



HOSPITAL CONFINEMENT INDEMNITY INSURANCE POLICY (A46000 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 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 19 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)

Payroll Account Name Payroll Account No. (Optional)

Do you have any other hospital indemnity coverage other than a hospital confinement sickness indemnity policy with Aflac? Yes No If yes, this must be a conversion of that coverage. Provide current policy number and see Item 15. 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: Individual Named Insured/Spouse Only One-Parent Family Two-Parent Family Optional Rider: Initial Hospitalization Benefit Rider (Rider Series A46050) \$250 per unit: UNITS: Pre-Tax or After-Tax

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

ALL OF THE FOLLOWING MUST BE COMPLETED:

1. Is anyone to be covered currently confined in a Hospital or nursing home, or has a member of the medical profession recommended hospitalization or nursing home confinement? Yes No

2. Has anyone to be covered ever been medically treated or diagnosed by a member of the medical profession as having any of the following? Yes No
 - * Alzheimer's disease
 - * senile dementia
 - * uncorrected congenital heart defect (excluding mitral valve prolapse)
 - * kidney disease (not including kidney stones)
 - * systemic lupus
 - * insulin-dependent diabetes
 - * end-stage renal disease

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

4. Has anyone to be covered been medically treated or diagnosed by a member of the medical profession for an internal cancer (which includes melanoma of Clark's Level III or higher, or a Breslow level greater than 1.5 mm) within the last five years? Yes No

5. Has anyone to be covered been hospitalized or missed five consecutive days of work within the last 36 months for any of the following? Yes No
 - * angina (heart-related chest pain)
 - * heart surgery
 - * congestive heart failure
 - * heart attack
 - * Parkinson's disease
 - * transient ischemic attack (TIA) (ministroke)
 - * stroke
 - * cerebral vascular insufficiency
 - * peripheral vascular disease (circulatory problems)
 - * Crohn's disease

6. Has anyone to be covered been confined in a Hospital or received medical treatment by a member of the medical profession in an emergency room within the last 12 months for any of the following? Yes No
 - * emphysema
 - * sickle cell anemia
 - * Type II diabetes
 - * hypertension
 - * ulcerative colitis
 - * liver disease or disorder (excluding Hepatitis A)
 - * chronic obstructive pulmonary disease

7. Has anyone to be covered been confined in a Hospital within the last 12 months for treatment of asthma? Yes No

8. **If any one of Questions 1 through 7 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.

9. List all hospital indemnity policies you currently have in force, other than Aflac hospital indemnity policies, and provide the daily benefit amount. _____

APPLICANT'S STATEMENTS AND AGREEMENTS:

10. 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. **Benefits are not payable for any illness, disease, or disorder that is diagnosed by a Physician or medically treated before coverage has been in force 30 days from the Effective Date as shown in the Policy Schedule unless the loss begins more than six months after the Effective Date of coverage.**
11. I understand that the policy I am applying for will not cover any person who has attained age 71 before the Effective Date of the policy.
12. I understand that dependent children, if any, must be under age 19 at the time of application. Once covered, coverage will be extended until the anniversary date of the policy following their 19th birthday (23rd if a full-time student).

13. I acknowledge receipt of, if applicable:

Replacement Notice Outline of Coverage Guide to Health Insurance for People with Medicare

14. I understand 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.
15. If this is an application for a conversion of coverage, the following conditions will apply: (a) If any one of Questions 1 through 7 are answered yes, the policy for which this application is made for the person(s) identified in Item 8 will be void, and coverage will continue under the terms of the previous policy, which may remain in force. Benefits that may be due any person(s) listed in Item 8 will be paid under the previous policy. (b) Any person(s) not listed in Item 8, 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 premium amount listed on this application represents the premium amount that my employer will remit to Aflac on my behalf. 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 indemnity 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/Employee's Signature _____

I certify that I personally saw the Proposed Insured/Employee when the application was written, and each question was asked of the Proposed Insured/Employee 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**

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.

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 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).

AMERICAN FAMILY LIFE ASSURANCE COMPANY OF COLUMBUS (AFLAC)
Worldwide Headquarters: Columbus, Georgia 31999
A Stock Company

ARBITRATION AGREEMENT

I, _____ (Applicant's Name), have applied for a policy of insurance from AFLAC and if AFLAC will issue the policy to me, I want to make this agreement with AFLAC.

I agree that binding arbitration will be used to resolve the following claims, disputes or lawsuits:

1. Any and all claims, disputes or lawsuits that I have concerning my AFLAC policy; and/or
2. Any claims, disputes or lawsuits that I have concerning any relationships that my AFLAC insurance policy creates; and/or
3. Any claims, disputes or lawsuits concerning the validity of this arbitration agreement; and/or
4. Any and all claims, disputes or lawsuits that I have that come up from the proposed sale of the policy by any agent or employee of AFLAC, **including any allegation of fraud or improper act.**

I understand that binding arbitration is the hearing and determining of a dispute I have with AFLAC by three persons, one chosen by me, one chosen by AFLAC and a third neutral person appointed by my representative and AFLAC's representative by agreement. I also understand that if my representative and AFLAC's representative cannot agree on a third neutral party then a list of arbitrators will be provided by the American Arbitration Association to my representative and AFLAC's representative who will then select the third neutral arbitrator from that list. I understand that I will have the choice of having AFLAC pay the fees of the third neutral arbitrator or if I prefer, AFLAC and I will equally divide the expenses and fees of the third neutral arbitrator. Both I and AFLAC agree and understand that we are choosing **ARBITRATION INSTEAD OF LITIGATION** to resolve any of the above described disputes. Both I and AFLAC understand that we have a right or opportunity to litigate disputes through the court but that we prefer to resolve our disputes through arbitration.

Initials _____

Both I and AFLAC voluntarily and with full understanding **WAIVE ANY RIGHT WE HAVE TO A JURY TRIAL**. This waiver applies either to arbitration under this agreement or to a court action filed by me. Both I and AFLAC agree and understand that all disputes arising under law, whether made by the courts or the legislature or any other law which includes but is not limited to all contract, tort and third party disputes, will be decided by the use of binding arbitration. The three arbitrators selected will meet, set a date for a hearing, notify AFLAC and me of that date, have a hearing and make the final decision. Both I and AFLAC agree and understand that the arbitrators shall have all power provided by the law subject to this agreement and the insurance policy. AFLAC and I agree and understand that my insurance policy with AFLAC and all related matters are business transactions involving interstate commerce and shall be governed by the Federal Arbitration act, at 9 U.S.C. Section 1.

Initials _____

AFLAC and I understand that this arbitration agreement constitutes a portion of my application for insurance. AFLAC and I further understand that there is no insurance contract unless and until my application is accepted by AFLAC. Upon acceptance of my application by AFLAC, as evidenced by the issuance of an insurance policy, this arbitration agreement shall be incorporated by this reference into any insurance policy issued. The overall Insurance Contract shall consist of this Arbitration Agreement, the application for insurance and the insurance policy.

Initials _____

By my signature below, I agree that I have read this Arbitration Agreement and understand it.

Witness

Applicant's Signature

Date

Date

Line of Business