Admin. Use Only:-

Worksite

**Application for Cancer Indemnity Insurance (B70000 Series)**
Application to: American Family Life Assurance Company of Columbus
(herein referred to as Aflac)
Worldwide Headquarters • Columbus, Georgia 31999

❑ New
❑ Internal Replacement
❑ Downgrade

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

Address _____
Street or Post Office Box Apt. No.

City _____ State _____ ZIP _____

Telephone ( ) _____

Email Address _____

Are you applying for Dependent Child(ren) coverage? ❑ **Yes** ❑ **No**
If yes, Dependent Children must be under age 26 as of the Effective Date of coverage.

**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

Account Name _____ Account No. _____

Name of Employer _____

**Are you, the Proposed Insured, currently reporting to work (not out on leave, FML, disability, hiatus, or layoff) with the employer listed on this application?** ❑ **Yes** ❑ **No**

**If no, a policy will not be issued; therefore, do not submit this application.**

Is this insurance intended to replace any other health insurance now in force? ❑ **Yes** ❑ **No**
If yes, please read and sign the Replacement Notice provided by your associate/agent.

Is anyone to be covered also covered under any other Cancer coverage with Aflac, **other than** an Aflac Lump Sum Critical Illness policy that includes cancer coverage or a Lump Sum Cancer Benefit Rider? ❑ **Yes** ❑ **No**

If yes, are you the Named Insured on that coverage? ❑ **Yes** ❑ **No**

If yes, then this must be an internal replacement of that coverage.

If your current Cancer coverage is a B70200 or B70300 Series policy and you are applying to decrease your current coverage by selecting a lower B70000 Series policy level, then it is a downgrade.

Are you applying for a downgrade of coverage as described above? ❑ **Yes** ❑ **No**

If yes, please complete the Downgrade Notice and Acknowledgment Form.

Please indicate the current policy number(s) below and see Applicant's Statements and Agreements concerning internal replacements and downgrades.

Policy Number(s) of Coverage to be Replaced: _____

If no, is the person covered:

❑ You? ❑ Your Spouse? ❑ Your Child? If "Your Child," please list the name(s) of the child(ren):

_____

Any person(s) indicated above is/are not eligible for coverage under this policy. If the person indicated above is the Proposed Insured, a policy will not be issued; therefore, do not submit this application.

If a child, are any other children to be covered? ❑ **Yes** ❑ **No**

Were you the Named Insured on Cancer coverage with Aflac, other than an Aflac Lump Sum Critical Illness policy that includes cancer coverage or Lump Sum Cancer Benefit Rider, that was in force within the last 6 months, but is now terminated? ❑ **Yes** ❑ **No**

If yes, you must submit an application for reinstatement of that coverage before applying to replace it with this coverage; therefore, **do not submit this application until the previous coverage has been reinstated**. **If you are not eligible to reinstate your previous coverage then you are not eligible for this policy.**

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

**Cancer Indemnity Policy (Issue Ages 18-75):**

**Policy Selection:**

❑ **Policy (Series B70100)**
❑ **Policy (Series B70200)**
❑ **Policy (Series B70300)**

**Optional Riders:**

❑ **Initial Diagnosis Building Benefit Rider (Series B70050)** Units _____

**(Issue Ages 18-75)**

Options: ❑ No rider ❑ New rider ❑ Retain current rider

❑ **Dependent Child Rider (Series B70051)** Units _____

**(Only available with One-Parent Family or Two-Parent Family coverage. Dependent Children must be under age 26 as of the Effective Date of coverage.)**

Options: ❑ No rider ❑ New rider ❑ Retain current rider

❑ **Specified-Disease Benefit Rider (Series B70052)**

**(Issue Ages 18-75)**

Options: ❑ No rider ❑ New rider ❑ Retain current rider

❑ Pre-Tax
❑ After-Tax

**Billing Method:**
❑ Payroll Deduction
❑ Bank Draft (B/D)
❑ Credit Card (C/C)

**Mode:**
❑ 01 Weekly
❑ 01 14-Day Biweekly
❑ 01 Semimonthly
❑ 01 28-Day Biweekly
❑ 01 Monthly
❑ 03 Quarterly
❑ 06 Semiannual
❑ 12 Annual

**PLEASE NOTE: If B/D or C/C billing method is checked, only the following modes of payment are available: Monthly, Quarterly, Semiannual, or Annual.**

Employee No. _____ Dept. No. _____ Assoc./Agent's No. _____

Billable Premium $ _____ Premium Collected $ _____ Sit. Code _____

**ASSOCIATED CANCEROUS CONDITION:** a myelodysplastic blood disorder, myeloproliferative blood disorder, or internal carcinoma in situ (in the natural or normal place, confined to the site of origin without having invaded neighboring tissue). An Associated Cancerous Condition is limited to only the conditions listed above.

**CANCER:** a disease manifested by the presence of a malignant tumor and characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue. "Cancer" also includes but is not limited to leukemia, Hodgkin's disease, and melanoma.

**INTERNAL CANCER:** all Cancers other than Nonmelanoma Skin Cancer.

**PLEASE COMPLETE THE FOLLOWING UNDERWRITING QUESTIONS.**

**(NOT REQUIRED FOR A DECREASE IN COVERAGE ONLY)**

**Where used in the following questions, the term 'treated' is defined as (1) any consultation, care, or services provided by a member of the medical profession for Cancer or an Associated Cancerous Condition, (2) taking prescribed medications or drugs for Cancer or an Associated Cancerous Condition, or (3) any immunotherapy or chemoprevention therapy meant to decrease the risk of recurrence of Cancer or an Associated Cancerous Condition.**

**1.** Has anyone to be covered ever been diagnosed with or treated for Cancer or an Associated Cancerous Condition of any type or form, **other than Nonmelanoma Skin Cancer**? **❑ Yes ❑ No**

**If yes, please complete Questions 2 through 4. If no, skip to question 4.**

**2.** Has anyone to be covered had Internal Cancer or an Associated Cancerous Condition that was diagnosed or last treated **within the last five years** or received preventive hormonal therapy **within the last 12 months**? **❑ Yes ❑ No**

If yes, was it the ❑ Named Insured ❑ Spouse ❑ Child? Name of the child(ren):

_____

**Any person(s) so designated will not be covered under the policy. If the named person is the Proposed Insured, a policy will not be issued.**

**If a child, are any other children to be covered?** **❑ Yes ❑ No**

**3.** Has anyone to be covered had Internal Cancer or an Associated Cancerous Condition that was diagnosed or last treated **over five years ago**? **❑ Yes ❑ No**

If yes, was it the ❑ Named Insured ❑ Spouse ❑ Child? Name of the child(ren):

_____

**If yes, please complete a Cancer History Form provided by your associate/agent on any individual(s) listed. Additional underwriting may be required.**

**4.** Has anyone to be covered had Nonmelanoma Skin Cancer that was diagnosed or last treated **within the last five years**? **❑ Yes ❑ No**

If yes, was it the ❑ Named Insured ❑ Spouse ❑ Child? Name of the child(ren):

_____

**Any person(s) so designated will be issued a Skin Cancer Exclusion Rider. Benefits will not be payable under the policy for the indicated individual(s) for the treatment of Skin Cancer.**

**If yes and this is an internal replacement, the person(s) so designated is/are not eligible for the replacement coverage.**

**Proposed Insured's Initials** _____

**PLEASE ANSWER THE FOLLOWING QUESTION IF APPLYING FOR THE SPECIFIED-DISEASE RIDER.**

**5.** Has anyone to be covered ever had adrenal hypofunction (Addison's disease), amyotrophic lateral sclerosis (ALS or Lou Gehrig's disease), botulism, bubonic plague, cerebral palsy, cholera, cystic fibrosis, diphtheria, encephalitis (including encephalitis contracted from West Nile virus), Huntington's disease, Lyme disease, malaria, meningitis (bacterial), multiple sclerosis, muscular dystrophy, myasthenia gravis, necrotizing fasciitis, osteomyelitis, polio, rabies, Reye's syndrome, scleroderma, sickle-cell anemia, systemic lupus, tetanus, toxic shock syndrome, tuberculosis, tularemia, typhoid fever, variant Creutzfeldt-Jakob disease (mad cow disease), or yellow fever in any form? ❑ **Yes** ❑ **No**

If yes, was it the ❑ Named Insured ❑ Spouse ❑ Child? Name of the child(ren): _____

**Any person(s) so designated above will not be covered under the Specified-Disease Rider. If the named person is the Proposed Insured and you are applying for Individual coverage, the rider will not be issued.**

**If a child, are any other children to be covered?** ❑ **Yes** ❑ **No**

**APPLICANT'S STATEMENTS AND AGREEMENTS**

- I acknowledge that I have been informed whether there is/are any optional rider(s) available. If any optional rider(s) is/are available, then I acknowledge that I have personally determined which, if any, is/are best for me.

  **Proposed Insured's Initials** _____

- I agree the Effective Date of the policy may not be the date I requested or the date I signed this application. I understand the Effective Date of the policy will be the date recorded in the Policy Schedule by Aflac Worldwide Headquarters.
- I understand that the policy contains a 30-day waiting period. If a Covered Person has Cancer or an Associated Cancerous Condition diagnosed before his or her coverage has been in force 30 days, benefits for treatment of that Cancer or Associated Cancerous Condition, or any recurrence, extension, or metastatic spread of that same Cancer or Associated Cancerous Condition, will apply only to treatment occurring after two years from the Effective Date of the policy or, at my option, I may elect to void the policy from its beginning and receive a full refund of premium.

  **Proposed Insured's Initials** _____

- I understand that the policy and/or rider(s) I am applying for will not cover any person who has reached his or her 76th birthday before the Effective Date of coverage.
- I understand that Dependent Children, if any, must be under age 26 as of the Effective Date of coverage. Once covered, Dependent Children will continue to be covered until their 26th birthday. When coverage on all Dependent Children terminates, you must notify Aflac, in writing, and elect whether to continue the coverage on an Individual or Named Insured/Spouse Only basis. After such notice, Aflac will arrange for the payment of the appropriate premium due, including returning any unearned premium.
- I acknowledge receipt of, if applicable:
  - ❑ Replacement Notice
  - ❑ *Guide to Health Insurance for People with Medicare*
  - ❑ Outline of Coverage
  - ❑ Electronic Delivery Notice
- If this is an application for an internal replacement and it does not qualify as a downgrade, then the following conditions apply: (1) If Cancer or an Associated Cancerous Condition is diagnosed between the date this application is signed and the Effective Date of coverage shown in the Policy Schedule, the coverage for which this application is made will be void, and coverage will continue under the terms of the policy in force prior to this application. (2) If the internal replacement is issued, benefits that may be due any person(s) listed in Question 2 or 4 will be paid under the terms of the policy in force prior to this application. Any person(s) not listed in Question 2 or 4, if eligible, will be covered under the internal replacement. For internal replacements including those that qualify as downgrades, the following conditions apply: (1) the waiting period and the Time Limit on Certain Defenses provision will run from the Effective Date of the internal replacement; and (2) the policy in force prior to this application will be terminated as of the Effective Date of the internal replacement. Any premium paid on the coverage under the policy in force prior to this application that is unearned as of the Effective Date of the internal replacement will be applied to the internal replacement.

  **Proposed Insured's Initials** _____

- I understand that (1) the policy, together with this application, endorsements, benefit agreements, riders, and attached papers, if any, constitutes the entire contract of insurance, and (2) no change to the policy will be valid until approved by Aflac's president and secretary, and noted in or attached to the policy.
- I understand that (1) Aflac is not bound by any statement made by me, or any associate/agent of Aflac, unless written herein, and (2) the associate/agent cannot change the provisions of the policy or waive any of its provisions either orally or in writing.
- 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 on an online enrollment system, if applicable.
- I have read, or had read to me, the statements and answers I have provided on this application. I understand that the policy and/or rider(s) is/are to be issued based upon these statements and answers, and any other pertinent information Aflac may require for proper underwriting. The answers are complete and true. I understand that all statements made in this application are deemed representations and not warranties, but that material misrepresentations herein may result in loss of coverage under the policy and/or rider(s).
- I understand that the purchase of this policy and/or rider(s) is intended to supplement my existing comprehensive health care coverage. It is not intended to replace or be issued in lieu of that coverage.

**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, Kansas, Maine, Massachusetts, Minnesota, Montana, Nevada, New Jersey, North Carolina, Ohio, Oregon, and Virginia.

I prefer to receive an electronic copy of my policy instead of a paper copy. ❑ **Yes** ❑ **No**
If yes, **please enter your email address on Page 1**.

The policy provides limited benefits. Review your policy carefully.

Signed and Dated at _____ on _____
City and State Date

Proposed Insured's Signature _____

**WAS THE ASSOCIATE/AGENT PRESENT AT THE TIME THE APPLICATION WAS COMPLETED? ❑Yes ❑ No**

**If yes, 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 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 WEBSITE 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 pays a fixed amount, regardless of your expenses, if you meet the policy conditions, for one of the specific diseases or health conditions named in the policy. 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
* 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).