Payroll

Application for Individual Life Insurance (Series ICC1368000)
Application to:
AMERICAN FAMILY LIFE ASSURANCE COMPANY OF COLUMBUS
(herein referred to as Aflac)
Worldwide Headquarters • Columbus, Georgia 31999

Policy Number
❑ New

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

Proposed Insured's Name _____
Last First MI

DOB _____ Sex _____ Height _____ _____ Current Weight _____ SSN _____ - _____ - _____
Month/Day/Year ft. in. lbs. (Required)

Driver's License Number _____ State of Issue _____ State of Birth _____

Proposed Insured's Address _____
Street or Post Office Box Apt. No.

City _____ State _____ ZIP Code _____

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

E-mail Address (optional) _____

Name of Proposed Insured's Employer _____

Occupation _____

Employee Hire Date _____

(Write spouse's name below if spouse is applying for coverage; if no spouse or spouse will not be covered, put "N/A" or "none.")

Spouse's Name _____ DOB _____ Sex _____
Last First MI Month/Day/Year

PLEASE COMPLETE THE FOLLOWING ELIGIBILITY QUESTIONS

1. **Are you, the Proposed Insured, actively working with the employer listed on this application?** **❑ Yes ❑ No**
   If no, 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**
3. **(a) Is your Spouse, if applying for coverage, actively working?** **❑ N/A ❑ Yes ❑ No**
   (b) If no to 3(a), is your Spouse now hospitalized, in a nursing facility, or unable to work due to a medical condition, injury or disability? *If yes to 3(b), your Spouse is not eligible for coverage.* **❑ N/A ❑ Yes ❑ No**
   (c) Within the last 12 months, has your spouse used tobacco products, products containing nicotine, and/or any nicotine delivery system? **❑ N/A ❑ Yes ❑ No**

Do you have any other life coverage, not to include Voluntary Group Term Life, with Aflac? ❑ Yes ❑ No
If yes, give current policy number: _____

Will the purchase of this life insurance policy give you more than $500,000 total face value ($200,000 if over age 50) of life insurance coverage with Aflac? ❑ Yes ❑ No

Will the purchase of the spouse rider give your spouse more than $50,000 total face value of life insurance coverage with Aflac? ❑ N/A ❑ Yes ❑ No

Is the purchase of this policy intended to replace any life insurance or annuity now in force? ❑ Yes ❑ No
If yes, please read and sign the Replacement Notice provided by your associate/agent, if applicable.

Total life coverage with Aflac for the Proposed Insured cannot exceed $500,000 ($200,000 if over age 50).
Total life coverage with Aflac for the proposed spouse cannot exceed $50,000.

Total number of units for the Proposed Insured are limited as follows:
- 2 to 100 units at $5,000 per unit if age 50 or younger
- 2 to 40 units at $5,000 per unit if age 51 or older

PLEASE NOTE: The optional spouse rider coverage equals $2,500 per unit. The term and number of units of the optional spouse rider coverage must match the Proposed Insured's coverage, not to exceed 20 units.

Exception: If the spouse does not qualify by age for the matching term, he or she may apply for a 10-year term rider, if eligible.

CHECK COVERAGE DESIRED:	**Issue Ages**	**Total Number of Units**	**Face Amount of Insurance**
WHOLE LIFE **NOT AVAILABLE ON A GUARANTEED-ISSUE BASIS**			
☐ Whole Life Policy (Series ICC1368100) ☐ **Automatic Premium Loan**	18-70		
☐ Spouse 10-Year Term Life Insurance Rider (Series ICC1368050)	18-68		

TERM LIFE			
☐ 10-Year Term Policy (Series ICC1368200)	18–68		
☐ Spouse 10-Year Term Life Insurance Rider (Series ICC1368050)	18–68		
☐ 20-Year Term Policy (Series ICC1368300)	18–60		
☐ Spouse 20-Year Term Life Insurance Rider (Series ICC1368051)	18–60		
☐ Spouse 10-Year Term Life Insurance Rider (Series ICC1368050)	18–68		
☐ 30-Year Term Policy (Series ICC1368400)	18–50		
☐ Spouse 30-Year Term Life Insurance Rider (Series ICC1368052)	18–50		
☐ Spouse 10-Year Term Life Insurance Rider (Series ICC1368050)	18–68		

Optional Child Rider **PLEASE NOTE: $1,250 per unit (total number of units must match the Proposed Insured, not to exceed 12 units.)**	**Issue Ages**	**Total Number of Units**	**Face Amount of Insurance**
☐ Child Term Life Insurance Rider (Series ICC1368053)	14 days* to 17 years		

*The Effective Date of coverage for any eligible newborn child will not begin until the later of: (1) the date any eligible newborn child attains the age of 14 days or (2) the date any eligible newborn child is first released from the hospital after birth.

Optional Riders (Proposed Insured Only)
☐ Waiver of Premium Rider (Series ICC1368054) Issue Ages 18-59 **NOT AVAILABLE ON A GUARANTEED-ISSUE BASIS**
☐ Accidental-Death Benefit Rider (Series ICC1368055)

Billing Method:	**Mode:**	
❑ Payroll Deduction	❑ 01 Weekly	❑ 01 Monthly
❑ Bank Draft (B/D)	❑ 01 14-Day Biweekly	❑ 03 Quarterly
❑ Credit Card (C/C)	❑ 01 Semimonthly	❑ 06 Semiannual
	❑ 01 28-Day Biweekly	❑ 12 Annual

PLEASE NOTE: If the B/D or C/C billing method is checked, only the following modes of payment are available: Monthly, Quarterly, Semiannual, or Annual.

Employee No. _____ Dept. No. _____ Assoc./Agent's No. _____

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

I am applying for the Guaranteed-Issue Amount of $20,000 or $25,000; therefore, the underwriting questions are not required to be answered by the primary Proposed Insured. ❑ Yes ❑ No

PLEASE COMPLETE QUESTIONS 1-7 IF: (1) NOT APPLYING FOR A GUARANTEED-ISSUE AMOUNT, (2) APPLYING FOR A WHOLE LIFE POLICY, OR (3) APPLYING FOR A SPOUSE OR CHILD TERM RIDER.

1. 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, or been charged five or more times with a moving violation; or is anyone to be covered currently on parole or incarcerated in any detention facility or penal institution? ❑ Yes ❑ No

2. 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

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

4. 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

5. 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)

6. 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
Parkinson's disease
diabetes (Type II) diagnosed prior to age 30
end-stage renal failure
terminal condition
amyotrophic lateral sclerosis (ALS)
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

If you answered yes to any of Questions 1–6, 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).

7. Is anyone to be covered currently disabled due to sickness or injury, or within 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
   If yes, provide details in Item 12 and continue with Questions 8–11.

PLEASE COMPLETE QUESTION 8 IF APPLYING FOR THE CHILD RIDER

8. Has any child to be covered ever 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 yes, provide details in Item 12 and continue with Questions 9–11.

PLEASE COMPLETE QUESTIONS 9–11 IF (1) YOU ANSWERED YES TO QUESTION 7, 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.

9. Has anyone to be covered ever been diagnosed by a member of the medical profession or within the last 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

10. Within 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

11. Within 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

If you answered yes to any of Questions 7–11, please provide details in Item 12.

12. **Details to Questions 7–11**

	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 7					
Question 8					
Question 9					
Question 10					
Question 11					

13. 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.

BENEFICIARY INFORMATION

PLEASE NOTE: Your Beneficiary will be your estate unless otherwise indicated.

If you name a trust as your Beneficiary, please include full name of trust.

We do not recommend that you 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. We suggest you obtain legal advice before naming a minor child as your Beneficiary.

Primary Beneficiary(ies):
NOTE: Total % of Proceeds must equal 100%

(1) Name _____ % of Proceeds _____
Last Name First Name MI

Or Trustee(s) of _____
Name of Trust

Trust under trust agreement dated _____

Address _____
Street Address City State Zip

Telephone No. _____ SSN _____ - _____ - _____

Date of Birth _____ Relationship to Insured _____

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(2) Name _____ % of Proceeds _____
Last Name First Name MI

Or Trustee(s) of _____
Name of Trust

Trust under trust agreement dated _____

Address _____
Street Address City State Zip

Telephone No. _____ SSN _____ - _____ - _____

Date of Birth _____ Relationship to Insured _____

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(3) Name _____ % of Proceeds _____
Last Name First Name MI

Or Trustee(s) of _____
Name of Trust

Trust under trust agreement dated _____

Address _____
Street Address City State Zip

Telephone No. _____ SSN _____ - _____ - _____

Date of Birth _____ Relationship to Insured _____

(4) Name _____ % of Proceeds _____
Last Name First Name MI

Or Trustee(s) of _____
Name of Trust

Trust under trust agreement dated _____

Address _____
Street Address City State Zip

Telephone No. _____ SSN _____ - _____ - _____

Date of Birth _____ Relationship to Insured _____

Contingent Beneficiary(ies):
NOTE: Total % of Proceeds must equal 100%

(1) Name _____ % of Proceeds _____
Last Name First Name MI

Or Trustee(s) of _____
Name of Trust

Trust under trust agreement dated _____

Address _____
Street Address City State Zip

Telephone No. _____ SSN _____ - _____ - _____

Date of Birth _____ Relationship to Insured _____

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(2) Name _____ % of Proceeds _____
Last Name First Name MI

Or Trustee(s) of _____
Name of Trust

Trust under trust agreement dated _____

Address _____
Street Address City State Zip

Telephone No. _____ SSN _____ - _____ - _____

Date of Birth _____ Relationship to Insured _____

(3) Name _____ % of Proceeds _____
Last Name First Name MI

Or Trustee(s) of _____
Name of Trust

Trust under trust agreement dated _____

Address _____
Street Address City State Zip

Telephone No. _____ SSN _____ - _____ - _____

Date of Birth _____ Relationship to Insured _____

(4) Name _____ % of Proceeds _____
Last Name First Name MI

Or Trustee(s) of _____
Name of Trust

Trust under trust agreement dated _____

Address _____
Street Address City State Zip

Telephone No. _____ SSN _____ - _____ - _____

Date of Birth _____ Relationship to Insured _____

PROPOSED INSURED'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 I signed this application.
- I acknowledge receipt of, if applicable:
  - ❑ Replacement Notice
  - ❑ Life Buyer's Guide
- I understand that (1) the policy, together with this application, 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 (1) Aflac is not bound by any statement made by me, or any associate/agent of Aflac, unless written herein, and (2) the associate/agent cannot change the provisions of the policy or waive any of its provisions either orally or in writing.
- 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 have read, or had read to me, 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 understand that Aflac will have no liability until (1) a policy is issued on this application and delivered to and accepted by the Owner, and (2) the first premium due is paid in full while each Proposed Insured is alive.

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, 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.

I prefer to receive an electronic copy of my policy instead of a paper copy. ❑ Yes ❑ No
If yes, please enter your email address on Page 1.

Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Signed and Dated At _____ on _____
City and State Date

Proposed Insured's Signature _____

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

To the best of my knowledge, this policy will ❑ will not ❑ replace or change any existing life insurance or annuity policy(ies).

Associate's/Agent's Signature _____ Date _____
Licensed Associate/Agent

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.