

Non-Payroll

**HOSPITAL INTENSIVE CARE PROTECTION INSURANCE POLICY  
(A18400 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 Proposed Insured**

Proposed Insured's Name \_\_\_\_\_  
Last First MI

DOB \_\_\_\_\_ Sex \_\_\_\_\_ SSN \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Month/Day/Year

Are you applying for Dependent Child(ren) coverage?  Yes  No  
If yes, Dependent Children must be under age 26 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 ( ) \_\_\_\_\_

Name of Employer/Association \_\_\_\_\_ Account No. \_\_\_\_\_  
(Optional)

Is this insurance intended to replace any other hospital intensive care insurance now in force?  Yes  No  
If yes, please read and sign the Replacement Notice provided by your associate/agent, if applicable.

Does anyone to be covered have any other hospital intensive care coverage with Aflac?  Yes  No  
If yes, this must be a conversion of that coverage. If yes, give current policy number and see Item 18.  
Policy Number: \_\_\_\_\_

Does anyone to be covered have a Specified Health Event policy with Aflac which contains intensive care benefits?  Yes  No  
If yes, please complete the Supplemental Notification section at the end of this application and be aware that you cannot have this policy without canceling the Aflac policy with intensive care benefits.

**TO BE COMPLETED BY AFLAC ASSOCIATE/AGENT**

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

- Plan 1: (Policy Series A18400)
- Plan 2: (Policy Series A1840H)

**Billing Method:**  
 Direct  Emp. Nonpayroll/Assoc.  01 Monthly (B/D & C/C Only)  06 Semiannual  
 Bank Draft (B/D, ACH)  Credit Card (C/C)  03 Quarterly  12 Annual  
 List Bill

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's/Agent's No. \_\_\_\_\_ Sit. Code \_\_\_\_\_ Billable Premium \$ \_\_\_\_\_ Premium Collected \$ \_\_\_\_\_

**ALL OF THE FOLLOWING MUST BE COMPLETED:**

1. Is anyone to be covered the mother or father of a child currently conceived but as yet unborn?  Yes  No

**If yes, this policy will not be issued.**

2. Is anyone to be covered currently confined in a hospital or nursing home, or has hospitalization been recommended by a Physician?  Yes  No

3. Has anyone to be covered been hospitalized three or more times in the last two years?  Yes  No

4. Has anyone to be covered ever been treated with dialysis (not to include an acute event) or been diagnosed with or treated by a member of the medical profession for chronic kidney disease to include glomerulonephritis, nephrotic syndrome, or polycystic kidney disease or impaired kidney function (not including kidney stones), chronic liver disease, sickle cell anemia, or cystic fibrosis?  Yes  No

5. Has anyone to be covered ever been diagnosed with or medically treated by a member of the medical profession for emphysema, or has anyone to be covered required the use of oxygen for a chronic respiratory disease/disorder, excluding the use of a CPAP machine for the treatment of sleep apnea?  Yes  No

6. Has anyone to be covered ever been diagnosed with or medically treated for acquired immune deficiency syndrome (AIDS) by a member of the medical profession, or has anyone to be covered tested positive for human immunodeficiency virus (HIV)?  Yes  No

7. Has anyone to be covered ever had or been advised to have a Major Organ Transplant or consulted with or been evaluated by a member of the medical profession of the need to have a Major Organ Transplant?  Yes  No

8. In the last five years, has anyone to be covered been diagnosed with or medically treated by a member of the medical profession for:  Yes  No

Angina  
Congestive heart failure  
Heart Attack  
Stroke  
Diabetes requiring the use of insulin

9. In the last five years, has anyone to be covered had or been advised to have any of the following:  Yes  No

Coronary Angioplasty  
Coronary atherectomy  
Coronary bypass surgery  
Heart valve surgery  
Surgery for congenital heart defects

10. In the last 12 months, has anyone to be covered received treatment in a Hospital Intensive Care Unit or a Step-Down Intensive Care Unit (not including treatment as a result of an accident)?  Yes  No

11. In the last 12 months, has anyone to be covered been prescribed or taken any medication for the treatment of infertility?  Yes  No

**12. If any one of Questions 2 through 11 is answered yes, was it the:**

- Proposed 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.**

**If the person named is the Proposed Insured named on the front of this application, a policy will not be issued.**

**APPLICANT'S STATEMENTS AND AGREEMENTS:**

13. I understand that the Effective Date of the policy will be the date recorded in the Policy Schedule by Aflac Worldwide Headquarters.
14. 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. **Benefits of this policy reduce to half at age 70.**
15. I understand that unmarried Dependent Children, if any, must be under age 27 at the time of application. Once covered, Dependent Children will continue to be covered until the anniversary date of the policy following their 27<sup>th</sup> birthday.
16. I acknowledge receipt of, if applicable:  
 Outline of Coverage  Replacement Notice  
 *Guide To Health Insurance for People with Medicare*
17. I understand that the insurance I am applying for will be issued based solely upon the written answers to questions and information asked for in this application and that: (a) Aflac is not bound by any statement made by me, the Proposed Insured 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, riders, and attached papers, 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.

18. If this is an application for a conversion of coverage, the following conditions will apply: (a) If any one of Questions 2 through 11, is answered yes, the policy for which this application is made for the person(s) identified in Item 12 above shall be void, and coverage will continue for this person under the terms of the previous policy, if such policy remains in force. (b) 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.

**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.

**SUPPLEMENTAL NOTIFICATION**

**COMPLETE IF YOU ARE REPLACING/TERMINATING EXISTING AFLAC COVERAGE THAT CONTAINS HOSPITAL INTENSIVE CARE BENEFITS.**

I, \_\_\_\_\_, am applying for Aflac's Hospital Intensive Care Policy. I currently have hospital intensive care benefits under Aflac's Specified Health Event Policy Number \_\_\_\_\_.

I understand that I must cancel existing Aflac Specified Health Event coverage to purchase this Hospital Intensive Care Policy.

- Please cancel my Specified Health Event Policy Number \_\_\_\_\_. I understand that I will be terminating benefits provided for in my current Specified Health Event Policy that will not be provided for in the new Hospital Intensive Care 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.**

If I am applying to replace existing Aflac Hospital Intensive Care 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 Aflac policy and its benefits for the benefits provided in this 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. All statements made in this application are deemed representations and not warranties. I realize that any material misrepresentation therein may result in loss of coverage under the policy.

Signed and Dated at \_\_\_\_\_ on \_\_\_\_\_  
City and State Date

Proposed Insured's Signature \_\_\_\_\_

**I certify that I personally saw the Proposed Insured when the application was written, and each question was asked of the Proposed Insured and answered as recorded. All answers above are correct to the best of my knowledge.**

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 AFLAC.COM.**

**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 provides limited benefits if you meet the conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

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

**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).



Payment Authorization Agreement

Policyholder / Applicant Information

Name: \_\_\_\_\_ Policy Numbers \_\_\_\_\_ Premium \$ \_\_\_\_\_ Policy Numbers \_\_\_\_\_ Premium \$ \_\_\_\_\_
Address: \_\_\_\_\_
City, State, ZIP: \_\_\_\_\_
Phone: \_\_\_\_\_ No. of policies [ ] Total: \$ \_\_\_\_\_

Deduction Information

For newly issued policies only: For ease of your policy administration, we will make the effective date of coverage the same as your selected draft date following the receipt of your application in worldwide headquarters if the policy is issued. Applicant's Initials \_\_\_\_\_

When would you like your premiums deducted?
How often? [ ] Monthly [ ] Quarterly [ ] Semiannually [ ] Annually
Please choose a month for the first deduction. \_\_\_\_\_
Please choose any day 1-28 for the first deduction. \_\_\_\_\_

[ ] I choose to pay by electronic draft.

Draftee Name: \_\_\_\_\_
Depository Name/Branch: \_\_\_\_\_
City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_
Transit/ABA Number: \_\_\_\_\_
Account Number: \_\_\_\_\_ [ ] Checking [ ] Savings

[ ] I choose to pay by credit or debit card.

[ ] Visa [ ] Credit card
[ ] MasterCard [ ] Debit card
[ ] American Express
Card Number: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

Confirmation

I authorize Aflac to initiate debit entries electronically to my account indicated above and I authorize the depository institution named above to debit same to such account. This authorization remains effective and in full force until Aflac and the depository/institution receive written notification from me of its termination in such time and in such manner to afford Aflac and the depository/institution a reasonable opportunity to act on it.

Account Holder's/Card Holder's Signature: \_\_\_\_\_ Date: \_\_\_\_\_
(Pf different from Policyholder/Applicant)
Policyholder's/Applicant's Signature: \_\_\_\_\_ Date: \_\_\_\_\_
Agent's Signature: \_\_\_\_\_ Writing Number: \_\_\_\_\_ Date: \_\_\_\_\_
(Required for SNG Only)

American Family Life Assurance Company of Columbus (Aflac)
Worldwide Headquarters • 1932 Wynnton Road • Columbus, GA 31999-0001
1.800.99.AFLAC. (1.800.992.3522) • aflac.com