APPLICATION FOR REINSTATEMENT/CHANGE FORM
Policy Series A64000
ATTENTION: POLICYHOLDER SERVICES
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_____ SSN_____
Last First M optional

Policy Number_____ Date of Birth_____

(The following is required for reinstatement only) Height _____ _____ Current Weight _____
ft. in. lbs

Current Address of Policyholder_____

City_____ State_____ ZIP_____ Telephone No._____

E-mail Address (optional) _____

Current Employer _____

Associate's/Agent's Signature and Writing Number_____
Licensed Associate/Agent

PLEASE MAKE THE FOLLOWING CHANGES TO MY POLICY:

❑ **ADDRESS CHANGE ONLY**

Former Address of Policyholder_____
Street Apt.No.

City_____ State_____ ZIP_____

New Address of Policyholder_____
Street Apt.No.

City_____ State_____ ZIP_____ Telephone No._____

❑ **TRANSFERS TO PAYROLL OR UNION BILLING ONLY**

Transfer From_____

Transfer To_____ Transfer To_____
Employer Name Account Number

Department No._____ Employee No._____

Amount Remitted $_____ Months_____

Billing Name_____
Last Name First Name MI

Effective Date of Transfer_____

❑ **TRANSFERS TO DIRECT BILLING ONLY**

❑ Bill at Home ❑ Bank Draft (Authorization Form Needed) ❑ Credit Card

Transfer From _____

Direct Billing Mode (select one) ❑ Monthly **(Bank Draft / Credit Card Only)** ❑ Quarterly ❑ Semiannual ❑ Annual

Amount Remitted $_____ Months_____

Effective Date of Transfer_____

❑ **NAME CHANGE ONLY**

Name Shown on Policy_____
Last Name First Name MI Title

Change Name To_____
Last Name First Name MI Title

Reason ❑ Marriage ❑ Divorce ❑ Death ❑ Request

Payroll Billing Name_____(if policy is on Payroll)

Draftee Name _____(if policy is on Bank Draft)

Effective Date of Change _____

NOTE: ADDITIONS CAN ONLY BE MADE TO TERM LIFE POLICIES.

❑ **ADDITIONS ONLY – Complete applicable questions.**

Person(s) to be Added_____
Last Name First Name MI Title

Sex ❑ Male ❑ Female

Relationship ❑ Insured ❑ Spouse ❑ Child

Spouse DOB, if adding spouse_____

Reason for Addition ❑ Marriage ❑ Birth ❑ Request

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

Date of Marriage/Birth/Request _____

CHANGE OF BENEFICIARY INFORMATION

Article 1. The beneficiary under each policy listed above is hereby changed and the following beneficiary is designated to whom the aggregate net proceeds of all said policies maturing as a death claim shall be paid in one sum as specified in this designation in lieu of all prior designations of beneficiaries or provisions for payment of proceeds. The right to change this beneficiary designation is reserved to the owner of the policy.

(Note: If Article 2 is elected, distribution will be made to children of deceased children of the insured in accordance with the provisions of said Article 2.)

BENEFICIARY INFORMATION

PLEASE NOTE: We recommend that you do not name a minor child as your Beneficiary. If you name a minor child as your Beneficiary, any benefits due your minor Beneficiary will not be payable until a guardian for the financial estate of the minor is appointed by the court or such Beneficiary reaches the age of majority as defined by your state. If there is no Beneficiary, Aflac will pay any applicable benefit to your estate.

PRIMARY BENEFICIARY

FULL NAME (Last, First, MI)	RELATIONSHIP	CITY/STATE	DATE OF BIRTH	% OF PROCEEDS

CONTINGENT BENEFICIARY

FULL NAME (Last, First, MI)	RELATIONSHIP	CITY/STATE	DATE OF BIRTH	% OF PROCEEDS

❑ **Article 2. Payment to Children of Deceased Children of the Insured by Representation:** If a child of the insured is designated as a beneficiary, and if such child shall die prior to the time for payment of a share of the net proceeds to such child, the share of net proceeds that would have been paid to such child, if living at the time for such payment, shall be paid in one sum in equal shares to his then living children, if any there be, otherwise in equal shares to the then living brothers and sisters of such deceased child of the insured; provided, however, that children then living of a deceased brother or sister shall receive, equally, the share of net proceeds that would have been paid to their parent if alive. If none of the beneficiaries described in this Article 2 are living at the time for payment as herein provided, the next class of designated beneficiary under Article 1 shall receive payment as provided in said Article 1 without reference to the provisions of this Article 2.

ANSWER THE QUESTIONS BELOW FOR REINSTATEMENTS OR ADDITIONS ON PAYROLL OR UNION SALES ONLY.

COMPLETE QUESTIONS 1–11

1. Are you, the Proposed Insured, actively employed 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. Within the last 12 months, have you used tobacco products, products containing nicotine, and/or any nicotine delivery system? ❑ Yes ❑ No
   If yes, you are not eligible for the 20- or 30-Year Term with Return of Premium Policy Form Series A64400 or A64600.

3. Within the last 12 months, has your spouse used tobacco products, products containing nicotine and/or any nicotine delivery system? ❑ Yes ❑ No ❑ N/A

4. Within the last 12 months, has anyone to be covered been declined for medical reasons on any life insurance application? ❑ Yes ❑ No

5. Within the last five years, has anyone to be covered been convicted of a felony, been charged two or more times with operating a vehicle while under the influence of alcohol or drugs, been charged five or more times with a moving violation, or is currently on parole or incarcerated in a correctional institution? ❑ Yes ❑ No

6. Within the last 12 months, has anyone to be covered been charged with operating a vehicle while under the influence of alcohol or drugs, or does anyone to be covered currently have a suspended or revoked driver's license? ❑ Yes ❑ No

7. Has anyone to be covered ever had an organ transplant, or within the past five years been advised by or consulted with a member of the medical profession about the need to have an organ transplant? ❑ Yes ❑ No

8. Within the last five years, has anyone to be covered been diagnosed with or treated by a member of the medical profession for major depression, bipolar disorder; schizophrenia; or a suicide attempt, or been confined in a hospital or a mental or psychiatric facility within the last 12 months for any mental or nervous disorder? ❑ Yes ❑ No

9. Within the last five years, has anyone to be covered been diagnosed with or treated by a member of the medical profession for: ❑ Yes ❑ No

heart attack
stroke/TIA
atrial fibrillation
heart surgery
pulmonary fibrosis
emphysema
multiple sclerosis
diabetes treated with insulin
coronary artery disease and used tobacco after diagnosis
systemic lupus
implant of pacemaker/defibrillator
chronic lung disease (excluding asthma)
diabetes and used tobacco after diagnosis
liver disease or disorder (excluding Hepatitis A)
kidney disease or disorder (not including stones)
alcohol or drug abuse
diabetes with complications to include nephropathy, neuropathy, or retinopathy
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)

10. Has anyone to be covered ever been diagnosed by a member of the medical profession with or within the last five years received treatment for: ❑ Yes ❑ No

AIDS
HIV-positive diagnosis
cystic fibrosis
chronic renal failure
renal hypertension
heart attack prior to age 40
coronary artery disease -– more than two vessels
cardiomyopathy
heart valve replacement or correction
congestive heart failure
chronic or relapsing pancreatitis
cirrhosis of liver
Parkinson's disease
diabetes (Type II) diagnosed prior to age 30
end-stage renal failure
terminal condition

If you answered yes to any of Questions 4–10, was it the: ❑ Proposed Insured ❑ Spouse ❑ Child?
If child, please list the name(s) of the child(ren).

_____

If a child, are there other children to be covered? ❑Yes ❑ No

If the person named is the Proposed Insured, a policy will not be issued; therefore, do not submit this application. If the person(s) named is the spouse or a child, that person is not eligible to be covered under the policy or any rider(s).

11. Is anyone to be covered currently disabled due to sickness or injury, or in the last two years, has anyone to be covered been hospitalized two or more times, or had surgery recommended that has not yet been performed? If yes, provide details in Item 16 and continue with Questions 12–17. ❑ Yes ❑ No

PLEASE COMPLETE QUESTIONS 12–17 IF (1) YOU ANSWERED YES TO QUESTION 11, OR (2) THE PURCHASE OF THIS COVERAGE WILL RESULT IN YOU HAVING $50,000 OR MORE OF TOTAL LIFE COVERAGE WITH AFLAC, OR (3) THE PURCHASE OF THIS COVERAGE WILL RESULT IN YOUR SPOUSE (IF APPLICABLE) HAVING $50,000 OF TOTAL LIFE COVERAGE WITH AFLAC.

12. Has anyone to be covered ever been diagnosed by a member of the medical profession or within the past five years been treated for a heart disease or disorder (including congenital), high blood pressure (hypertension), lupus, Crohn's disease, ulcerative colitis, diabetes, kidney disease, respiratory or neurological disorder or disease, depression, blood disorders, or a tumor or cancer? ❑ Yes ❑ No

13. In the last five years, has anyone to be covered missed five consecutive days of work due to sickness (not including days missed due to childbirth)? ❑ Yes ❑ No

14. In the last five years, has anyone to be covered been treated by a member of the medical profession or had surgery at a medical facility as an inpatient or outpatient (not including treatment or surgery due to childbirth) or had surgery recommended that has not yet been performed? ❑ Yes ❑ No

PLEASE COMPLETE THE FOLLOWING QUESTION IF APPLYING FOR THE CHILD RIDER

15. Has any child to be covered been diagnosed by a member of the medical profession or within the last five years been treated for a congenital heart defect or blood disorder? ❑ Yes ❑ No

If you answered yes to any Question 12–15, please provide details in Item 16.

16. **Details to Questions 11–15**

	Name of Individual(s)	Medical Condition(s)	Onset (mo/yr)	Surgery Performed or Recommended? (If yes, provide the type of procedure and date.)	For Hypertension and Diabetes, List the Average Reading (for the last three months).
Question 11					
Question 12					
Question 13					

Question 14					
Question 15					

17. Within the last six weeks, has anyone to be covered been prescribed or taken any medication recommended by a Physician (not including prescription contraceptives)? ❑ Yes ❑ No
If yes, please provide complete information below:

Name of Individual(s)	Name of Medication	Frequency of Intake	Date First Prescribed	Medical Condition Taken For

Your Physician's Name _____ Phone Number _____
(if no regular Physician, Physician last seen)

Address _____

Date Last Seen by Physician _____ Reason for Last Visit _____

Additional Underwriting May Be Required.

ANSWER THE QUESTIONS BELOW FOR REINSTATEMENTS OR ADDITIONS ON NONPAYROLL SALES ONLY.

COMPLETE QUESTIONS 1–16

1. Within the last 12 months, has anyone to be covered been declined for medical reasons on any life insurance application? ❑ Yes ❑ No

2. Within the last five years, has anyone to be covered been convicted of a felony, been charged two or more times with operating a vehicle while under the influence of alcohol or drugs, been charged five or more times with a moving violation, or is currently on parole or incarcerated in a correctional institution? ❑ Yes ❑ No

3. Within the last 12 months, has anyone to be covered been charged with operating a vehicle while under the influence of alcohol or drugs or does anyone to be covered currently have a suspended or revoked driver's license? ❑ Yes ❑ No

4. Has anyone to be covered ever had an organ transplant, or within the past five years been advised by or consulted with a member of the medical profession about the need to have an organ transplant? ❑ Yes ❑ No

5. Within the last five years, has anyone to be covered been diagnosed with or treated by a member of the medical profession for major depression, bipolar disorder; schizophrenia; or a suicide attempt, or been confined in a hospital or a mental or psychiatric facility within the last 12 months for any mental or nervous disorder? ❑ Yes ❑ No

6. Within the last five years, has anyone to be covered been diagnosed with or treated by a member of the medical profession for any of the following conditions? ❑ Yes ❑ No

heart attack
stroke/TIA
atrial fibrillation
heart surgery
pulmonary fibrosis
emphysema
multiple sclerosis
diabetes treated with insulin
coronary artery disease and used tobacco after diagnosis
systemic lupus
implant of pacemaker/defibrillator
chronic lung disease (excluding asthma)
diabetes and used tobacco after diagnosis
liver disease or disorder (excluding Hepatitis A)
kidney disease or disorder (not including stones)
alcohol or drug abuse
diabetes with complications to include nephropathy, neuropathy, or retinopathy
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)

7. Within the last five years, has anyone to be covered been diagnosed with or treated by a member of the medical profession for: ❑ Yes ❑ No

AIDS
HIV-positive diagnosis
cystic fibrosis
chronic renal failure
renal hypertension
heart attack prior to age 40
coronary artery disease – more than two vessels
cardiomyopathy
heart valve replacement or correction
congestive heart failure
chronic or relapsing pancreatitis
cirrhosis of liver
Parkinson's disease
diabetes (Type II) diagnosed prior to age 30
end stage renal failure
terminal condition

If you answered yes to any of Questions 1–7 was it the: ❑ Proposed Insured ❑ Child?
If child, please list the name(s) of the child(ren)

_____

If a child, are there other children to be covered? ❑ Yes ❑ No

If the person named is the Proposed Insured, a policy will not be issued; therefore, do not submit this application. If the person(s) named is the child, that person is not eligible to be covered under the policy or any rider(s).

8. Is anyone to be covered currently disabled due to sickness or injury or in the last two years, has anyone to be covered been hospitalized two or more times or had surgery recommended that has not yet been performed? ❑ Yes ❑ No

9. In the last five years, has anyone to be covered missed five consecutive days of work due to sickness (not including days missed due to childbirth)? ❑ Yes ❑ No

10. Has anyone to be covered ever been diagnosed by a member of the medical profession or within the past five years been treated for a heart disease or disorder (including congenital), high blood pressure (hypertension), lupus, Crohn's disease, ulcerative colitis, diabetes, kidney disease, respiratory, or neurological disorder or disease, depression, blood disorders, or a tumor or cancer? ❑ Yes ❑ No

IF YOU ANSWERED YES TO ANY OF QUESTIONS 8–10, COMPLETE ITEM 11 BELOW.

11. **Details to Questions 8–10**

	Name of Individual(s)	Medical Condition(s)	Onset (mo/yr)	Surgery Performed or Recommended? (If yes, provide the type of procedure and date.)	For Hypertension and Diabetes, List the Average Reading (for the last three months).
Question 8					
Question 9					
Question 10					

12. **Within the last six weeks, has anyone to be covered been prescribed or taken any medication recommended by a Physician (not including prescription contraceptives)?** ❑ Yes ❑ No
If yes, please provide complete information below:

Name of Individual(s)	Name of Medication	Frequency of Intake	Date First Prescribed	Medical Condition Taken For

Your Physician's Name_____ Phone Number_____
(if no regular Physician, Physician last seen)

Address_____

Date Last Seen by Physician_____ Reason for Last Visit_____

13. Are you a citizen of the United States? ❑ Yes ❑ No
If no, copies of your permanent visa or proof of permanent residence must be submitted with application.

QUESTIONS 15–16 DO NOT APPLY TO THE CHILD RIDER.

14. Have you ever engaged in or within the next two years do you intend to engage in any hazardous sports or avocations such as sky diving, scuba diving, hang gliding, motorized vehicle racing, cave exploration, bungee jumping, parachuting, or mountain or rock climbing; or operating, riding in, or descending from any aircraft while a pilot, officer, or member of the crew of an aircraft, having any duties aboard an aircraft, or giving or receiving any kind of training or instruction aboard an aircraft? ❑ Yes ❑ No

    If yes, list the activity and frequency _____

15. In the next two years, do you intend to travel or reside outside the United States? ❑ Yes ❑ No

    If yes, where? _____ When? _____

    Purpose/Why? _____

    Mode of travel? _____

    Length of stay? _____

16. Are you currently employed? ❑ Yes ❑ No
    If yes, what is your annual income? _____

Additional Underwriting May Be Required.

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, Kansas, Maine, Massachusetts, Minnesota, Montana, Nevada, New Jersey, North Carolina, Ohio, Oregon, Virginia, and Wisconsin.

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), 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 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 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, 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, 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.

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 the MIB, Inc., formerly known as Medical Information Bureau, 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 (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 www.mib.com.

I have read, or had read to me, the completed application. I realize that coverage under the policy is based upon statements and answers provided herein, and they are complete and true. All statements made in this application are deemed representations and not warranties. I realize that any material misrepresentation therein may result in loss of coverage under the policy.

Signed and Dated at_____ on_____
City and State Date

Applicant's Signature (X)_____

Owner, if Other Than Applicant_____ on_____

I certify that I personally saw the applicant when the application was completed, and each question was asked of the applicant and answered as recorded. All answers are correct to the best of my knowledge.

Associate's/Agent's Signature_____

Date_____ Associate's/Agent's Writing Number_____ Sit. Code_____

MAKE CHECKS PAYABLE TO AFLAC.
FOR INFORMATION, CALL TOLL-FREE 1-800-99-AFLAC (1-800-992-3522).
VISIT OUR WEB SITE AT AFLAC.COM.