



HOSPITAL INTENSIVE CARE PROTECTION INSURANCE POLICY (A18400 Series)

Conversion options: 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/Employee

Proposed Insured's Name Last First MI

DOB Month/Day/Year Sex SSN - -

Are you applying for Dependent Child(ren) coverage? Yes No
If yes, Dependent Children must be under age 25 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 Last First MI DOB Month/Day/Year Sex

Address Street or Post Office Box Apt. No.

City State ZIP

Home Telephone ()

Employee's Name Relationship (If other than Proposed Insured)

*Spouse includes domestic partner (when applicable).

Payroll Account Name Payroll Account No.

(Optional)

Is this insurance intended to replace any other hospital intensive care insurance now in force? Yes No

Does anyone to be covered have any other hospital intensive care coverage with Aflac? Yes No
Policy Number:

Does anyone to be covered have a Specified Health Event policy with Aflac that 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.

Are you covered by Medi-Cal? Yes No If "YES", then a policy will not be issued.

Are you covered by Medicare Parts A and B AND a Medicare Supplement policy or certificate, or contract and coverage for excess charges under Part B? Yes No If "YES", then a policy will not be issued.

Are you covered by a comprehensive health care policy or a comprehensive health maintenance organization (HMO) plan? Yes No

If the answer is "NO", then a policy cannot be issued.

If the applicant is age 65, list all health and disability policies that are still in force (by type and company):

Blank lines for listing health and disability policies.

TO BE COMPLETED BY AFLAC ASSOCIATE/AGENT

Check Coverage Desired:	<input type="checkbox"/> Individual	<input type="checkbox"/> Named Insured/ Spouse Only	<input type="checkbox"/> One-Parent Family	<input type="checkbox"/> Two-Parent Family
<input type="checkbox"/> Plan 1: (Policy Series A18400) <input type="checkbox"/> Plan 2: (Policy Series A1840H)				<input type="checkbox"/> Pre-Tax or <input type="checkbox"/> After-Tax

Billing Method:		Mode:		
<input type="checkbox"/> Payroll Deduction	<input type="checkbox"/> Payroll ACH	<input type="checkbox"/> 01 Weekly	<input type="checkbox"/> 01 14-Day Biweekly	<input type="checkbox"/> 01 28-Day Biweekly
		<input type="checkbox"/> 01 Semimonthly	<input type="checkbox"/> 01 Monthly	<input type="checkbox"/> 03 Quarterly
			<input type="checkbox"/> 06 Semiannual	<input type="checkbox"/> 12 Annual
Employee ID No. _____		Dept. No. _____		Assoc./Agent's No. _____
Billable Premium \$ _____		Premium Collected \$ _____		Sit. Code _____

ALL OF THE FOLLOWING MUST BE COMPLETED:

- Is anyone to be covered currently confined in a hospital or nursing home, or has hospitalization been recommended by a Physician? Yes No
- 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
- 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
- Has anyone to be covered ever been diagnosed with or medically treated for acquired immune deficiency syndrome (AIDS) or ARC by a member of the medical profession? Yes No
- 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
- 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	Stroke
Congestive heart failure	Diabetes requiring the use of insulin
Heart Attack	
- In the last five years, has anyone to be covered had or been advised to have any of the following: Yes No

Coronary Angioplasty	Heart valve surgery
Coronary atherectomy	Surgery for congenital heart defects
Coronary bypass surgery	
- In the last 12 months, has anyone to be covered received treatment for more than 24 hours in a Hospital Intensive Care Unit (not including treatment as a result of an accident)? Yes No

9. If any one of Questions 1 through 8 is answered yes, was it the:

- Proposed Insured/Employee? 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/Employee named on the front of this application, a policy will not be issued.

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

Please note, children born within 10 months of the Effective Date of this policy, as shown in the Policy Schedule, will not be covered for any losses or confinements that occur or begin within the first 28 days of life.

PLEASE INITIAL: _____
Proposed Insured/Employee

APPLICANT'S STATEMENTS AND AGREEMENTS:

11. I understand that the Effective Date of the policy will be the date recorded in the Policy Schedule by Aflac Worldwide Headquarters.
12. I understand that the policy I am applying for will not cover any person who has attained age 66 prior to the Effective Date of the policy. **Some benefits of this policy may reduce to half at age 70.**
13. I understand that unmarried Dependent Children, if any, must be under age 25 at the time of application. Once covered, Dependent Children will continue to be covered until the anniversary date of the policy following their 25th birthday.
14. I acknowledge receipt of, if applicable:
 Outline of Coverage Replacement Notice
 Guide To Health Insurance for People with Medicare
15. 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/Employee 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.

16. If this is an application for a conversion of coverage, the following conditions will apply: (a) If any one of Questions 1 through 8 is answered yes, the policy for which this application is made for the person(s) identified in Item 9 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. Information relating to HIV, AIDS, or ARC status will not be disclosed. 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 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.

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.

CALIFORNIA LAW PROHIBITS AN HIV TEST FROM BEING REQUIRED OR USED BY HEALTH INSURANCE COMPANIES AS A CONDITION OF OBTAINING HEALTH INSURANCE COVERAGE.

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/Employee'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).