

Nonpayroll

DENTAL INSURANCE POLICY (A-80000 Series)

- New
Conversion

Application to: American Family Life Assurance Company of Columbus (AFLAC)
Worldwide Headquarters: Columbus, Georgia 31999

Policy Number:

Please Print in Black Ink - To Be Completed by Applicant

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

Applicant's SSN Will dependent children be covered? Yes No

(Write spouse's name below if you are applying for One-Parent Family, Two-Parent Family or Husband and Wife Only coverage; if no spouse or spouse is not to be covered, put N/A in space below.)

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

Spouse's SSN

Address Street or Post Office Box Apt. No.

City State ZIP

Home Telephone

Name of Employer/Association:

Are you covered by any Title XIX program such as Medicaid? Yes No
If yes, you are not eligible for coverage; therefore, do not submit this application.

TO BE COMPLETED BY AFLAC ASSOCIATE/AGENT

Check Coverage Desired: Individual One-Parent Family Two-Parent Family Husband and Wife Only

- Level 1 Policy (Series A-80100) \$25 Dental Wellness
Level 2 Policy (Series A-80200) \$25 Dental Wellness
Level 3 Policy (Series A-80300) \$25 Dental Wellness
Level 4 Policy (Series A-80400) \$50 Dental Wellness
Level 5 Policy (Series A-80500) \$25 Dental Wellness
Level 6 Policy (Series A-80600) \$50 Dental Wellness

TO BE COMPLETED BY AFLAC ASSOCIATE/AGENT

Billing Method: Direct Association List Bill 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 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

Associate/Agent No. Sit. Code Billable Premium \$ Premium Collected \$

1. Have you or has anyone to be covered been diagnosed with or treated for any gum disease such as gingivitis within the last 24 months? Yes No

2. **If Question 1 is answered yes, was it the:**
 Named Insured Spouse Child? If "Child," please list the name of the child(ren)

Any person(s) so designated will not be covered under the policy.

The following information must be completed on each dependent child to be covered.

Name – Last, First, MI	Date of Birth	Sex	SSN	Check if:
		<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Handicapped child
		<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Handicapped child
		<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Handicapped child
		<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Handicapped child
		<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Handicapped child
		<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Handicapped child
		<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Handicapped child
		<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Handicapped child

If there are additional children to be covered, please complete the Additional Information Supplement Form.

Do you have any other dental insurance coverage in force with another company? Yes No
 Is this insurance intended to replace any other dental insurance now in force? Yes No
 If yes, please read and sign the Replacement Notice provided by your associate/agent, if applicable.

NOTE — IF THIS IS AN APPLICATION FOR CONVERSION: Any increased benefit amounts resulting from the replacement of the original AFLAC coverage with this new coverage will be subject to new waiting periods, if any, beginning with the effective date of this new coverage. The new waiting periods, if any, apply only to the amount of coverage being increased.

APPLICANT'S STATEMENTS AND AGREEMENTS:

1.	I understand that the effective date of the policy will be the date recorded in the Policy Schedule by AFLAC Worldwide Headquarters.
2.	I understand that the policy I am applying for will not cover any person who has attained age 64 before the effective date of the policy.
3.	I understand that the policy I am applying for contains different waiting periods for benefits listed in the Schedule of Dental Procedures in the policy. This means that no benefits are payable during the listed waiting period. The waiting period begins on the effective date of the policy.
4.	I understand that dependent children, if any, will be covered until age 19 (25 if full-time students).
5.	I acknowledge receipt of, if applicable: <input type="checkbox"/> Replacement Notice <input type="checkbox"/> Outline of Coverage <input type="checkbox"/> <i>Guide to Health Insurance for People with Medicare</i>

6. I understand that: (a) AFLAC is not bound by any statement made by me, the applicant, or any associate/agent of AFLAC unless written herein. (b) The associate/agent cannot change the provisions of the policy or waive any of its provisions either orally or in writing. (c) The policy, together with this application, endorsements, benefit agreements and riders, if any, is the entire contract of insurance. (d) No change to the policy will be valid until approved by AFLAC's president and secretary, 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.

If I am applying to replace existing coverage with this policy, I acknowledge that the policies may 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 terminating my current policy and its benefits and am applying for the benefits provided in the AFLAC 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.

Signed and Dated at _____ on _____
City and State Date

Applicant's Signature _____

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.

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).
VISIT OUR WEB SITE AT www.aflac.com.**