Application for Specified Disease Insurance (A-59000 Series)
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# _____ - _____ - _____ Dependent Children ❑ Yes ❑ No

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

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

Address _____
Street or Post Office Box Apt.#

City _____ State _____ ZIP Code _____

Home Telephone ( ) _____

Policyowner's Name _____ Relationship to Applicant _____
(if other than applicant)

Address _____ Owner's SS# _____ - _____ - _____
Street or Post Office Box Apt.#

City _____ State _____ ZIP Code _____

Name of Employer _____

Are you currently covered by a cancer insurance policy with us? ❑ Yes ❑ No If yes, this coverage must replace your existing coverage. You may have only one cancer insurance policy with us.

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.

TO BE COMPLETED BY AFLAC ASSOCIATE/AGENT

Check Coverage Desired:	❑ Individual ❑ Two-Parent Family	❑ One-Parent Family

Level 1: Policy (Series A-59100ICT)	❑ CCAIJ0	❑ CCAIJ1	❑ Pre-tax
Level 2: Policy (Series A-59200ICT)	❑ CCAIK0	❑ CCAIK1	❑ After-tax
Level 3: Policy (Series A-59300ICT)	❑ CCAIN0	❑ CCAIN1	

Optional Rider:

Building Benefit Rider (Series A-59050) Units ____	❑ CCAIFA	❑ CCAIFB

Billing Method:
❑ Payroll Deduction
❑ Emp. Non-payroll/Assoc.
❑ Direct
❑ Payroll ACH

Mode:
❑ 01 Weekly
❑ 01 Biweekly
❑ 01 28-day
❑ 01 Semimonthly
❑ 01 Monthly
❑ 03 Quarterly
❑ 06 Semiannual
❑ 12 Annual

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

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

APPLICANT'S STATEMENTS AND AGREEMENTS:

1. Have you or anyone to be covered under this policy ever been diagnosed or treated for cancer of any type or form? ❑ Yes ❑ No **If no, please skip to Item 6 (If conversion, please skip to conversion section below).** If yes, was it the ❑ Named Insured ❑ Spouse ❑ Child?
   If "child," please list the name of the child(ren) _____.
   If yes, please complete Question 2 below.
2. Has the person(s) designated above:
   (a) received treatment for cancer in the last five years? ❑ Yes ❑ No
   (b) received hormonal therapy for cancer within the last 12 months? ❑ Yes ❑ No
   If no to (a) and (b), please complete Internal Malignancy Form provided by your associate/agent and skip to Item 6.
   If yes to (a), what type of cancer was it:
   - ❑ Skin cancer or Melanomas of Clark's Level I or II? (Policy may be issued with a Skin Cancer Waiver.)
   - ❑ Internal cancer or Melanomas of Clark's Level III or higher? (These individuals will not be covered under this policy.)

   If yes to (b), the individual(s) will not be covered under this policy.

COMPLETE THIS SECTION ONLY IF THIS IS A CONVERSION.

If this is an application to convert coverage from an existing AFLAC cancer policy to this new AFLAC cancer policy, please complete Question 1 above. **IF** your answer to Question 1 above was "yes," complete Question 3 below.

3. Have you or any person to be covered under this policy received benefits, other than Wellness Benefits, if any, under your existing AFLAC cancer policy in the last five years? ❑ Yes ❑ No
   If no, please complete the Internal Malignancy Form provided by your associate/agent.
   If yes, that person will not be covered under the new policy.
4. 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 and the Time Limit on Certain Defenses 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.
5. 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. I also acknowledge that I was offered the Building Benefit Rider and declined it.

6. I understand that the Effective Date of the policy will be the date recorded on the Policy Schedule by AFLAC**. It is not the date the application is signed.**

7. The policy has a 30-day waiting period that begins on the Effective Date of the policy. This means that no benefits are payable for any covered person who has cancer diagnosed before coverage has been in force 30 days from the Effective Date shown in the Policy Schedule. If a covered person has cancer diagnosed during the 30-day waiting period, benefits for treatment of that cancer will apply only to treatment occurring after one year 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.

8. I acknowledge receipt of, if applicable:
   ❑ Fair Credit Reporting Notice ❑ Replacement Notice ❑ Outline of Coverage
   ❑ *Guide To Health Insurance for People with Medicare*
9. I understand that: the policy of insurance I am now applying for will be issued based solely upon the written answers to questions and information asked for in this application and any other pertinent information AFLAC may require for proper underwriting; AFLAC is not bound by any statement made by me, the applicant, or by any associate/agent of AFLAC, unless written herein; the associate/agent cannot change the provisions of the policy or waive any of its provisions either orally or in writing; the policy together with this application and any endorsements, waivers or riders, if any, is the entire contract of insurance; and no change to the policy will be valid until approved by AFLAC's secretary and president, which must be noted on 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.

I understand that the premium amount listed on this application represents the premium amount that my employer will remit to AFLAC on my behalf; and 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 by my associate/agent.

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 policy issuance is based upon statements and answers provided herein, and they are complete and true to the best of my knowledge and belief.

Notice: If you are already covered by Medicaid, you should not purchase this coverage.

Applicant's Signature _____ Date _____

Associate's/agent's Signature _____ Date _____

Licensed Resident Associate/agent

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.