Aflac Application

Thank you for your interest in applying for the Aflac Medicare Supplement plan!

Attached is a copy of the policy Enrollment Form and we have supplied you with a link to a printable copy of the Outline of Coverage.

Should you decide to apply by mail/fax/email, the printable application needs to be reviewed and signed by an Agent before it can be submitted to Aflac. You may email, fax or mail it in to CDA Insurance:

- Fax: 1.541.284.2994
- Email: client.services@cda-insurance.com
- Mail: CDA Insurance LLC
  PO Box 26540
  Eugene, Oregon 97402

Other Important Information
Download Medicare's Choosing a Medigap Policy Guide (.pdf) Download Policy Outline (.pdf)

Our website: http://www.orhi.us

If you should have any questions on the application, please call us at 1.800.884.2343 or 1.541.434.9613.

Application for Medicare Supplement Insurance (A19MS Series)
Application to: American Family Life Assurance Company of Columbus
(herein referred to as Aflac)
Worldwide Headquarters • Columbus, Georgia 31999
Administration: P.O. Box 13547
Pensacola, Fl 32591

SECTION A. PROPOSED INSURED INFORMATION

Applicant Name *(exactly as it appears on your Medicare card)*	Male ☐ Female ☐
Street Address	City, State, ZIP Code
Mailing Address *(if different from street address)*	City, State, ZIP Code
Phone *(with area code)*	Email Address *(optional)*
Date of Birth *(mm/dd/yyyy)*	Current Age
Medicare Card No.	Social Security No.
Height (*feet and inches)*	Weight *(pounds)*

SECTION B. PLAN AND PREMIUM INFORMATION

You may be eligible for a policy with a lower premium rate based on your answer to the following questions:

Household does not include any type of licensed facility that provides care.

Does a member of your household with whom you have continuously resided for the last 12 months have an existing Medicare supplement policy with Aflac? Yes ☐ No ☐

Or

Is a member of your household with whom you have continuously resided for the last 12 months applying for a Medicare supplement policy with Aflac? Yes ☐ No ☐

If you answered "yes" to either question above, please provide the following information for that household member:

Name *(exactly as it appears on Medicare card)*

Medicare Card No.

Aflac Policy Number, if applicable

Plan – *(You Are Currently Applying For)*	Requested Policy Effective Date
Premium $	Policy Fee $
Premium Collected $	Payment Method: Bank Draft ☐ Direct Bill ☐

Payment Mode: Monthly ☐ *(Bank Draft ONLY)* Annual ☐ Semiannual ☐ Quarterly ☐

SECTION C. PLEASE ANSWER ALL ELIGIBILITY QUESTIONS

1. Have you used tobacco in any form in the past 12 months? Yes ☐ No ☐
2. Are you covered under Medicare Part A? Yes ☐ No ☐
   If yes, what is your Part A effective date? / /
   If no, what is your eligibility date? / /
3. Are you covered under Medicare Part B? Yes ☐ No ☐
   If yes, what is your Part B effective date? / /
   If no, what is your eligibility date? / /
4. Are you applying during a guaranteed-issue period? (If yes, please attach proof of eligibility.) Yes ☐ No ☐
5. If you are currently on Medicare Disability, are you eligible for Medicare due to disability or end-stage renal disease (ESRD)? Yes ☐ No ☐

   IF yes, please check the box that applies. ☐ Disability ☐ End-Stage Renal Disease (ESRD)

SECTION D. HEALTH QUESTIONS

If applying during open enrollment or a guaranteed-issue period, go to **SECTION F**.

If not, **PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS**. If you answer yes to any of the following Questions 1–7, you are not eligible for coverage.

1. Are you currently hospitalized, confined to a nursing facility, receiving the services of a home health agency, bedridden, or do you require the use of a wheel chair or motorized mobility aid? Yes ☐ No ☐
2. Are you now receiving, or have you ever received medical advice or treatment for, been advised to have treatment or surgery for, or taken medication for any of the following conditions:
   A. Emphysema, chronic obstructive pulmonary disease (COPD), sarcoidosis, scleroderma, chronic pulmonary disorders, or any chronic pulmonary disease requiring the use of oxygen? Yes ☐ No ☐
   B. Parkinson's disease, systemic lupus, myasthenia gravis, multiple or lateral sclerosis, osteoporosis with fractures, cirrhosis, hepatitis C, or kidney disease? Yes ☐ No ☐
   C. Alzheimer’s disease, senile dementia, or any other cognitive disorder? Yes ☐ No ☐
   D. Acquired immune deficiency syndrome (AIDS) or AIDS-related complex (ARC)? Yes ☐ No ☐
   E. Diabetes with peripheral vascular disease, neuropathy, any type heart condition, kidney disease, retinopathy, or high blood pressure? Yes ☐ No ☐
3. Are you now receiving, or in the last three years have you received medical advice or treatment for, been advised to have treatment or surgery for, or taken medication for any of the following conditions:
   A. Cancer, leukemia, malignant melanoma, Hodgkin's disease, or lymphoma? Yes ☐ No ☐
   B. Ulcerative colitis or Crohn’s disease? Yes ☐ No ☐
   C. Alcoholism or drug abuse? Yes ☐ No ☐

D. Joint replacement? Yes ☐ No ☐

E. Heart attack, heart disease, coronary artery disease, cardiomyopathy, enlarged heart, stroke, transient ischemic attacks (TIA)? Yes ☐ No ☐

F. Congestive heart failure, peripheral vascular disease, heart valve disease, carotid artery disease (not including high blood pressure), heart rhythm disorders? Yes ☐ No ☐

G. Any amputation caused by disease? Yes ☐ No ☐

H. Degenerative bone disease, or rheumatoid or disabling arthritis? Yes ☐ No ☐

I. Major depression, bi-polar disorder, schizophrenia, a paranoid disorder, or any other mental or nervous disorder requiring psychiatric care? Yes ☐ No ☐

J. Diabetes treated with insulin or other injectables? Yes ☐ No ☐

4. Have you been advised by a physician that surgery may be required within 12 months for cataracts? Yes ☐ No ☐

5. In the last three years, have you been advised by a physician to have surgery, medical tests, treatment, or therapy that has not been performed? Yes ☐ No ☐

6. In the last two years, have you been hospitalized three or more times, received home health care three or more times, or been confined to a nursing facility for more than 30 days? Yes ☐ No ☐

7. Have you had an organ transplant or been advised by a physician to have an organ transplant? Yes ☐ No ☐

SECTION E. MEDICATION HISTORY

Are you taking or have you taken any prescription or over-the-counter medications within the past 12 months? Yes ☐ No ☐
If YES, please list the drug(s) and the condition(s) below. Attach a separate sheet if needed.

Medication Name (copy from pharmacy label)	
Date **Originally** Prescribed	
Dosage and Frequency	
Diagnosis/Condition	
Medication Name (copy from pharmacy label)	
Date **Originally** Prescribed	
Dosage and Frequency	
Diagnosis/Condition	
Medication Name (copy from pharmacy label)	
Date **Originally** Prescribed	
Dosage and Frequency	
Diagnosis/Condition	

Medication Name (copy from pharmacy label)	
Date **Originally** Prescribed	
Dosage and Frequency	
Diagnosis/Condition	

SECTION F. FOR YOUR PROTECTION, the National Association of Insurance Commissioners requires that we ask the following questions about insurance policies or certificates you may have.

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you are eligible for guaranteed issue of a Medicare supplement insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare supplement plans. Please include a copy of the notice from your previous insurer with your application.
PLEASE ANSWER ALL QUESTIONS.

To the Best of Your Knowledge:

1. (a) Did you turn age 65 in the last six months? Yes ☐ No ☐
   (b) Did you enroll in Medicare Part B in the last six months? Yes ☐ No ☐
   (c) If yes, indicate your effective date. / /

2. Are you covered for medical assistance through the state Medicaid program? Yes ☐ No ☐
   (NOTE TO APPLICANT: If you are participating in a spend-down program and have not met your share of cost, please answer no to the above question.)
   If yes, answer (a) and (b) below.
   (a) Will Medicaid pay your premiums for this Medicare supplement policy? Yes ☐ No ☐
   (b) Do you receive any benefits from Medicaid OTHER THAN payment toward your Medicare Part B premium? Yes ☐ No ☐

3. Have you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO)? Yes ☐ No ☐
   If yes, answer (a)–(g) below.
   (a) Name of Company _____
   Plan Type & Policy/Certificate No. _____
   Company Telephone No. _____
   Coverage Dates: START DATE / /
   (If you are still covered under this plan, leave end date blank.) END DATE / /
   (b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy? Yes ☐ No ☐
   If yes, have you received a copy of the replacement notice? Yes ☐ No ☐
   (c) Reason for termination/disenrollment: _____
   (d) Planned date of termination/disenrollment: / /
   (e) Was this your first time participating in this type of Medicare plan? Yes ☐ No ☐
   (f) Did you drop a Medicare supplement or Medicare select policy/certificate to enroll in this Medicare plan? Yes ☐ No ☐
   (g) Is your former Medicare supplement or Medicare select policy/certificate still available? Yes ☐ No ☐

4. Do you have another Medicare supplement or Medicare select insurance policy in force? Yes ☐ No ☐
   If yes, answer (a)–(d) below.

(a) Name of Company

Plan Type & Policy/Certificate No.

Company Telephone No.

Issue Date / /

(b) Do you intend to replace your current Medicare supplement or Medicare select policy/certificate with this policy? Yes ☐ No ☐

(c) Indicate termination date. / /

(d) Have you received a copy of the replacement notice? Yes ☐ No ☐

5. Have you had coverage under any other health insurance within the past 63 days? (for example, an employer, union, or individual non-Medicare supplement plan) Yes ☐ No ☐

If yes, answer (a)–(c) below.

(a) Name of Company

Plan Type & Policy/Certificate No.

Company Telephone No.

Coverage Dates: START DATE / /

(If you are still covered under this plan, leave end date blank.) END DATE / /

(b) Reason for termination or disenrollment:

(c) Planned date of termination/disenrollment: / /

Do you or your spouse have other coverage with Aflac? Yes ☐ No ☐

This section to be completed only by an agent, if applicable.

Agents will list any other health insurance policies they have sold to the applicant.

1. List policies sold that are still in force.

Name of Company

Policy/Certificate Number

Description of Benefits

Effective Date of Coverage

Name of Company

Policy/Certificate Number

Description of Benefits

Effective Date of Coverage

Name of Company

Policy/Certificate Number

Description of Benefits

Effective Date of Coverage

2. List policies sold in the past five years that are no longer in force.
Name of Company
Policy/Certificate Number
Description of Benefits
Effective Date of Coverage
Name of Company
Policy/Certificate Number
Description of Benefits
Effective Date of Coverage
Name of Company
Policy/Certificate Number
Description of Benefits
Effective Date of Coverage

IMPORTANT STATEMENTS TO BE READ BY APPLICANT

- You do not need more than one Medicare supplement policy.
- If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
- You may be eligible for benefits under Medicaid and may not need a Medicare supplement insurance policy.
- If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement insurance policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstated, if requested, within 90 days of losing Medicaid eligibility. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of suspension.
- If you are eligible for, and have enrolled in, a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstated, if requested, within 90 days of losing your employer or union-based group health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of suspension.
- Counseling services may be available in your state to provide advice concerning your purchase of a Medicare supplement insurance policy and concerning medical assistance through the state Medicaid program, including benefits as a qualified Medicare beneficiary (QMB) and a specified low-income Medicare beneficiary (SLMB).

INFORMATION REGARDING THE MEDICAL INFORMATION BUREAU (MIB)
PRENOTICE

Information regarding your insurability will be treated as confidential. Aflac may, however, make a brief report thereon to MIB Inc. (formerly known as the Medical Information Bureau), a not-for-profit membership organization of insurance companies that operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or submit a claim for benefits 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 (TTY 1-866-346-3642). 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, Massachusetts 02184-8734.

Aflac 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 Web site at mib.com.

I request that a copy of my application, outline of coverage and premium rate be provided to my advisor (lawyer, financial consultant or my closest relative, etc.). (If you do not wish to name an advisor, so state on the lines below):

Last Name | First Name | MI | ( ) Phone

Street/P.O. Box | City | State | ZIP Code

Protection Against Unintended Lapse (Optional)

I request that a notice of cancellation for nonpayment of premium be provided to the person designated below.

Last Name | First Name | MI

Street/P.O. Box

City | State | ZIP Code

I understand that I have the right to designate at least one (1) person other than myself to receive notice of lapse or termination of this Medicare supplement insurance policy for nonpayment of premium. I understand that notice will not be given until 30 days after a premium is due and unpaid. I elect NOT to designate any person to receive this notice.

Proposed Insured's Signature: X _____ Date _____

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

I wish to apply for a Medicare supplement insurance policy. I acknowledge that I have received or been given access to review or print: (a) an outline of coverage for the policy applied for, and (b) a *Guide to Health Insurance for People with Medicare*.

Signed at: _____ _____ _____

State Applicant's Signature Date

Signed at: _____ 02481 _____

State Agent's Signature and Writing Number Date

MAKE CHECK OR MONEY ORDER PAYABLE TO AFLAC.
FOR INFORMATION, CALL TOLL-FREE 1.855.207.2078.
VISIT OUR WEB SITE AT AFLAC.COM.

AUTHORIZATION TO OBTAIN INFORMATION

MAIL TO: American Family Life Assurance Company of Columbus
1932 Wynnton Road
Columbus, Georgia 31999-0001

I authorize American Family Life Assurance Company of Columbus, American Family Life Assurance Company of New York, and Continental American Insurance Company (collectively, "Aflac") to make a brief report of my personal health information to MIB, Inc. (formerly known as the Medical Information Bureau).

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 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 authorization is signed.

I agree that a copy of this authorization is as valid as the original and that I or an authorized representative may request a copy of this authorization.

_____
Printed Name of Individual Subject to Disclosure

_____ _____
Signature Date

If this authorization has been signed by a personal representative on behalf of an individual, his/her authority to act on behalf of the individual must be set forth here:

_____ _____
Printed Name of Legal/Personal Representative Legal Relationship
(e.g. Power of Attorney, Estate Executor)

AUTHORIZATION TO DISCLOSE INFORMATION

MAIL TO: American Family Life Assurance Company of Columbus
1932 Wynnton Road
Columbus, Georgia 31999-0001

I authorize American Family Life Assurance Company of Columbus, American Family Life Assurance Company of New York, and Continental American Insurance Company (collectively, "Aflac") to make a brief report of my personal health information to MIB, Inc. (formerly known as the Medical Information Bureau).

I understand that this information will be used by MIB, Inc. for the purpose of assisting the insurance industry in the accurate underwriting of insurance products as well as assisting the insurance industry in facilitating the fair pricing of insurance products through more accurate risk assessment.

"Information" includes information in Aflac's possession relating to my physical or mental health or condition (excluding psychotherapy notes, but including, for example, medical diagnosis/treatment information related to underwriting), and nonmedical financial information (including, for example, policy status).

I understand that any disclosure of health information to MIB, Inc. 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 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.

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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 authorization is signed.

I agree that a copy of this authorization is as valid as the original and that I or an authorized representative may request a copy of this authorization.

_____
Printed Name of Individual Subject to Disclosure

_____ _____
Signature Date

If this authorization has been signed by a personal representative on behalf of an individual, his/her authority to act on behalf of the individual must be set forth here:

_____ _____
Printed Name of Legal/Personal Representative Legal Relationship
(e.g. Power of Attorney, Estate Executor)

NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE OR MEDICARE ADVANTAGE

AMERICAN FAMILY LIFE ASSURANCE COMPANY OF COLUMBUS (herein referred to as Aflac) WORLDWIDE HEADQUARTERS Columbus, GA 31999

Aflac Medicare Supplement Administrative Office: PO Box 13547 Pensacola, Fl 32591

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE

According to your application, you intend to terminate existing Medicare supplement or Medicare Advantage insurance and replace it with a policy to be issued by Aflac. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of this Medicare supplement coverage is a wise decision, you should terminate your present Medicare supplement or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

STATEMENT TO APPLICANT BY AGENT:

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare supplement policy will not duplicate your existing Medicare supplement or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare supplement coverage or leave your Medicare Advantage plan. The replacement policy is being purchased for the following reason (check one):

_____ Additional benefits.

_____ No change in benefits, but lower premiums.

_____ Fewer benefits and lower premiums.

_____ Change in benefits. **(Gaining additional benefit(s) but losing some existing benefit(s)).**

_____ My plan has outpatient drug coverage and I am enrolling in Part D.

_____ Disenrollment from a Medicare Advantage plan. Please explain reason for disenrollment.

_____

_____ Other (please specify) _____

If, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

_____
Signature of Agent, Broker or Other Representative

Dann Loewenthal - PO Box 26540, Eugene, OR 97402
Name and Address of Agent

The above "Notice to Applicant" was delivered to me on:

_____ _____
Applicant's Signature Date

NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE OR MEDICARE ADVANTAGE

AMERICAN FAMILY LIFE ASSURANCE COMPANY OF COLUMBUS (herein referred to as Aflac) WORLDWIDE HEADQUARTERS Columbus, GA 31999

Aflac Medicare Supplement Administrative Office: PO Box 13547 Pensacola, Fl 32591

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You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of this Medicare supplement coverage is a wise decision, you should terminate your present Medicare supplement or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

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I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare supplement policy will not duplicate your existing Medicare supplement or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare supplement coverage or leave your Medicare Advantage plan. The replacement policy is being purchased for the following reason (check one):

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_____ No change in benefits, but lower premiums.

_____ Fewer benefits and lower premiums.

_____ Change in benefits. **(Gaining additional benefit(s) but losing some existing benefit(s)).**

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_____ Disenrollment from a Medicare Advantage plan. Please explain reason for disenrollment.

_____

_____ Other (please specify) _____

If, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

_____
Signature of Agent, Broker or Other Representative

Dann Loewenthal - PO Box 26540, Eugene, OR 97402
Name and Address of Agent

The above "Notice to Applicant" was delivered to me on:

_____ _____
Applicant's Signature Date

American Family Life Assurance Company of Columbus (Aflac)
Worldwide Headquarters

NOTICE OF INFORMATION PRACTICES

Thank you for your application. As part of our normal underwriting procedure, we need to obtain information to determine a proposed insured's eligibility for insurance. Much of that information will come from you; however, we often obtain additional information or verify information through other sources.

COLLECTION

Your application, including the medical questionnaire and any exams, is our main source of information. However, we may need to obtain additional information from other sources about your age, physical condition, occupation, other insurance coverage, health history, financial history, avocations, general reputation and lifestyle.

We may obtain this information from:

- physicians, hospitals, clinics, or other medical professionals or medical care facilities
- the MIB, Inc. as described in this notice or other insurance support organizations
- consumer reporting agencies as described below
- other insurance companies and our reinsurance companies
- employers

We may collect information:

- in person
- by telephone
- by exchanges of correspondence

DISCLOSURES

We will not disclose to others the information that we obtain about you without your prior authorization except as necessary to conduct our business (and then only if disclosure is permitted by law). Most disclosures made by us are to identify you for collection of information, for reinsurance or other services, or to help detect or prevent fraud and misrepresentation.

ACCESS TO INFORMATION

You have the right to access recorded personal information about you that is in our files and we can locate within reason. To ensure the security of information in our files, we will require positive identification before we allow access to that information. To obtain a copy of our information concerning you, send a signed, written request to the address at the end of this notice. Give your full name, address, telephone number, and policy number if a policy has been issued, or if the policy has not been issued, give the application date. Within 30 business days after we receive your request, we will inform you of the recorded personal information that we can locate and retrieve in our files. We will also tell you to whom we have disclosed this information within the last two years. If you wish, we can show you the information at our headquarters, or we will mail copies to you. However, we reserve the right to disclose medical information only through a medical professional of your choice. You may have to pay a reasonable charge to cover the cost of the copies.

ADVERSE UNDERWRITING DECISIONS

If you are refused insurance or if your application for insurance is postponed, you have the right to contact us about this decision within 90 business days from the date of the mailing of the notice or other communication of an adverse underwriting decision. Within 21 business days after we receive your request, we will notify you about the information that we can locate and retrieve in our files. We will also tell you to whom we have disclosed this information within the last two years. If you wish, we can show you the information at our headquarters, or we will mail copies to you. However, we reserve the right to disclose medical information only through a medical professional of your choice.

I hereby certify I have provided the applicant with the Notice of Information Practices.

_____ _____

Associate's signature Date

I, the undersigned, hereby acknowledge I have received and read the above Notice of Information Practices.

_____ _____

Applicant's signature Date

CORRECTION OF INFORMATION

If, after receiving this information, you believe that it is not completely accurate, you also have the right to request that we correct, amend or delete any portion of this information. Within 30 business days from the date we receive your written

request, we will either correct, amend or delete the portion of the recorded personal information in dispute, or we will notify you in writing of the reasons for refusal and your right to file a statement if you disagree. If you disagree, you will be permitted to file a concise statement showing what you think is correct, relevant, or fair information and the reasons why you disagree with the refusal to correct, amend, or delete recorded personal information. Your statement will be filed with the disputed recorded personal information. We will give your statement of disagreement to anyone we have given the information to within the preceding two years and to anyone we give it to in the future. If we correct, amend, or delete any recorded personal information, we will notify you in writing and furnish the correction, amendment, or deletion to any person designated by you who, within the preceding two years, may have received the recorded personal information.

MEDICAL INFORMATION BUREAU

We may make a brief report to the MIB, Inc., formerly known as Medical Information Bureau, Inc. (MIB) an organization of similar insurance companies that operates an information exchange. Upon request by another insurance company to which you have applied for life or health insurance or submitted a claim, the MIB will supply the information in their files.

We, or our reinsurers, may also release information to other insurance companies to which you may submit a claim or apply to for life or health insurance. Upon a request from you, the MIB will disclose any information in your file (medical information will be given only to your attending physician). If the information is inaccurate, you may contact the MIB for a correction as set forth in the Federal Fair Credit Reporting Act. The address of the MIB's Information Office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734; Telephone Number, 866-692-6901 (TTY 866-346-3642). Information for consumers about MIB may be obtained on its website at www.mib.com.

INVESTIGATIVE CONSUMER REPORT

In processing your application, we may make an investigative consumer report as to your insurability, including information as to character, general reputation, personal characteristics and mode of living. This information will be obtained through personal interviews with your friends, neighbors or others with whom you are acquainted. We will furnish you additional information about the report upon your written request. Write to the designated address within a reasonable time after you receive this notice. Within five business days of your request, we will give you the name, address and telephone number of the consumer reporting agency from which we requested the report.

You can ask that the consumer reporting agency interview you by so stating on the authorization form.

A consumer reporting agency may collect information and submit a report to us. That agency may keep the report on file and disclose its contents to others who request its services.

You may receive a copy of the report from the consumer reporting agency if you request it and give proper identification.

ADDITIONAL INFORMATION

We hope this information helps you understand how and why we obtain information about you and how we use the information. However, if you have any other questions about our information practices, send them to:

American Family Life Assurance Company of Columbus (Aflac)

Worldwide Headquarters

Columbus, Georgia 31999

1.800.99.AFLAC (1.800.992.3522)

American Family Life Assurance Company of Columbus (Aflac)
Worldwide Headquarters

NOTICE OF INFORMATION PRACTICES

Thank you for your application. As part of our normal underwriting procedure, we need to obtain information to determine a proposed insured's eligibility for insurance. Much of that information will come from you; however, we often obtain additional information or verify information through other sources.

COLLECTION

Your application, including the medical questionnaire and any exams, is our main source of information. However, we may need to obtain additional information from other sources about your age, physical condition, occupation, other insurance coverage, health history, financial history, avocations, general reputation and lifestyle.

We may obtain this information from:

- physicians, hospitals, clinics, or other medical professionals or medical care facilities
- the MIB, Inc. as described in this notice or other insurance support organizations
- consumer reporting agencies as described below
- other insurance companies and our reinsurance companies
- employers

We may collect information:

- in person
- by telephone
- by exchanges of correspondence

DISCLOSURES

We will not disclose to others the information that we obtain about you without your prior authorization except as necessary to conduct our business (and then only if disclosure is permitted by law). Most disclosures made by us are to identify you for collection of information, for reinsurance or other services, or to help detect or prevent fraud and misrepresentation.

ACCESS TO INFORMATION

You have the right to access recorded personal information about you that is in our files and we can locate within reason. To ensure the security of information in our files, we will require positive identification before we allow access to that information. To obtain a copy of our information concerning you, send a signed, written request to the address at the end of this notice. Give your full name, address, telephone number, and policy number if a policy has been issued, or if the policy has not been issued, give the application date. Within 30 business days after we receive your request, we will inform you of the recorded personal information that we can locate and retrieve in our files. We will also tell you to whom we have disclosed this information within the last two years. If you wish, we can show you the information at our headquarters, or we will mail copies to you. However, we reserve the right to disclose medical information only through a medical professional of your choice. You may have to pay a reasonable charge to cover the cost of the copies.

ADVERSE UNDERWRITING DECISIONS

If you are refused insurance or if your application for insurance is postponed, you have the right to contact us about this decision within 90 business days from the date of the mailing of the notice or other communication of an adverse underwriting decision. Within 21 business days after we receive your request, we will notify you about the information that we can locate and retrieve in our files. We will also tell you to whom we have disclosed this information within the last two years. If you wish, we can show you the information at our headquarters, or we will mail copies to you. However, we reserve the right to disclose medical information only through a medical professional of your choice.

I hereby certify I have provided the applicant with the Notice of Information Practices.

_____ _____

Associate's signature Date

I, the undersigned, hereby acknowledge I have received and read the above Notice of Information Practices.

_____ _____

Applicant's signature Date

CORRECTION OF INFORMATION

If, after receiving this information, you believe that it is not completely accurate, you also have the right to request that we correct, amend or delete any portion of this information. Within 30 business days from the date we receive your written

request, we will either correct, amend or delete the portion of the recorded personal information in dispute, or we will notify you in writing of the reasons for refusal and your right to file a statement if you disagree. If you disagree, you will be permitted to file a concise statement showing what you think is correct, relevant, or fair information and the reasons why you disagree with the refusal to correct, amend, or delete recorded personal information. Your statement will be filed with the disputed recorded personal information. We will give your statement of disagreement to anyone we have given the information to within the preceding two years and to anyone we give it to in the future. If we correct, amend, or delete any recorded personal information, we will notify you in writing and furnish the correction, amendment, or deletion to any person designated by you who, within the preceding two years, may have received the recorded personal information.

MEDICAL INFORMATION BUREAU

We may make a brief report to the MIB, Inc., formerly known as Medical Information Bureau, Inc. (MIB) an organization of similar insurance companies that operates an information exchange. Upon request by another insurance company to which you have applied for life or health insurance or submitted a claim, the MIB will supply the information in their files.

We, or our reinsurers, may also release information to other insurance companies to which you may submit a claim or apply to for life or health insurance. Upon a request from you, the MIB will disclose any information in your file (medical information will be given only to your attending physician). If the information is inaccurate, you may contact the MIB for a correction as set forth in the Federal Fair Credit Reporting Act. The address of the MIB's Information Office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734; Telephone Number, 866-692-6901 (TTY 866-346-3642). Information for consumers about MIB may be obtained on its website at www.mib.com.

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Worldwide Headquarters • Columbus, Georgia 31999

STATEMENT OF UNDERSTANDING AND AGREEMENT

I, the undersigned, understand and agree that the Medicare supplement policy that I am applying for will not be effective until _____ , if issued, because of the advanced effective date. I understand that if I receive any medical treatment prior to the _____ effective date of the policy, no benefits will be due me, and Aflac will not be liable for any such claims. I have submitted $ _____ for the initial premium and registration fee for _____ months of coverage beginning _____.

Policyholder's Printed Name: _____

Address: _____

Policy Number: _____

Signature of Applicant: _____

Date Signed: _____

Signature of Associate: _____

NAME OF INSURED (Please Print)

_____

☐ Check here when reporting a change and provide Policy Number:

PRE-AUTHORIZATION FORM

To Honor Drafts or Electronic Debits

As a convenience to me, I hereby request and authorize you to pay and charge my bank checking or savings account drafts or electronic debits drawn by and payable to the order of the Insurance Company provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights in respect to each draft or debit shall be the same as if it were a draft on you and signed personally by me. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice I agree that you shall be fully protected in honoring any such draft or debit. I further agree that if any such draft or debit be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

_____ Date

_____ Bank Account Number ☐ Checking ☐ Savings

_____ Bank Name (Please Print)

_____ Bank Routing Number

_____ Street Address or P.O. Box

_____ Depositor's Name as it appears on Bank Records

☐ Withdraw on the premium due date of my policy

☐ Withdraw on the following date*: _____

SUBMIT THIS FORM AND A VOIDED CHECK TO THE HOME OFFICE

*You may select any draft date from the 1st through the 28th of the month, even though the policy due date might be the first of the month. However, if the requested draft date is more than 15 days after the due date, we will draft the month prior. (Note: This does not apply to the initial premium in the case where an application is submitted without premium. In that case, the initial premium is drafted on the approval date, and subsequent premiums are drafted on the requested date.)

RETURN TO COMPANY

RECEIPT

Received of

_____

this _____ day of _____ the sum of

$_____ being the payment of

_____ Premium.

The insurance applied for shall not take effect until the effective date of the policy and the payment of the first premium. In the event the application is declined, any payments made by the Applicant will be returned.

_____

AGENT'S SIGNATURE

Make checks payable to Aflac.
Do not make payable to agent or leave payee blank.

Underwritten by:

Aflac®

American Family Life Assurance Company of Columbus

aflac.com