Nonpayroll Base

Application for Accident Insurance (A-34000 Series) – base plan
Application to American Family Life Assurance Company of Columbus (AFLAC)
Worldwide Headquarters: Columbus, Georgia 31999

❑ New
❑ Conversion

Policy Number

Please print in black ink.

TO BE COMPLETED BY APPLICANT

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

Applicant's SS No. _____ - _____ - _____ Dependent Children ❑ Yes ❑ No

(Write spouse's name below if you are applying for family coverage; if no spouse or if spouse is not to be covered, put N/A in space below.)

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

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

City _____ State _____ ZIP _____

Home Telephone (____) _____ Business Telephone (____) _____ Best Time to Call _____

Name of Employer _____ Type of Business _____

Job Duties _____

Job Title _____

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

Do you have another accident policy with AFLAC? ❑ Yes ❑ No
If yes, is this a change of that coverage? ❑ Yes ❑ No If yes, give current policy number: _____
Is the purchase of this coverage intended to replace any other health insurance now in force? ❑ Yes ❑ No
If yes, please read and sign the Replacement Notice, if applicable, provided by your associate/agent and provide the policy number here _____

TO BE COMPLETED BY AFLAC ASSOCIATE/AGENT

Billing Method:
❑ Direct
❑ Emp. Nonpayroll/Assoc.
❑ Bank Draft (B/D, ACH)
❑ Credit Card (C/C)

Mode:
❑ 01 Monthly (B/D & C/C Only)
❑ 03 Quarterly
❑ 06 Semiannual
❑ 12 Annual

Card Name _____ Card No. _____ Expiration Date _____

I authorize American Family Life Assurance Company of Columbus (AFLAC) to charge my VISA/MASTERCARD/AMERICAN EXPRESS account in accordance with the premium rate that I have chosen. Premiums will be advanced by my bank until I cancel authorization in writing to AFLAC. Cancellation will be effective on the first day of the month following AFLAC's receipt of notice to cancel.

Signature _____ Date _____

Assoc./Agent No. _____ Sit. Code _____ Billable Premium $ _____ Premium Collected $ _____

CHECK COVERAGE DESIRED: ❑ Individual ❑ One-Parent Family ❑ Two-Parent Family ❑ Named Insured/Spouse Only

Class: ☐ A ☐ B ☐ C ☐ D ☐ E

	Total No. of Units	Premium
❑ Level 1 Policy Series A-34100		
❑ Level 2 Policy Series A-34200		
	Total Premium	

PLEASE COMPLETE QUESTIONS 1 and 2

1. Have you or has anyone to be covered by this policy been charged with driving under the influence of alcohol or any narcotic within the last 12 months or been charged two or more times within the last five years? If yes, please list the name and the relationship of each person on the line below. Any person so named will not be covered under the policy. ❑ Yes ❑ No

   _____

   If a person so named is the primary insured, a policy will not be issued; therefore, do not submit this application.
2. In the past 12 months, has a member of the medical profession diagnosed you (or anyone to be covered) with or treated you for an Injury, disease, or disorder of the back, the neck, or a joint? ❑ Yes ❑ No

IF YOU ANSWERED YES TO QUESTION 2, YOU MUST COMPLETE ITEM 3 AND PROVIDE DETAILS IN ITEM 4.

3. **Within the last six weeks, have you been prescribed any medication by a Physician or taken any prescription medication (not including prescription contraceptives)?** If yes, please provide complete information below. ❑ Yes ❑ No

Medication Name	Dosage	Frequency	Date First Prescribed	Reason

4. **Details to Question 2**

	Medical Conditions	Onset (mo/yr)	Surgery Performed? (If yes, provide the type of procedure and date)
Question 2			

APPLICANT'S STATEMENTS AND AGREEMENTS

5. I understand that the Effective Date of the policy will be the date recorded in the Policy Schedule by AFLAC Worldwide Headquarters.
6. I acknowledge receipt of, if applicable:
   - ❑ Replacement Notice
   - ❑ Outline of Coverage
   - ❑ *Guide to Health Insurance for People With Medicare*
   - ❑ Fair Credit Reporting Notice
7. I understand that: (1) the policy of insurance I am now applying for will be issued based upon the written answers to the questions and information asked for in this application and any other pertinent information AFLAC may require for proper underwriting; (2) AFLAC is not bound by any statement made by me, or any associate/agent of AFLAC, unless written herein; (3) the associate/agent cannot change the provisions of the policy or waive any of its provisions either orally or in writing; (4) the policy, together with this application, endorsements, benefit agreements, riders, and attached papers, if any, constitutes the entire contract of insurance; and (5) no change to the policy will be valid until approved by AFLAC's secretary and president and noted in or attached to the policy.

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, Nevada, New Jersey, North Carolina, Ohio, Oregon, and Virginia.

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), 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 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 re-disclosed 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, 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 have read, or had read to me, the completed application and realize that policy issuance 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 to the best of my knowledge and belief.

I elect this coverage as individual coverage.

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or associate/agent of an insurance company who knowingly provides false, incomplete, or misleading information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Signed and Dated at _____ on _____
City and State Date

Applicant's Signature (X)_____

Beneficiary (your estate unless otherwise indicated) _____
Relationship

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

Associate/Agent Signature _____ _____
Licensed Associate/Agent Date

MAKE CHECK OR MONEY ORDER PAYABLE TO AFLAC.
FOR INFORMATION, CALL TOLL-FREE 1-800-99-AFLAC (1-800-992-3522).

For policies that provide benefits for expenses incurred for an accidental injury only

IMPORTANT NOTICE TO PERSONS ON MEDICARE:
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE.

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses that result from accidental injury. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

* hospitalization
* physician services
* other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance:

* Check the coverage in **all** health insurance policies you already have.
* For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
* For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.