AMERICAN HERITAGE LIFE INSURANCE COMPANY (AHL)
1776 AMERICAN HERITAGE LIFE DRIVE
JACKSONVILLE, FL 32224

Allstate. BENEFITS

Group Enrollment and Evidence of Insurability Form

☒ Check if custom form

Account No.	Employee ID	Requested Effective Date	First Deduction Date	Account	Location	Situs State
32734						**FL**

Deduction Mode: ☒ Bi-Weekly

Remarks	*AHL home office use only*	Dep Code ☐ **E** ☐ **S** ☐ **C** ☐ **F**

General Information

All references to spouse include domestic partner relationships.

Employee (Payor/Owner/Certificate holder) Name *(Last, First, M.I.)*	Birth Date	Social Security No.	☐ Male ☐ Female
Residence Street Address		Phone No.	
City, State, Zip	Email Address		
Employer/Association/Union **Tampa Hillsborough Expressway**	Hire Date	Occupation*	

**Occupation with the employer in the General Information section.*

Complete for all other persons you (the employee) are requesting to be insured

Last Name	First Name	Relationship	Gender	Birth Date	Social Security No.

Tobacco Use

If applying for Life or Critical Illness, has the employee used tobacco in the last 12 months? **Employee** ☐ Yes ☐ No

If applying for Life or Critical Illness, has the employee's spouse used tobacco in the last 12 months? **Spouse** ☐ Yes ☐ No

If applying for Life coverage for a dependent child (age 19 or older) as the proposed insured, has that dependent child used tobacco in the last 12 months? **Child** ☐ Yes ☐ No

Qualifying Life Event

Are you applying for coverage or changing existing coverage due to a qualifying event? ☐ Yes ☐ No

Check the qualifying event: ☐ Marriage/Divorce ☐ Birth/Adoption ☐ Spouse New Job/Job Loss ☐ Termination ☐ Work Status Change ☐ Eligible/Ineligible Child ☐ Spouse/Dependent Child Death ☐ Employee Death

Qualifying event date _____ Current certificate number(s) _____

Termination of Current Coverage

Do you currently have any individual coverages with AHL that you wish to terminate in conjunction with this enrollment for group coverage? ☐ Yes ☐ No

If yes, enter the following information: Effective date of termination _____ Policy Number _____

Select the type of coverage: ☐ Accident ☐ Critical Illness ☐ Hospital Indemnity

Employee Name _____ Account No. 32734

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Selection of Coverage

Answer yes or no and complete for each coverage selected.

Accident (GVAP1 On and Off the Job Accident)

Do you want this coverage? ☐ Yes ☐ No Section 125 ☐

Who do you want to cover?

- ☐ Employee Only
- ☐ Employee + Spouse
- ☐ Employee + Child(ren)
- ☐ Family

	Units
Base Coverage	2
☒ Benefit Enhancement Rider	2

Total Deduction

Critical Illness (GVCIP2)

Do you want this coverage? ☐ Yes ☐ No Section 125 ☐

Who do you want to cover?

- ☐ Employee Only
- ☐ Employee + Spouse
- ☐ Employee + Child(ren)
- ☐ Family

- ☒ Second Event Initial Critical Illness Option
- ☒ Wellness Option Units 4
- ☒ Supplemental Critical Illness Option II

Basic Benefit Amount: $ 15,000

Total Deduction

Hospital Indemnity (GVSP1)

Do you want this coverage? ☐ Yes ☐ No Section 125 ☐

Who do you want to cover?

- ☐ Employee Only
- ☐ Employee + Spouse
- ☐ Employee + Child(ren)
- ☐ Family

Choose coverage:	☐ Plan 1	☐ Plan 2
Hospital Related	1	2
Surgery/Inpatient Physician	1	1
Outpatient Related	1	1

Total Deduction

Life

Do you want this coverage? ☐ Yes ☐ No ☐ *Guaranteed Issue* ☐ *Contingent Guaranteed Issue* ☐ *Simplified Issue*

Life product being offered: ☒ Term Life

Requested Face Amount $ _____

Employee Annual Base Salary $ _____

Total Deduction

Riders being applied for:	Units/Amt.
GTLPWP	
GTLLBR	

Employee Name _____ Account No. 32734

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If the proposed insured is your spouse, child or grandchild, provide the following for that proposed insured. ☐ Spouse ☐ Child ☐ Grandchild

Proposed Insured Name *(Last, First, M.I.)*	Social Security No.	☐ Male ☐ Female
Residence Street Address		Birth Date
City, State, Zip	Phone No.	Email Address
Employer of Proposed Insured	Annual Salary	Occupation

Is the child or grandchild proposed for coverage a full-time student? ☐ Yes ☐ No

If the answer is no and the child or grandchild is 19 or older, is he/she actively at work now, for wage or profit, and has he/she worked at least 20 hours each week performing all duties of his/her regular occupation at his/her regular place of employment for at least the last 3 months except for minor illness or injury of 1 week or less, or normal pregnancy? ☐ Yes ☐ No

If you are requesting rider coverage for your spouse or child(ren) and his/her contact information is different from yours, provide his/her name, address, and phone number below.

Replacement and Existing Insurance *(Must answer)*

1a. Replacement. Proposed Insured. Is this insurance to replace or change any existing life coverage? ☐ Yes ☒ No

If yes, indicate product being replaced or changed and complete replacement form provided by your agent (producer), if required by your state.

1b. Agent (Producer). To your knowledge, is change or replacement involved? ☐ Yes ☒ No

2a. Existing Insurance. Proposed Insured. Is there any other (not listed in Question 1a.) life insurance in force or applied for on the proposed insured? If yes, list company name, policy number, year issued, type of coverage, and amount of benefit. ☐ Yes ☒ No

2b. Agent (Producer). To your knowledge, does the proposed insured have existing coverage in force? ☐ Yes ☐ No

Illustration Regulation Certification for Term Life

OWNER. The owner must select one of the following statements.

☐ I certify that I have received an illustration conforming to the coverage applied for. I will complete the applicable illustration certification form provided, if required in my state.

☒ I certify that I did **not** receive an illustration conforming to the coverage applied for. I understand that an illustration conforming to the coverage issued will be provided upon delivery of the certificate.

Agent (Producer). The agent (producer) must select one of the following statements.

☐ I certify that an illustration conforming to the coverage applied for was provided. I will complete the applicable illustration certification form provided, if required.

☒ I certify that **no** illustration conforming to the coverage applied for was provided, but that an illustration conforming to the coverage issued will be provided upon delivery of the certificate.

Employee Name _____ Account No. 32734

Group Enrollment and Evidence of Insurability Form

Beneficiary Designation

Your beneficiary designations will apply to all coverages and riders applied for, including designations for a spouse or covered dependent. For additional beneficiary designation options, complete form ABJ040.

Primary Beneficiary Name *(Last, First, M.I.)*		Social Security No.
Residence Address	Birth Date	Relationship
City, State, Zip	Phone No.	
Contingent Beneficiary Name *(Last, First, M.I.)*		Social Security No.
Residence Address	Birth Date	Relationship
City, State, Zip	Phone No.	

Eligibility Questions

GI -- Guaranteed Issue
CGI -- Contingent Guaranteed Issue
SI -- Simplified Issue

Answer each question for the coverages for which you are applying.

Employee answer for the following: Critical Illness, Hospital Indemnity, GI Life, CGI Life, SI Life

Employee Actively At Work. Is the employee actively at work now, for wage or profit, and has he/she worked at least 20 hours each week performing all duties of his/her regular occupation at his/her regular place of employment for at least the last 3 months except for minor illness or injury of 1 week or less, or normal pregnancy?

Employee ☐ Yes ☐ No

Spouse answer for the following: CGI Life, SI Life

Spouse Actively At Work. Is the employee's spouse actively at work now, for wage or profit, and has he/she worked at least 20 hours each week performing all duties of his/her regular occupation at his/her regular place of employment for at least the last 3 months except for minor illness or injury of 1 week or less, or normal pregnancy?

Spouse ☐ Yes ☐ No

Underwriting Questions for Life Coverage and Late Enrollment Health Coverage

*Answer each question for the coverages for which you are applying. If any of the questions below are answered yes, list the required health history at the end of the section. *For Critical Illness, underwriting questions are not applicable to children.*

Answer for the following: Critical Illness*, Hospital Indemnity, CGI Life, SI Life

1. AIDS History. In the last 5 years, has the person(s) to be insured tested positive for exposure to the HIV infection or been diagnosed by a licensed health care practitioner as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) caused by the HIV infection or other sickness or condition derived from such infection?

Employee ☐ Yes ☐ No
Spouse ☐ Yes ☐ No
Child(ren) ☐ Yes ☐ No

Answer for the following: CGI Life, SI Life

2. Recently Disabled/Hospitalized. In the last 6 months, has the person(s) to be insured been disabled or hospitalized for anything other than lacerations or broken bones due to an accident, or normal pregnancy?

Employee ☐ Yes ☐ No
Spouse ☐ Yes ☐ No
Child(ren) ☐ Yes ☐ No

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Answer for the following: SI Life

3. Chronic Disease History. In the last 2 years, has a licensed health care practitioner diagnosed or treated the person(s) to be insured for any of the following?

- Anemia (other than iron deficiency)
- Anxiety, depression or other mental or nervous illness (that resulted in hospitalizations, disability from work, or suicide attempts)
- Asthma (only if taking steroidal medication and/or have been hospitalized)
- Cancer, except basal cell carcinoma
- Diabetes
- Epilepsy and/or seizure disorder
- Heart attack, cardiomyopathy, congestive heart failure, heart murmur (and taking medication(s)), angioplasty, coronary artery bypass surgery, coronary artery disease, stent, pacemaker, heart valve replacement or any other heart disorder
- Hemophilia
- Hepatitis
- Kidney Disease/Disorder (including dialysis and/or chronic renal failure)
- Liver Disease/Disorder
- Lou Gehrig's Disease (ALS)
- Lung Disease/Disorder (other than asthma)
- Lupus
- Multiple Sclerosis
- Muscular Dystrophy
- Parkinson's Disease, scleroderma, polymyositis, or fibromyalgia
- Stroke including aneurysm, transient ischemic attack (TIA), or arteriovenous malformation
- Transplant of any organ
- Counseling for, or excessive use of, alcohol or any type of drugs

Employee ☐ Yes ☐ No
Spouse ☐ Yes ☐ No
Child(ren) ☐ Yes ☐ No

Answer for the following: Critical Illness*, Hospital Indemnity, SI Life

4. Blood Pressure History. In the last year, has the person(s) to be insured had a systolic blood pressure reading higher than 150 more than once or a diastolic blood pressure reading higher than 100 more than once that was confirmed by a licensed health care practitioner?

Employee ☐ Yes ☐ No
Spouse ☐ Yes ☐ No
Child(ren) ☐ Yes ☐ No

Answer for the following: SI Life

5. Driving History. In the last 3 years, has the person(s) to be insured had his/her driver's license suspended or revoked due to driving violations, been convicted of reckless driving or driving under the influence, been involved in 3 or more motor vehicle accidents, or received 3 or more moving violations? If yes, provide details including license number and state of issue.

Employee ☐ Yes ☐ No
Spouse ☐ Yes ☐ No
Child(ren) ☐ Yes ☐ No

Answer for the following: Hospital Indemnity

6a. Cancer Diagnosis/Treatment History. Has a licensed health care practitioner ever diagnosed or treated the person(s) to be insured for any type of cancer (except basal cell carcinoma)?

Employee ☐ Yes ☐ No
Spouse ☐ Yes ☐ No
Child(ren) ☐ Yes ☐ No

6b. Cancer Leukemia/Lymphoma. If the answer to the Cancer Diagnosis/Treatment History question is yes, has a licensed health care practitioner diagnosed or treated that person(s) for Leukemia, Hodgkin's Disease, Lymphoma, or cancer with any lymph node involvement or metastasis?

Employee ☐ Yes ☐ No
Spouse ☐ Yes ☐ No
Child(ren) ☐ Yes ☐ No

6c. Cancer Other. If the answer to the Cancer Diagnosis/Treatment History question is yes, in the last 5 years has a licensed health care practitioner diagnosed or treated that person(s) for any other type of cancer (other than those listed in the Cancer Leukemia/Lymphoma question and/or basal cell carcinoma)?

Employee ☐ Yes ☐ No
Spouse ☐ Yes ☐ No
Child(ren) ☐ Yes ☐ No

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Answer for the following: Critical Illness

7. Major Medical Condition History. In the last 2 years, has a licensed health care practitioner diagnosed or treated the person(s) to be insured for any of the following?

Employee ☐ Yes ☐ No
Spouse ☐ Yes ☐ No

- Cancer (except basal cell carcinoma)
- Central Nervous System Disease or disorder (to include Multiple Sclerosis or Muscular Dystrophy)
- Chronic Fatigue Syndrome
- Counseling for alcohol or drug abuse
- Diabetes
- Emphysema
- Fibromyalgia
- Heart Disease/Disorder
- Kidney Disease/Disorder (including dialysis and/or chronic renal failure)
- Liver Disease/Disorder
- Lung Disease/Disorder
- Lupus
- Optic Neuritis
- Pancreas Disease
- Parkinson's Disease
- Paralysis
- Rheumatoid Arthritis
- Stroke including aneurysm, transient ischemic attack (TIA), or arteriovenous malformation

Answer for the following: Critical Illness*, Hospital Indemnity, SI Life

8. Advised Medical Procedure History. In the last 5 years, has a licensed health care practitioner advised or recommended that the person(s) to be insured have any medical or surgical procedures (including organ transplant), which have not yet been performed?

Employee ☐ Yes ☐ No
Spouse ☐ Yes ☐ No
Child(ren) ☐ Yes ☐ No

Answer for the following: Supplemental Critical Illness Benefits Option

9. Brain/Eye/Hearing Disorder History. In the last 5 years, has a licensed health care practitioner diagnosed, advised, treated, or consulted the person(s) to be insured for any of the following?

Employee ☐ Yes ☐ No
Spouse ☐ Yes ☐ No

- Alzheimer's Disease, dementia, senility or organic brain syndrome
- Macular degeneration, glaucoma, optic neuritis, or cataracts
- An average hearing threshold sensitivity for air conduction of 40 decibels or greater

Provide height and weight.

10. Employee for the following: SI Life, Critical Illness, Hospital Indemnity — **Height:** _____ ft. _____ in **Weight:** _____ lbs.

Spouse for the following: SI Life (when proposed insured) — **Height:** _____ ft. _____ in **Weight:** _____ lbs.

Child for the following: SI Life (when proposed insured) — **Height:** _____ ft. _____ in **Weight:** _____ lbs.

Answer for the following: SI Life (over $150,000)

11. Physician Information. Provide the names and addresses of all physicians (or other licensed health care practitioners) for each person to be insured. The required health history section may be used if additional space is needed.

Answer for the following: All products

12. Required Health History. Provide health history for any yes answers to the underwriting questions (except questions about AIDS). Include physician's (or other licensed health care practitioners') name, address and telephone number:

Employee Name _____ Account No. 32734

Group Enrollment and Evidence of Insurability Form

REPRESENTATION. I have read or had read to me this completed form and understand that any misstatement or misrepresentation in this form may result in loss of coverage. I represent that statements and answers contained in this form are representations, not warranties, and are true, complete, and correctly recorded. **UNDERSTANDING.** I understand that: if premiums for the coverage(s) is (are) to be paid by payroll deductions, these deductions may start before the "effective date" of coverage(s) and that this does not change the effective date of coverage; and the "effective date" for health insurance coverages will be the date recorded on the policy/certificate/benefit statement, not the date the application is signed. If the coverage(s) is (are) not issued, AHL will refund any deductions it receives. I also understand that no agent (producer) has authority to waive any answer or otherwise modify this application, or to bind AHL in any way by making any promise or representation that is not set out in writing in this application. I understand that if I refuse any coverage for which I am eligible, satisfactory proof of insurability may be required, at my own expense, should I desire to apply for it at a later date. Any such form may be declined on the basis of such proof. **PREMIUM DEDUCTION AUTHORIZATION (EMPLOYEE). I AUTHORIZE** my employer to deduct from my salary or wages, if applicable, the necessary premium for the coverages requested. **AUTHORIZATION TO OBTAIN AND DISCLOSE CERTAIN DATA (FOR SI LIFE AND CRITICAL ILLNESS)**. I authorize any physician, medical practitioner, hospital, clinic or other medical facility, Pharmacy Benefit Managers, insurance company, MIB, Inc. or other organization, institution or person, that has records or knowledge of me or my health including my prescription medication history to give to AHL, its subsidiaries or its reinsurers any information. I also authorize AHL, or its reinsurers, to make a brief report of my health information to MIB, Inc. I understand that there is a possibility of redisclosure of any information disclosed pursuant to this authorization and that information, once disclosed, may no longer be protected by federal rules governing privacy and confidentiality. I acknowledge receipt of the Important Notice About Privacy and MIB Notice form. A copy of this authorization is as valid as the original. This authorization applies to any minor dependent for whom insurance is requested. This authorization is valid for 24 months from the date signed. I understand that I may revoke this authorization at any time by notifying AHL in writing of my desire to do so.

FRAUD NOTICE: Any person who knowingly and with intent to injure, defraud or deceive any insurer, files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Employee/Payor/Owner Signature _____ City/State _____ Date Signed _____

Proposed Insured Signature (if not employee/payor/owner and if required by your state or face amount being requested) _____

Agent's (Producer's) Statement. I certify that to the best of my knowledge and belief the information on this form is complete, accurate and correctly recorded.

Soliciting Florida Agent (Producer) Signature _____ Soliciting Agent (Producer) Name Printed _____

Florida Agent License Number _____

Home office or agent (producer) to complete before issue:

Agent (Producer) Name	Agent (Producer) Number	Percentage Credit	Agent (Producer) Name	Agent (Producer) Number	Percentage Credit
Servicing Agent (Producer)			Soliciting Agent (Producer)		

PAYROLL DEDUCTION AUTHORIZATION FORM

AGENT NAME/#_____

EMPLOYEE NAME:_____DEPT/EMPLOYER_____/XWAY AUTHORITY

EMPLOYEE ID #:_____MODE OF DEDUCT.:BIWK_____DATE OF FIRST DEDUCTION:1/1/2026

PER OPEN ENROLLMENT

PLAN/CARRIER	PRE TAX	POST TAX	PLAN/CARRIER	PRE TAX	POST TAX	PLAN/CARRIER	POST TAX
AFLAC ACCIDENT			ALLSTATE ACCIDENT			**US LEGAL TOTAL**	
AFLAC CANCER			ALLSTATE CANCER			LEGAL TOTAL - OTHER	
AFLAC HOSPITAL			ALLSTATE HOSPITAL				
AFLAC SICKNESS			ALLSTATE GIM			AIP TOTAL	
AFLAC CRITICAL CARE			ALLSTATE CRITICAL ILLNESS				
AFLAC DENTAL			ALLSTATE LIFE	N/A		PET PLAN TOTAL	
AFLAC D.I.	N/A		ALLSTATE D.I.	N/A			
AFLAC - OTHER			ALLSTATE - OTHER			LIFE TOTAL - OTHER	
AFLAC TOTALS:			**ALLSTATE TOTALS:**				

I authorize my employer to deduct from my pay such amounts as marked above.

I understand that pre-tax elections cannot be changed prior to the next plan anniversary date, unless due to a qualifying event per IRS guidelines.

APPLICANT SIGNATURE:_____ DATE:_____

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 agent and provide the policy number, company name, and Effective Date of the policy being replaced here: _____

_____

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.**

If applying for an optional lump sum critical illness benefit rider (Aflac Plus Rider), please answer the following questions:

Is the lump sum critical illness benefit rider intended to replace any other health insurance now in force? ❑ **Yes** ❑ **No**
If yes, please read and sign the Replacement Notice provided by your agent and provide the policy number, company name, and Effective Date of the policy being replaced here:_____

_____

Is anyone to be covered also covered under any other lump sum critical illness benefit rider on any other policy? ❑ **Yes** ❑ **No**
If yes, anyone covered under an existing lump sum critical illness benefit rider cannot be covered under the new rider; therefore, the new rider will not be issued.

Are you applying to convert your current HSA-compatible lump sum critical illness benefit rider (Series CIRIDERH) to the lump sum critical illness benefit rider (Series CIRIDER) that is not HSA-compatible? ❑ **Yes** ❑ **No**
If yes, please complete the Notice and Acknowledgment Regarding Conversion form provided by your agent.

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

Optional Lump Sum Critical Illness Benefit Riders (Issue Ages 18-70):
Select One Rider:

❑ **Aflac Plus Rider (Series CIRIDER)** **or** ❑ **Aflac Plus Rider (Series CIRIDERH)**
Options: ❑ No rider ❑ New rider ❑ Retain current rider ❑ Convert 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. _____ 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 by a licensed member of the medical profession 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 by a licensed member of the medical profession **within the last five years (two years for breast cancer)** 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 by a licensed member of the medical profession **over five years ago (two years for breast cancer)**? ❑ **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 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 by a licensed member of the medical profession **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 diagnosed or treated by a licensed member of the medical profession? ❑ **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 120 days 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*
  - ❑ Aflac Plus Rider Conversion Notice
  - ❑ Aflac Plus Rider Outline of Coverage
  - ❑ Outline of Coverage
  - ❑ Electronic Delivery Notice
  - ❑ Aflac Plus Rider Replacement 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)**;** (2) the waiting period and the Time Limit on Certain Defenses provision will run from the Effective Date of the internal replacement; and (2)**;** (3) 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 agent of Aflac, unless written herein, and (2) the 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 to the best of my knowledge. 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.

ADDITIONAL APPLICANT'S STATEMENTS AND AGREEMENTS FOR LUMP SUM CRITICAL ILLNESS BENEFIT RIDER:

- I understand that the lump sum critical illness rider I am applying for will not cover any person who has reached his or her 71st birthday before the Effective Date of the rider.
- I understand that coverage is not provided for any illness, disease, infection, disorder, or injury for which, within the 12-month period before the Effective Date of coverage, medication prescribed by a medical professional was taken or medical testing, medical advice, consultation, or treatment was recommended by or received from a medical professional, or for which conditions existed that would ordinarily cause a prudent person to seek diagnosis, care, or treatment from a medical professional. Benefits for a loss that is caused by a Pre-existing Condition will not be covered unless the Onset Date is more than 12 months after the Effective Date of coverage. If this coverage is a replacement of similar coverage, we will give credit for the time the person was covered under previous coverage when determining the Pre-existing Conditions Limitation, exclusive of any applicable waiting periods under the new coverage.

Proposed Insured's Initials _____

- If this is an application for a conversion of the lump sum critical illness benefit rider, I understand that: (1) the Time Limit on Certain Defenses provision will run from the Effective Date of the new coverage, (2) the original coverage(s) will be terminated as of the Effective Date of the new coverage, and (3) the Pre-existing Conditions provision in the new coverage will run from the original coverage's Effective Date.

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

Any person who knowingly and with intent to injure, defraud or deceive any insurer, files a statement of claim or an application containing any false, incomplete or misleading information, is guilty of a felony of the third degree.

Proposed Insured's Signature _____

WAS THE 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.

Agent's Signature _____ Date _____
Licensed Agent

Typed or Printed Name of Agent: _____

Agent Telephone Number: _____

Agent Florida License Number: _____

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).

Payroll

Application for Dental Insurance (A82000 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/Employee's Name _____
Last First MI

DOB _____ Sex _____ SSN _____ - _____ - _____
Month/Day/Year (Optional)

Address _____
Street or Post Office Box Apt. No.

City _____ State _____ ZIP _____

Home Telephone ( ) _____ Business Telephone ( ) _____

E-Mail Address (optional) _____

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

Name of Dental Provider (optional): _____

Payroll Account Name _____ Payroll Account No. _____

Name of Employer _____

Does anyone to be covered have any other dental insurance coverage in force with another company? ❑ Yes ❑ No

Does anyone to be covered have any other Aflac dental insurance? ❑ Yes ❑ No
If yes, this must be a conversion of that coverage.
Please provide your current policy number. _____

Does the policy listed above include the orthodontic and/or cosmetic rider? ❑ Yes ❑ No
Please read the **NOTE – IF THIS IS AN APPLICATION FOR CONVERSION** section on Page 2.

Is this insurance intended to replace any other dental insurance now in force? ❑ Yes ❑ No
If yes, please read and sign the Replacement Notice provided by your agent and provide the policy number, company name, and Effective Date of the policy being replaced here: _____

TO BE COMPLETED BY AFLAC AGENT

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

❑ Essentials Policy (Series A82100) $30 Dental Wellness
❑ Level 1 Policy (Series A82200) $60 Dental Wellness
❑ Level 2 Policy (Series A82300) $60 Dental Wellness
❑ Level 3 Policy (Series A82400) $90 Dental Wellness

❑ Pre-Tax
or
❑ After-Tax

❑ Orthodontic Benefit Rider (Series A82050)

❑ Cosmetic Benefit Rider (Series A82051) ❑ After-Tax Only

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

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

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

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

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

NOTE – IF THIS IS AN APPLICATION FOR CONVERSION: Any increased benefit amounts resulting from the replacement of Aflac coverage with this new coverage will be subject to new Waiting Periods, if any, beginning with the Effective Date of this new coverage. The new Waiting Periods, if any, apply only to the amount of coverage being increased. If the Waiting Period is not met on the new policy, then any benefits due will be paid under the previous plan.

If I am applying to replace existing Aflac 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, including any attached rider(s) and its benefits, for the benefits provided in this Aflac policy.

Proposed Insured's Initials _____

APPLICANT'S STATEMENTS AND AGREEMENTS

- I understand that the Effective Date of the policy will be the date recorded in the Policy Schedule by Aflac Worldwide Headquarters. It is not the date this application was signed by me.
- 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.
- I understand that the policy I am applying for contains different Waiting Periods for benefits listed in the Schedule of Dental Procedures in the policy. This means that no benefits are payable during the listed Waiting Period. The Waiting Period begins on the Effective Date of the policy.
- I understand that Dependent Children, if any, must be under age 26 at the time of application. Once covered, Dependent Children will continue to be covered until their 26th birthday.
- I acknowledge receipt of, if applicable:
  ❑ Replacement Notice ❑ Outline of Coverage ❑ *Guide To Health Insurance for People with Medicare*
- I understand that (1) The policy of insurance I am now applying for will be issued based upon the written answers to the questions and information asked for in this application and any other pertinent information Aflac may require for proper underwriting; (2) The policy, together with this application, endorsements, benefit agreements, riders, and attached papers, if any, constitutes the entire contract of insurance; and (3) 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 agent of Aflac, unless written herein and (2) The 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, if applicable. 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 agent.
- I have reviewed the statements and answers I have provided on this application. I understand that this policy is 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 to the best of my knowledge and belief. 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 this policy.

I would prefer to receive an electronic copy of my policy(ies) instead of paper. ❑ Yes ❑ No

Any person who knowingly and with intent to injure, defraud or deceive any insurer, files a statement of claim or an application containing any false, incomplete or misleading information, is guilty of a felony of the third degree.

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.

Agent's Signature _____ Date _____
Licensed Resident Agent

Typed or Printed Name of Agent: _____

Agent Telephone Number: _____

Agent Address: _____

Agent Florida License Number: _____

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.

American Family Life Assurance Company of Columbus (Aflac)
Worldwide Headquarters • Columbus, Georgia 31999
For information, call toll-free 1.800.99.AFLAC (1.800.992.3522).

Additional Information Supplement Form

This is part of the application and will become part of the policy.

Proposed Insured _____

Policy Number (if applicable) _____

The following information must be completed on each Dependent Child to be covered.

Name – Last, First, MI	Date of Birth	Sex
		❑ M ❑ F
		❑ M ❑ F
		❑ M ❑ F
		❑ M ❑ F
		❑ M ❑ F
		❑ M ❑ F
		❑ M ❑ F
		❑ M ❑ F
		❑ M ❑ F
		❑ M ❑ F
		❑ M ❑ F
		❑ M ❑ F
		❑ M ❑ F
		❑ M ❑ F
		❑ M ❑ F

Any Dependent Child whose dependency has terminated and who desires to continue coverage as a named insured under a separate policy may do so by notifying Aflac of the request in writing prior to 31 days after the date he or she is no longer considered a Dependent Child.

American Family Life Assurance Company of Columbus
(herein referred to as Aflac)
Worldwide Headquarters • Columbus, GA 31999
For information, call toll-free 1.800.99.AFLAC (1.800.992.3522).

Suitability Notice

I, _____, have reviewed the benefits and premium of the insurance
Proposed Insured's Name

policy(ies) and/or riders that I am applying for and agree to the following.

- I understand the impact that the premium for this coverage has on my paycheck/income;
- I understand the impact that the total Aflac premium for this coverage and any other Aflac coverage has on my paycheck/income and believe it to be appropriate for me; and
- I have considered all of my existing health insurance coverage, with Aflac and/or with other carriers, and believe this additional coverage is appropriate for my insurance needs. I further understand that I can contact Aflac and/or other insurance carriers to assist in evaluating the suitability of insurance coverage for me.

Proposed Insured's Signature _____ Date _____

I certify that I have advised the applicant to consider the impact that this Aflac coverage has on his or her paycheck/income, and I agree with the applicant's decision that it is appropriate for purchase.

Associate's/Agent's Signature _____ Date _____
Licensed Associate/Agent

Application

Full Name _____ Date of Birth _____
Last *First* *Middle*

Spouse Name _____ Date of Birth _____
Last *First* *Middle*

Address _____
Street Address *Apartment/Unit #*

_____
City *State* *Zip Code*

Phone _____ Email _____
*(*Required as this will be where policy and ID are delivered)*

Social Security Number or Employee ID _____

Employer Name _____

I want to enroll:
(based on 26 deductions per year)

☐ **Family Defender** $8.65 BI-WEEKLY
☐
☐

Disclaimer and Signature

I declare, under penalty of perjury, that the information provided in this application is true and correct to the best of my knowledge. I understand that legal services will be provided as outlined in the contract and that I will be responsible for any filing fees, court costs, etc. associated with any action. By submitting this application, I authorize for a monthly payment to be collected as indicated in this application or by any other method I change to in the future. I understand that the attorney-client relationship is confidential and such relationship is with my assigned attorney and not with U.S. Legal Services. By submitting this application, I understand that U.S. Legal Services will deliver electronically, via email, both the Plan Policy and Member ID Card. I understand that the Plan Policy will be made available at **www.uslegalservices.net.** I understand that I have the option to receive a hard copy of the Plan Policy and can do so by contacting U.S. Legal Services at **fulfillment@uslegalservices.net.** Electronic delivery may be limited in some states; in those circumstances, U.S. Legal Services will deliver the Plan Policy via U.S. Mail. Not sponsored or approved by the United States Government or any Department or Agency thereof.

Signature _____ Date _____

BeneCom℠

PAYROLL DEDUCTION AUTHORIZATION FORM

AGENT NAME/#_____

EMPLOYEE NAME:_____DEPT/EMPLOYER_____/_____

EMPLOYEE ID #:_____MODE OF DEDUCT.:_____DATE OF FIRST DEDUCTION:_____

PLAN/CARRIER	PRE TAX	POST TAX	PLAN/CARRIER	PRE TAX	POST TAX	PLAN/CARRIER	POST TAX
AFLAC ACCIDENT			ALLSTATE ACCIDENT			**US LEGAL TOTAL**	
AFLAC CANCER			ALLSTATE CANCER			LEGAL TOTAL - OTHER	
AFLAC HOSPITAL			ALLSTATE HOSPITAL				
AFLAC SICKNESS			ALLSTATE GIM			AIP TOTAL	
AFLAC CRITICAL CARE			ALLSTATE CRITICAL ILLNESS				
AFLAC DENTAL			ALLSTATE LIFE	N/A		PET PLAN TOTAL	
AFLAC D.I.	N/A		ALLSTATE D.I.	N/A			
AFLAC - OTHER			ALLSTATE - OTHER			LIFE TOTAL - OTHER	
AFLAC TOTALS:			**ALLSTATE TOTALS:**				

I authorize my employer to deduct from my pay such amounts as marked above.
I understand that pre-tax elections cannot be changed prior to the next plan anniversary date, unless due to a qualifying event per IRS guidelines.

APPLICANT SIGNATURE:_____ DATE:_____