

Nonpayroll

**APPLICATION FOR HOSPITAL INDEMNITY INSURANCE (A-44000 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 SSN \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Dependent Children  Yes  No

(Write spouse's name below if you are applying for One-Parent Family or Two-Parent 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. No.

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Home Telephone ( ) \_\_\_\_\_

Policyowner's Name \_\_\_\_\_ Relationship to Applicant \_\_\_\_\_  
If other than applicant

Address \_\_\_\_\_ Owner's SSN \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Street or Post Office Box Apt. No.

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

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.  
Do you have any other hospital indemnity coverage with AFLAC?  Yes  No  
If yes, this must be a conversion of that coverage. Provide current policy number and see item 17.  
Policy Number: \_\_\_\_\_

Is this insurance intended to replace any other hospital indemnity 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:**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Individual        | <input type="checkbox"/> One-Parent Family | <input type="checkbox"/> Named Insured-Spouse Only |
| <input type="checkbox"/> Two-Parent Family |  |  |

Level 1: Policy Series A-44100  DHIP7D  DHIP8D  DHIP9D

Level 2: Policy Series A-44200  DHIP7E  DHIP8E  DHIP9E

**Optional Rider:**

Initial Hospitalization Series A-44150 — \$250  DHIP7F  DHIP8F  DHIP9F

Initial Hospitalization Series A-44250 — \$500  DHIP7G  DHIP8G  DHIP9G

**Billing Method:**

- Direct
- Association List Bill
- Bank Draft (B/D, ACH)
- Credit Card (C/C)

**Modes:**

- 01 Monthly (B/D & C/C Only)
- 06 Semiannual
- 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 \$ \_\_\_\_\_

**PLEASE COMPLETE ALL OF THE FOLLOWING:**

1. Is anyone to be covered currently confined in a hospital or nursing home, or has a physician recommended hospitalization?  Yes  No

2. Has anyone to be covered ever been diagnosed or treated by a member of the medical profession as having any of the following?  Yes  No

- \* Alzheimer's disease
- \* Senile dementia
- \* Emphysema
- \* Cerebral vascular insufficiency
- \* Heart bypass surgery (involving four or more vessels)
- \* Uncorrected congenital heart defect (excluding mitral valve prolapse)
- \* Stroke
- \* Cardiomyopathy
- \* Type I diabetes
- \* Transient ischemic attack (TIA)
- \* Psoriatic arthritis
- \* Cystic fibrosis
- \* Systemic lupus
- \* End-stage renal disease
- \* Kidney failure
- \* Kidney disease or disorder (excluding stones)
- \* Liver disease or disorder
- \* Cirrhosis
- \* Hepatitis (excluding Type A)
- \* Muscular dystrophy
- \* Crohn's disease
- \* Sickle cell anemia

3. Has anyone to be covered ever been diagnosed with or received treatment by a member of the medical profession for Type II diabetes diagnosed prior to age 30; Type II diabetes with complications to include retinopathy, neuropathy, or nephropathy; Type II diabetes that required insulin use within the last 12 months; or Type II diabetes with continued tobacco use?  Yes  No

4. Has anyone to be covered ever been diagnosed or treated by a member of the medical profession as having AIDS, or has anyone to be covered ever tested positive for the human immunodeficiency virus (HIV) or HTLV-III (antibodies to human T-lymphotropic virus Type III)?  Yes  No

5. Has anyone to be covered ever had or been advised to have an organ transplant, or consulted with or been evaluated by a member of the medical profession of the need to have an organ transplant?  Yes  No

6. During the past 36 months, has anyone to be covered been diagnosed or received treatment by a member of the medical profession for any of the following?  Yes  No

- \* Angina (chest pains)
- \* Congestive heart failure
- \* Heart attack
- \* Heart bypass surgery (involving 3 or less vessels)
- \* Angioplasty or stent placement
- \* Chronic obstructive pulmonary disease (COPD)
- \* Peripheral vascular disease (circulatory problems)
- \* Arrhythmia (with pacemaker or defibrillator)
- \* Pancreatitis
- \* Ulcerative colitis
- \* Alcohol or drug abuse
- \* Parkinson's disease
- \* Multiple sclerosis
- \* Cancer (excluding non-melanoma skin cancer)

7. During the past 12 months, has anyone to be covered been hospitalized two or more times; hospitalized five or more days; or missed more than seven consecutive days of work due to injury or sickness (excluding a normal pregnancy)?  Yes  No

8. During the past 12 months, has anyone to be covered been treated in a hospital or hospital emergency room for any respiratory disorders or psoriasis?  Yes  No

9. During the past six months, has anyone to be covered had any surgical procedure or have they been advised by a physician to have tests, treatment, or surgery that has not yet been done; or is he/she undergoing evaluation following an abnormal test result?  Yes  No

10. **If any one of Questions 1 through 9 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.**

11. List all hospital indemnity policies you currently have in force and provide the daily benefit amount. \_\_\_\_\_

**APPLICANT'S STATEMENTS AND AGREEMENTS:**

- 12. I understand that the effective date of the policy will be the date recorded in the Policy Schedule by AFLAC Worldwide Headquarters. The policy has a 30-day waiting period for sickness that begins on the effective date of the policy.
- 13. I understand that the policy I am applying for will not cover any person who has attained age 65 prior to the effective date of the policy.
- 14. I acknowledge receipt of, if applicable:
  - Fair Credit Reporting Notice  Replacement Notice
  - Outline of Coverage  Guide to Health Insurance for People with Medicare
- 15. **I understand that coverage is not provided until six months after the Effective Date for health conditions for which symptoms were evident or for which medical advice or treatment was recommended or received within the 12-month period before the Effective Date of coverage.**
- 16. I understand that: (a) The insurance I am applying for will be issued based solely upon the written answers to questions and information asked for in this application. (b) AFLAC is not bound by any statement made by me, the applicant, 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 and riders, if any, is 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.

17. If this is an application for a conversion of coverage, the following conditions shall apply: (a) If you answered "yes" to any one of Questions 1 through 9, the policy for which this application is made for the person(s) identified in Item 10 shall be void, and coverage shall continue under the terms of the previous policy, which may remain in force. Benefits that may be due any person(s) listed in Item 10 will be paid under the previous policy. (b) Any person(s) not listed in Item 10, if eligible, will be covered under the new policy. (c) 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. (d) The Pre-existing Conditions provision in the new policy will run from the original policy's effective date for the benefits provided under the original policy. For the increased benefit amount, the Pre-existing Conditions provision in the new policy will run from the new policy's effective date.

**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 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.**

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 and am applying 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.

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/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](http://www.aflac.com).**

For indemnity policies and other policies that pay a fixed dollar amount per day, excluding long-term care policies.

**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. Medicare generally pays for most or all of these expenses.

This insurance pays a fixed dollar amount, regardless of your expenses, for each day you meet the policy conditions. 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.