Non-Payroll

Application for Cancer Indemnity Insurance
(Forms A761ESID and A76100ID)
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 Proposed Insured

Proposed Insured's Name ______________________________
Last First MI

DOB ____________ Sex ________ SSN ________ - ________ - ________
Month/Day/Year (optional)

Are you applying for Dependent Child(ren) coverage? ❑Yes ❑No
If yes, Dependent Children must be under age 25 at the time of application.

Write spouse's name below if you are applying for Two-Parent Family or Named Insured/Spouse Only coverage; if you have no spouse or your spouse is not to be covered, put N/A in the space below.

Spouse's Name ______________________ DOB ____________ Sex ________
Last First MI Month/Day/Year

Address ______________________________
Street or Post Office Box Apt. No.

City ____________________ State ________ ZIP____________

Home Telephone ( ) ____________ E-Mail Address (optional) ____________

Name of Employer/Association ____________________ Account No.____________
(Optional)

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 associate/agent, if applicable.

Do you currently have an active Aflac Cancer Policy Form A76100ID? ❑ Yes ❑ No
If yes, then you may not use this application. **Please use Application Form A76005ID.**
You may be eligible to apply for additional coverage.
If no, do you currently have an active Aflac cancer policy that has been in force for 12 months or more? ❑ Yes ❑ No

TO BE COMPLETED BY AFLAC ASSOCIATE/AGENT

Check Coverage Desired:	❑ Individual	❑ Named Insured/ Spouse Only	❑ One-Parent Family	❑ Two-Parent Family

❑ Policy (Form A76100ID) ❑ Policy (Form A761ESID)

Optional Riders:

Initial Diagnosis Benefit Rider (Form A76050ID)

Options: ❑ **No rider** ❑**$2,500** ❑**$5,000**

Cancer Screening
and Annual Care Benefit Rider (Form A76051)

Options: ❑ **No rider** ❑**$50** ❑**$75**

Specified-Disease Benefit Rider (Form A76052ID)

Options: ❑ **No rider** ❑ **New rider** ❑**Retain current rider**

Return of Premium Benefit Rider (Form A76053)
Options: ❑ **No rider** ❑ **New rider** ❑ **Retain current rider**
(Factor amt. ____________)

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Billing Method:

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

Modes:

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

Assoc./Agent's No. __________ Sit. Code ___________ Billable Premium $ __________ Premium Collected $ ________

ASSOCIATED CANCEROUS CONDITION: a myelodysplastic blood disorder, myeloproliferative blood disorder, or carcinoma in situ (in the natural or normal place, confined to the site of origin without having invaded neighboring tissue). An Associated Cancerous Condition is limited to only the conditions listed above.

CANCER: a disease manifested by the presence of a malignant tumor characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue. "Cancer" also includes, but is not limited to, leukemia, Hodgkin's disease, and melanoma.

INTERNAL CANCER means all Cancers other than Nonmelanoma Skin Cancer.

PLEASE COMPLETE THE FOLLOWING:

Are you or any other person to be covered under this policy, covered by Medicaid or any Title XIX program?

❑ **Yes** ❑ **No**

If yes, please list the person covered by Medicaid or any Title XIX program in the following space:

____

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

PLEASE COMPLETE THE FOLLOWING QUESTIONS

1. Have you or has anyone to be covered had Internal Cancer or an Associated Cancerous Condition that was diagnosed or last treated **within the last ten years** or received preventive hormonal therapy within the last 12 months?

❑**Yes** ❑ **No**

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

____

Any person(s) so designated will not be covered under the policy. If the named person is the Proposed Insured, a policy will not be issued.

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

2. Have you or has anyone to be covered had Internal Cancer or an Associated Cancerous Condition that was diagnosed or last treated **over ten years ago**? ❑**Yes** ❑ **No**

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

____

If yes, please complete a Cancer History Form provided by your associate/agent on any individual(s) listed.

3. Have you or has anyone to be covered had three or more Nonmelanoma Skin Cancers, of any type or form, that was diagnosed, treated, or removed within the last 12 months? ❑**Yes** ❑ **No**

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

____

Any person(s) so designated will not be covered under the policy. If the named person is the Proposed Insured/Employee, a policy will not be issued.

If yes, and this is a conversion, the person(s) so designated is not eligible for coverage under the converted policy.

Proposed Insured's/Employee's Initials ______________________________

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

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4. Have you or has anyone to be covered received a health screening (such as a mammogram, Pap smear, PSA, chest X-ray or colonoscopy) that tests for the presence of Cancer or an Associated Cancerous Condition, **for which you have not received the results**? ❑**Yes** ❑ **No**

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

____

Any person(s) so designated will not be covered under the policy. If the named person is the Proposed Insured, a policy will not be issued.

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

5. Have you or has anyone to be covered been advised by a member of the medical profession to receive a follow-up test for the potential presence of Cancer or an Associated Cancerous Condition **for which you have not received the results?** ❑**Yes** ❑ **No**

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

____

Any person(s) so designated will not be covered under the policy. If the named person is the Proposed Insured, a policy will not be issued.

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

6. Within the past 90 days have you or has anyone to be covered received abnormal test results from a health screening test? ❑**Yes** ❑ **No**

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

____

Any person(s) so designated will not be covered under the policy. If the named person is the Proposed Insured, a policy will not be issued.

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

PLEASE READ NUMBER 7 IF THIS IS A CONVERSION AND YOU DID NOT SELECT ANY OF THE OPTIONAL RIDERS.

7. I acknowledge that I was offered the Optional Riders and declined one or more of them.

Proposed Insured's Initials ___________

PLEASE ANSWER THE FOLLOWING QUESTION IF APPLYING FOR THE SPECIFIED-DISEASE RIDER

8. Does anyone to be covered currently have or in the last ten years has anyone to be covered under this policy 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, malaria, meningitis (bacterial), multiple sclerosis, muscular dystrophy, myasthenia gravis, necrotizing fasciitis, osteomyelitis, polio, rabies, Reye's syndrome, 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? Name of the child(ren):

____

Any person(s) so designated above will not be covered under Specified-Disease Rider Form A76052ID.

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

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APPLICANT'S STATEMENTS AND AGREEMENTS

9. I understand that 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 or an Associated Cancerous Condition diagnosed before coverage has been in force 30 days, benefits for treatment of that Cancer or Associated Cancerous Condition will apply only to treatment occurring on or after 31 days from the Effective Date of the policy.

10. I acknowledge receipt of, if applicable:

- ❑ *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 associate/agent of Aflac, unless written herein; (c) the associate/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; and (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.

12. If this is an application for a conversion, the following conditions apply: (a) If Cancer or Associated Cancerous Condition 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 of the new policy 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.

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 compare them to 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.

Proposed Insured's Signature ______________________________ Date ______________

Associate's/Agent's Signature ______________________________ Date ______________
Licensed Resident Associate/Agent

The policy provides limited benefits. Review your policy carefully.

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

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For policies that pay fixed dollar amounts for specified diseases or other specified impairments. 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
* outpatient prescription drugs if you are enrolled in Medicare Part D
* 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 health insurance assistance program (SHIP).

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