

Non-Payroll

Application for Cancer Indemnity Insurance (A-75000 Series)
Application to: American Family Life Assurance Company of Columbus (AFLAC)
Worldwide Headquarters: Columbus, Georgia 31999

Policy Number:
[ ] New
[ ] Conversion

To Be Completed by Applicant: Please Print in Black Ink

Applicant's Name Last First MI DOB Month/Day/Year Sex
Applicant's SSN - - Dependent Children [ ] Yes [ ] No
Spouse's Name Last First MI DOB Month/Day/Year Sex
Address Street or Post Office Box Apt.No.
City State ZIP Code
Home Telephone ( )
Policyowner's Name Relationship to Applicant
Address Street or Post Office Box Apt.No.
City State ZIP Code

Is this insurance intended to replace any other health insurance now in force? [ ] Yes [ ] No
If yes, please read and sign the Replacement Notice provided by your agent and provide policy number and company name here:

TO BE COMPLETED BY AFLAC AGENT

Check Coverage Desired:
[ ] Individual [ ] One-Parent Family
[ ] Two-Parent Family [ ] Family
Level 1: Policy (Series A-75100) [ ] CCAIPA [ ] CCAIPD
Level 2: Policy (Series A-75200) [ ] CCAIPB [ ] CCAIPE
Level 3: Policy (Series A-75300) [ ] CCAIPC [ ] CCAIPF

Optional Rider:
Building Benefit Rider (Series A-75050) Units [ ] CCAIPG [ ] CCAIPK
Return of Premium Rider (Series A-75051) [ ] CCAIPH [ ] CCAIPL
Specified-Disease Rider (Series A-75052) [ ] CCAIPJ [ ] CCAIPM

Billing Method: [ ] Direct [ ] Emp. Non-payroll/Assoc. [ ] 01 Monthly (B/D & C/C Only) [ ] 06 Semiannual
[ ] Bank Draft (B/D, ACH) [ ] Credit Card (C/C) [ ] 03 Quarterly [ ] 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...
Signature Date
Agent's No. Sit. Code Billable Premium \$ Premium Collected \$

**PLEASE COMPLETE THE FOLLOWING QUESTIONS:**

1. Have you or has anyone to be covered received a health screening that tests for the presence of Cancer, (such as a mammogram, Pap smear, PSA, chest x-ray or colonoscopy), or been advised by a member of the medical profession to receive a follow-up test for the presence of Cancer, for which you have not received the results?  Yes  No

If yes, was it the  Named Insured  Spouse  Child? Name of the child(ren):

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**Any individual(s) indicated above will not be covered under the policy.**

2. Within the past 90 days have you or has anyone to be covered received abnormal test results from a health screening test for evaluation of the presence of Cancer?  Yes  No

If yes, was it the  Named Insured  Spouse  Child? Name of the child(ren):

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**Any individual(s) indicated above will not be covered under the policy.**

3. Have you or has anyone to be covered under this policy ever been diagnosed or treated for Cancer of any type or form?  Yes  No

If no skip to number 9 or number 7 if this is a conversion. If yes, please complete numbers 4 and 5.

4. Was any Cancer referred to in number 3 an internal Cancer (which includes melanomas Clark's Level III, or higher or a Breslow level greater than 1.5 mm):
- (a) diagnosed or treated within the last ten years (two years for breast cancer) or for which preventive Hormonal Therapy has been received within the last 12 months?  Yes  No

If yes, was it the  Named Insured  Spouse  Child? Name of the child(ren):

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**Any individual(s) indicated above will not be covered under the policy.**

- (b) last diagnosed or treated over ten years (two years for breast cancer) ago?  Yes  No
- If yes, was it the  Named Insured  Spouse  Child? Name of the child(ren):

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**Please complete a Cancer History Form provided by your agent on any individual(s) listed.**

5. Was any Cancer referred to in number 3 a Skin Cancer (which includes melanomas Clark's Level I or II, or a Breslow level less than or equal to 1.5 mm):
- (a) diagnosed or treated within the last ten years?  Yes  No

If yes, was it the  Named Insured  Spouse  Child? Name of the child(ren):

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**Any individual(s) indicated above will be issued a Skin Cancer Exclusion Rider. Benefits will not be payable under this policy for the indicated individual for the treatment of Skin Cancer.**

- (b) last diagnosed or treated over ten years ago?  Yes  No
- If yes, was it the  Named Insured  Spouse  Child? Name of the child(ren):

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**Any individual(s) indicated above will not be issued a Skin Cancer Exclusion Rider. Benefits will be payable under this policy for the indicated individual for the treatment of Skin Cancer.**

If you answered yes to number 3 and this is a conversion, please complete the conversion section below.

**YOU MUST COMPLETE THIS SECTION IF THIS IS A CONVERSION.**

**IF** your answer to number 3 above was “yes,” complete number 6 below. If no, skip to number 7.

6. Have you or any person to be covered under this policy received benefits, other than Wellness Benefits, under your existing AFLAC Cancer policy in the last ten years?  Yes  No  
If yes, was it  Named Insured  Spouse  Child? Name of the child(ren):

**Any individual(s) indicated above will not be covered under the policy.**

7. If this is an application for a conversion, the following conditions apply: (a) If Cancer is diagnosed between the date this application is signed and the Effective Date of the policy shown in the Policy Schedule, the policy for which this application is made will be void and coverage will continue under the terms of the previous policy, which may remain in force. Any benefits that may be due will be paid under the previous policy. (b) The waiting period provision will run from the Effective Date of the original policy, and the original policy will be terminated as of the Effective Date of the new policy. Any premium paid on the original policy that is unearned as of the Effective Date of the new policy will be applied to the new policy.
8. I acknowledge that I was offered the Building Benefit Rider and declined it. I understand that by not applying for the Building Benefit Rider that I will lose the building benefit accrued in my previous policy, if any.  
 Yes  
Applicant's Initials: \_\_\_\_\_  
 N/A

9. The Effective Date of this policy will be the date recorded on the Policy Schedule by AFLAC. **It is not the date the application is signed.** This policy contains a 30-day waiting period. If a covered person has Cancer diagnosed before coverage has been in force 30 days from the Effective Date of coverage shown in the Policy Schedule, benefits for treatment of that Cancer will apply only to treatment occurring after two years from the Effective Date of the policy or, at your option, you may elect to void the policy from its beginning and receive a full refund of premium.
10. I acknowledge receipt of, if applicable:  
 Fair Credit Reporting Notice  *Guide To Health Insurance for People with Medicare*  
 Replacement Notice  Outline of Coverage
11. I understand that: (a) the policy of insurance I am now applying for will be issued based upon the written answers to questions and information asked for in this application and any other pertinent information AFLAC may require for proper underwriting; (b) AFLAC is not bound by any statement made by me, or any agent of AFLAC, unless written herein; (c) the agent cannot change the provisions of the policy or waive any of its provisions either orally or in writing; (d) the policy, together with this application, endorsements, benefit agreements, riders and attached papers, if any, constitutes the entire contract of insurance; (e) no change to the policy will be valid until approved by AFLAC's secretary and president and noted in or attached to the policy; and (f) all statements in this application are representations and not warranties.

**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.

Complete this section if applicant is applying for Specified-Disease Rider Series A-75052.

**American Family Life Assurance Company of Columbus (AFLAC)  
Worldwide Headquarters: 1932 Wynnton Road, Columbus, Georgia 31999**

**SUPPLEMENTAL MEDICAL INFORMATION QUESTIONNAIRE FOR SPECIFIED DISEASE RIDER**

Have you or anyone to be covered under this policy ever had adrenal hypofunction (Addison's disease), ALS (amyotrophic lateral sclerosis) or Lou Gehrig's disease, botulism, bubonic plague, cerebral palsy, cholera, cystic fibrosis, diphtheria, encephalitis (including Encephalitis contracted from West Nile virus), Huntington's chorea, Legionnaires' disease, malaria, meningitis (bacterial), multiple sclerosis, muscular dystrophy, myasthenia gravis, necrotizing fasciitis, osteomyelitis, polio, rabies, Reye's syndrome, scarlet fever, scleroderma, sickle-cell anemia, systemic lupus, tetanus, toxic shock syndrome, tuberculosis, tularemia, typhoid fever, Variant Creutzfeldt-Jakob disease (mad cow disease), or yellow fever in any form?  Yes  No

If yes, was it the:  Named Insured  Spouse  Child?

If "child," please list the name of the child(ren) \_\_\_\_\_.

Any person(s) named will not be covered under Specified Disease Rider, Form Series A-75052.

**I understand that the purchase of this policy is intended to supplement my existing comprehensive health care coverage. It is not intended to replace or be issued in lieu of that coverage. I also understand that if I am receiving any Medicaid benefits, the purchase of this supplemental coverage is not necessary.**

If I am applying to convert my current policy to another AFLAC policy, I acknowledge that I have been advised that the policies have different benefits and that I should make a comparison to personally determine which is best for me. I understand and agree that I am giving up my current policy and its benefits for the benefits provided in the new policy.

I have read, or had read to me, the completed application, and I realize that policy issuance is based upon statements and answers provided herein, and they are complete and true to the best of my knowledge and belief. I realize that any false statement or misrepresentation hereon may result in loss of coverage under the policy.

**Any person who knowingly and with intent to injure, defraud or deceive any insurer, files a statement of claim or an application containing any false, incomplete or misleading information, is guilty of a felony of the third degree.**

Applicant's Signature \_\_\_\_\_ Date \_\_\_\_\_

Agent's Signature \_\_\_\_\_ Date \_\_\_\_\_

Licensed Resident Agent

Typed or Printed Name of Agent: \_\_\_\_\_

Agent Telephone Number: \_\_\_\_\_

Agent Address: \_\_\_\_\_

Agent Florida License Number: \_\_\_\_\_

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

For policies that pay fixed dollar amounts for specified disease(s) or other specified impairment(s). This includes cancer, specified disease and other health insurance policies that pay a scheduled benefit or specific payment based on diagnosis of the conditions named in the policy.

**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 pays a fixed amount, regardless of your expenses, if you meet the policy conditions, for one of the specific diseases or health conditions named in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

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

- \* hospitalization
- \* physician services
- \* hospice
- \* 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.