ENROLLMENT FORM FOR LIFE INSURANCE

American Family Life Assurance Company of Columbus (AFLAC)
Worldwide Headquarters: Columbus, Georgia 31999

❒ **I desire to become a member of the AFLAC INSURANCE TRUST**

Plan Code: GBGA

If you have been issued our Convalescent Care or Medicare Supplement policy within the last 60 days, this coverage is guaranteed issue. The underwriting question is waived. Your Convalescent Care or Medicare Supplement policy number is:_____

Number of units applied for: ☐

BILLING TYPE

INFORMATION FOR PROPOSED INSURED: MODE: ☐ Mo ☐ Qrtly ☐ S-A ☐ Annual PR ☐ BD ☐ Direct ☐ CC ☐

FULL NAME	FULL MAILING ADDRESS		
	Street		
Phone No.:( )	City	State	Zip Code

Sex _____ Age _____ Date of Birth _____ - _____ - ____ Social Security Number _____ - _____ - _____

Height _____ ft. _____ ins. Weight _____ lbs. Occupation _____ Married: ☐ Yes ☐ No

Name of Employer/Organization: _____
If none, so state

Beneficiary: _____
Name, Address, Relationship

PLEASE COMPLETE THE FOLLOWING MEDICAL INFORMATION FOR PROPOSED INSURED:

During the last two years have you been diagnosed as having or been treated for cancer, heart disease, heart attack, stroke, any type circulatory disorder or are you currently in a hospital or any type nursing facility? . . . . . ☐ Yes ☐ No

IF "YES," GIVE DETAILS IN THE SPACE PROVIDED BELOW: Provide name of condition, date diagnosed, date treatment ended and the name and address of the attending physician.

N/A

(Additional space provided on back of this application)

Personal Physician of Proposed Insured: (If none, write none) Name: _____ Phone Number: _____

Address: _____

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

I understand: that no insurance is in effect until I am issued a Certificate of Coverage by American Family Life Assurance Company (AFLAC); that the effective date of the coverage will not be the date I signed this application but will be the date shown in the Certificate of Coverage; and that during the first 2 years of coverage only the Accidental-Death Benefit or return of premium is payable.

I authorize the following to give information (defined below) to American Family Life Assurance Company (AFLAC) or any person or group acting on the part of American Family Life Assurance Company (AFLAC): any medical professional, medical care institution, the Medical Information Bureau, Inc., insurer, reinsurer, government agency, consumer reporting

agency, or employer. "Information" means facts of: a medical nature in regard to my physical or mental condition: employment; other insurance coverage; or any other non-medical facts. I understand that this information will be used by American Family Life Assurance Company (AFLAC) to determine eligibility for insurance. I agree that this Authorization is valid for two and one-half years from the date signed. I know that I have the right to receive a copy of this Authorization upon request. I agree that a photographic copy of this Authorization is as valid as the original.

I acknowledge receipt of the Notice of Information Practices, including the notices explaining my rights under the Fair Credit Reporting Act as it pertains to investigative consumer reports and the Medical Information Bureau.

To the best of my knowledge and belief the statements and answers recorded in this application are true and complete.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

Dated At _____ this _____ day of _____, 19 _____

Proposed Insured's Signature: X _____

To the best of my knowledge and belief the proposed insured is a good risk for the insurance being applied for.

Associate's Signature: _____ Writing No. _____ Sit Code _____ Premium Sub._____

Associate's Address _____ Associate's Telephone No._____