTATING A BENEFIT PERIOD GREATER THAN SIX MONTHS OR MORE THAN 30 TOTAL UNITS OF COVERAGE.
Additional underwriting may be required.

9. Within the last six months, have you been diagnosed by a member of the medical profession with any medical condition; received any medical treatment, 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)			
Type of Treatment (e.g. – name of 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)			
Type of Treatment (e.g. – name of 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)			

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

11. 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 Yes to 11a or 11b, please list your monthly benefit amounts/percentages:____________, your Benefit Period:______________, and your Elimination Period:________________.

PLEASE COMPLETE THE FOLLOWING QUESTION FOR REINSTATEMENT OF THE ON-THE-JOB INJURY RIDER.

12. 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 to Question 12, 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.

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

I, ___________________________________, am applying to reinstate 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 reinstate 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 reinstated Short-Term Disability policy.

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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.

INFORMATION REGARDING THE MIB PRENOTICE

Information regarding your insurability will be treated as confidential. Aflac or its reinsurers may, however, make a brief report thereon to MIB, Inc., a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted 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. 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, MA 02184-8734.

Aflac, or its reinsurers, 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 website at www.mib.com.

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.

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I, the undersigned Policyholder, agree that by signing below I am submitting an application to Aflac for the reinstatement of my policy. The reinstated policy will cover only loss resulting from a condition that begins on or after the date of reinstatement.

I have read, or had read to me, the completed application and realize policy reinstatement is based upon statements and answers provided herein, 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. I understand, for the purposes of the Time Limit on Certain Defenses provision of the policy, that the Effective Date of the policy shall now be the reinstatement date. I also understand that Aflac and I will have the same rights as provided under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed on or attached to the policy 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.

Signed and Dated at ____ on ______________________
City and State Date

Policyholder's Signature ____

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.

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