

Peace of Mind *and* Real Cash Benefits



VOLUNTARY INDEMNITY PLAN
HOSPITAL CONFINEMENT INDEMNITY INSURANCE

VIP²

To the employees of:



Underwritten by:
American Family Life Assurance Company of Columbus
Worldwide Headquarters | 1932 Wynnton Road | Columbus, Georgia 31999



VOLUNTARY INDEMNITY PLAN

HOSPITAL CONFINEMENT INDEMNITY INSURANCE

Policy A-44200-TX

VIP²

BENEFITS COVERED BY THE VOLUNTARY INDEMNITY PLAN:

HOSPITAL CONFINEMENT
SURGICAL

HEART ATTACK, SUDDEN CARDIAC ARREST,
STROKE, COMA, AND PARALYSIS

WELLNESS
PLUS MORE

Treatment or confinement in a U.S. government hospital does not require a charge for the benefits listed below to be payable.

BENEFIT	BENEFIT AMOUNT	LIFETIME MAXIMUM PER INSURED AND ADDITIONAL BENEFIT INFORMATION
HOSPITAL CONFINEMENT	\$100/day, Days 1–7 \$200/day, Days 8–30 \$400/day, Days 31–180	When a covered person requires hospital confinement for 14 or more hours for a covered Sickness or injury, Aflac will pay this benefit per day for each day a covered person is charged. Benefits are not payable for days beyond the 180th day in a period of hospital confinement. <i>No lifetime maximum.</i>
SHORT-STAY	\$100 for a period of at least 6 hours but less than 14 hours	Aflac will pay this benefit when a covered person incurs a charge for a bed due to a medically necessary confinement in a hospital for a period of at least six but less than 14 hours and is not eligible for any other benefit in the policy. This benefit is not payable for confinement or treatment in an emergency room and is payable only once per 24-hour period. <i>No lifetime maximum.</i>
SURGICAL	\$50–\$1,000 (based on the Schedule of Operations listed in the policy)	Payable when a surgical operation is performed on a covered person for a covered Sickness or injury in a hospital or ambulatory surgical center. Only one benefit is payable per 24-hour period for surgery even though more than one surgical procedure may be performed. The highest eligible benefit will be paid. Surgical Benefits are not payable for surgery performed in a doctor's or dentist's office, clinic, or other such location. Benefits are not payable within the first 12 months of the Effective Date of the policy for elective surgery that is not medically necessary. If any operation for the treatment of a covered Sickness or injury is performed other than those listed, Aflac will pay an amount comparable to the amount shown in the Schedule of Operations for the surgery most similar in severity and gravity. <i>No lifetime maximum.</i>
WELLNESS	\$50 once per 12-month period, payable after 12 months of paid premium	Payable if you or any one family member undergoes routine examinations or other preventive testing following each anniversary of the policy Effective Date. Benefits include and are payable for dental exams, annual physical exams, mammograms, Pap smears, eye exams, immunizations, flexible sigmoidoscopies, prostatic specific antigens (PSAs), ultrasounds, and blood screenings. Services must be under the supervision of or recommended by a physician, and a charge must be incurred. This benefit is payable only once per 12-month period. <i>No lifetime maximum.</i>
HEART ATTACK, SUDDEN CARDIAC ARREST, STROKE, COMA, AND PARALYSIS	\$2,000/\$1,000	Aflac will pay \$2,000 the first time a covered person is diagnosed as having had any one of the following, whichever occurs first: heart attack, sudden cardiac arrest, stroke, coma for a period of at least seven days, or paralysis for a period of at least 30 days. We will pay this benefit no more than once per covered person. <i>Lifetime maximum of \$2,000 per covered person.</i> Aflac will pay \$1,000 when a covered person is later diagnosed as having had any one of the following: heart attack, sudden cardiac arrest, stroke, coma for a period of at least seven days, or paralysis for a period of at least 30 days. The heart attack, sudden cardiac arrest, stroke, coma, or paralysis must occur more than 180 days after the above benefit becomes payable. This \$1,000 benefit will again become payable for a diagnosis occurring more than 180 days after it was last paid. The heart attack, sudden cardiac arrest, stroke, coma, or paralysis must occur while coverage is in force and is subject to a 30-day waiting period. <i>No lifetime maximum.</i>
AMBULANCE	\$100/\$1,000	Aflac will pay \$100 for ground ambulance and \$1,000 for air ambulance if, due to a covered Sickness or injury, a covered person requires transportation to or from a hospital. A licensed professional ambulance company must provide the ambulance service. This benefit is limited to two trips per calendar year, per covered person. <i>No lifetime maximum.</i>

Aflac herein means American Family Life Assurance Company of Columbus.

OTHER BENEFITS

WAIVER OF PREMIUM BENEFIT: After you have received Hospital Confinement Benefits for 30 days in a period of hospital confinement, Aflac will waive from month to month any premium(s) falling due during your continued hospital confinement. When Hospital Confinement Benefits are no longer being paid, premium payments must be resumed.

CONTINUATION OF COVERAGE BENEFIT: Aflac will waive all monthly premium due for the policy and riders for up to two months if you meet all of the following conditions: (1) The policy has been in force for at least six months; (2) We have received premiums for at least six consecutive months; (3) Your premiums have been paid through payroll deduction and you leave your employer for any reason; (4) You or your employer notifies us in writing within 30 days of the date your premium payments cease due to your leaving employment; and (5) You re-establish premium payments through your new employer's payroll deduction process or direct payment to Aflac. You will again become eligible to receive this benefit after you re-establish your premium payments through payroll deduction for a period of at least six months and we receive premiums for at least six consecutive months. *Payroll deduction* means your premium is remitted to Aflac for you by your employer through a payroll deduction process.

ADDITIONAL INFORMATION

PRE-EXISTING CONDITIONS: A *Pre-Existing Condition* is a Sickness or injury for which, within the 12-month period before the Effective Date of coverage, medical advice, consultation, or treatment was recommended or received, or for which symptoms existed that would ordinarily cause a prudent person to seek diagnosis, care, or treatment. Care or treatment caused by a Pre-Existing Condition will not be covered unless it begins more than six months after the Effective Date of coverage. A Sickness that is diagnosed or treated within the 30-day waiting period will not be covered for 12 months from the Effective Date of coverage.

A *Sickness* is an illness, disease, or disorder diagnosed or treated 30 days or more after the Effective Date of coverage and while coverage is in force. It also includes a pregnancy that starts more than 30 days after your Effective Date of coverage and while coverage is in force.

GUARANTEED-RENEWABLE: The policy is guaranteed-renewable for your lifetime, subject to Aflac's right to change the applicable table of premium rates by class upon any renewal date.

EFFECTIVE DATE: The Effective Date of the policy is the date shown in the Policy Schedule, not the date the application is signed.

FAMILY COVERAGE: Family coverage includes the insured, spouse, and dependent children to age 26. Newborn children are automatically insured from the moment of birth. One-parent family coverage includes the insured and all dependent children to age 26.

GRACE PERIOD: A Grace Period of 31 days will be granted for the payment of each premium falling due after the first premium. During the Grace Period, the policy shall continue in force.

PREMIUMS: Premiums are subject to change.

Risk Class: _____

Annual Semiannual Quarterly Monthly

Policy: A-44200-TX \$ _____ \$ _____ \$ _____ \$ _____

The person to whom the policy is issued is permitted to return the policy to Aflac within 30 days of its delivery and to have the premium paid refunded.

WHAT IS NOT COVERED

LIMITATIONS AND EXCLUSIONS: The Sickness benefits of the policy are subject to a 30-day waiting period. Benefits are not payable for any Sickness that is diagnosed or treated before coverage has been in force 30 days from the Effective Date shown in the Policy Schedule or any Sickness diagnosed or treated prior to the Effective Date of the policy. If the period of hospital confinement follows a previously covered confinement, it will be considered a continuation of the first confinement, unless the later confinement is the result of an entirely unrelated Sickness or injury, or the confinements are separated by 30 days or more. Newborn children born within the first ten months of the policy Effective Date will be subject to a 30-day waiting period for Sickness.

The policy does not cover losses caused by or resulting from: intentionally self-inflicting bodily injury or attempting suicide; participating in any illegal activity that is classified as a felony (the term *felony* is as defined by the law of the jurisdiction in which the activity takes place); being exposed to war or any act of war, declared or undeclared, or service in the armed forces; having treatment for a mental or nervous disorder without demonstrable organic disease; alcoholism or drug dependency; any loss sustained or contracted due to a covered person's being intoxicated or under the influence of alcohol, drugs, or any narcotic unless administered on the advice of a physician and taken according to the physician's instructions (the term *intoxicated* refers to that condition as defined by the law of the jurisdiction in which the injury or cause of the loss occurred); having cosmetic surgery that is not medically necessary; having elective surgery that is not medically necessary within the first 12 months of the Effective Date of the policy; being pregnant on the Effective Date of the policy (complications of such pregnancy will be covered to the same extent as a Sickness); routine nursing or routine well-baby care for a newborn child; being hospitalized before the Effective Date of coverage.

A hospital does not include any institution, or part thereof, used as an ambulatory surgical center; a hospice unit (including any bed designated as a hospice bed or a swing bed); a convalescent home; a rest or nursing facility; a psychiatric unit; an extended-care facility; a skilled nursing facility; or a facility primarily affording custodial, educational care, or care or treatment for persons suffering from mental disease or disorders, or care for the aged, drug addicts, or alcoholics.

A physician does not include a member of your immediate family.

VOLUNTARY INDEMNITY PLAN

HOSPITAL CONFINEMENT INDEMNITY INSURANCE

Policy A-44200-TX

SURGICAL BENEFIT

Aflac will pay benefits according to the Schedule of Operations when a covered person has surgery performed for a covered Sickness or injury in a hospital or ambulatory surgical center. **Only one benefit is payable per 24-hour period for surgery, even though more than one surgical procedure may be performed. The highest eligible benefit will be paid. Surgical Benefits are not payable for surgery performed in a doctor's or dentist's office, clinic, or other such location. Benefits are not payable within the first 12 months of the Effective Date of the policy for elective surgery that is not medically necessary.** (If any operation for the treatment of a covered Sickness or injury is performed other than those listed, Aflac will pay an amount comparable to the amount shown in the Schedule of Operations for the surgery most similar in severity and gravity.) **No lifetime maximum.**

SCHEDULE OF OPERATIONS		
BONE		
Bone marrow biopsy or aspiration	\$100	
Removal of knee cartilage	\$150	
Total knee replacement	\$500	
Total hip replacement	\$750	
BRAIN		
Burr holes not followed by surgery	\$300	
Exploratory craniotomy	\$700	
Excision brain tumor	\$1,000	
BREAST		
Needle biopsy	\$100	
Incisional biopsy, breast	\$100	
Lumpectomy	\$200	
Breast reduction	\$300	
Simple mastectomy	\$300	
Radical mastectomy	\$600	
DIGESTIVE		
Esophagoscopy	\$100	
Appendectomy	\$200	
ERCP	\$200	
Exploratory laparotomy	\$300	
Vagotomy	\$300	
Partial colectomy	\$400	
Colectomy with ileostomy	\$600	
Cholecystectomy	\$600	
Esophagectomy	\$750	
Partial gastrectomy	\$500	
Total gastrectomy	\$1,000	
EAR/NOSE		
Tympanotomy	\$100	
Myringoplasty	\$150	
Mastoidectomy, simple	\$150	
Mastoidectomy, radical	\$300	
EYE		
Cataract	\$200	
Enucleation	\$500	
Corneal transplant	\$750	
GYNECOLOGIC		
Dilation & curettage (D&C)	\$100	
Tubal ligations	\$150	
	GYNECOLOGIC (Continued)	
	Cesarean delivery	\$200
	Partial hysterectomy	\$400
	Total hysterectomy with or without tubes and ovaries	\$750
	HEART	
	Insertion of pacemaker	\$200
	Angioplasty, one vessel	\$500
	Angioplasty, two vessels	\$750
	Replacement of aortic valve	\$1,000
	Coronary artery with graft	\$1,000
	LARYNX	
	Laryngoscopy with biopsy	\$100
	Laryngectomy	\$500
	Laryngectomy with radical neck dissection	\$1,000
	LUNGS	
	Needle biopsy	\$200
	Bronchoscopy with biopsy	\$250
	Thoracotomy	\$400
	Pneumonectomy	\$750
	LYMPHATIC	
	Biopsy, lymph node	\$100
	Lymphadenectomy	\$500
	MISCELLANEOUS	
	Foot surgery	\$150
	Vasectomy	\$150
	Repair of hernia	\$250
	SKIN	
	Biopsy	\$50
	Excision of lesion of skin without flap or graft	\$100
	Excision of lesion of skin with flap or graft	\$300
	URINARY	
	Biopsy, prostate	\$100
	Cystoscopy	\$100
	Cystotomy	\$200
	TUR, prostate	\$300
	Biopsy, kidney	\$400
	Prostatectomy, radical	\$750
	Nephrectomy	\$750
	Cystectomy, partial	\$500
	Cystectomy, complete	\$750



CITY OF HOUSTON AFLAC BENEFITS PACKET & APPLICATION 2015

Let Aflac help you make a great benefits package even better.

Dear City of Houston Employee:

We recognize that you have an excellent benefits package. That's why we're happy to announce that Aflac insurance policies are again being made available to employees of the City of Houston through payroll deduction.

The fact is, no matter how good most major medical policies are, they're not designed to pay **all** the costs associated with an accident or illness. With Aflac, benefits are paid directly to you – not to the doctors or the hospital, unless you choose otherwise – regardless of any other insurance you may have. What's more, you can use your cash benefits to help with expenses such as:

- Travel-related expenses for medical treatment.
- Everyday living expenses like mortgage or rent payments, car payments, groceries, utilities, and more.

For nearly 60 years, Aflac has been helping to provide a little more stability and helping you have peace of mind just in case a covered accident or illness should happen.

Thank you for considering Aflac insurance. Please see the accompanying page for more information about the application process. We look forward to meeting with you during the 2015 Open Enrollment.

Sincerely,

Debra Schmidt, *District Sales Coordinator*

Michael Grass, *Market Director*



Coverage is underwritten by American Family Life Assurance Company of Columbus.

Additional Information

During the application process:

Please attend the benefits meeting scheduled for your department where an Aflac agent will be available to assist you in selecting your policy options and fully completing the applications. Also, read the brochures and outlines of coverage for each policy.

The policies being made available are:

- ✓ Accident/Disability – 24 Hour Coverage (On/Off the Job)
- ✓ Cancer
- ✓ Hospital Confinement Indemnity

You may choose to apply for the following types of coverage:

- ✓ Employee-Only
- ✓ Employee & Spouse
- ✓ Employee & Dependent Children
- ✓ Employee, Spouse & Dependent Children

Please complete the personal information section at the top of the first page of the applications for the policies you have selected.

- ★ *If you have owned your policies for more than 10 years, please check with the agent who visits your location to be sure you are aware of all available upgrade option and filed all eligible wellness benefit claims.*

During Open Enrollment & anytime throughout the year:

- If you need further assistance in completing your application(s), or if you have any questions, please contact the office of Debra Schmidt, *District Sales Coordinator*, at 281-440-1133. An Aflac agent will assist you over the phone, or set-up an appointment to meet with you.
- For assistance with premiums, policy issues, or your payroll deductions, please contact Heather Kirk at 281-440-1133 ext. 123, or via email at heather_kirk@us.aflac.com.
- For assistance in completing a claim, please contact Teresa Baldwin at 281-951-0101, or via email at teresa_baldwin@us.aflac.com. You can also fax your claim directly to Teresa at 281-200-0673.

AFLAC SEMIMONTHLY PAYROLL RATES

Please indicate the type of coverage for which you are applying, and complete the corresponding application.

VOLUNTARY INDEMNITY PLAN

(Hospital Plan)
POLICY A-44200-TX

	<u>18–39</u>	<u>40–49</u>	<u>50–59</u>	<u>60–70</u>
Individual	<input type="checkbox"/> \$9.95	<input type="checkbox"/> \$13.45	<input type="checkbox"/> \$17.95	<input type="checkbox"/> \$23.95
One-Parent Family	<input type="checkbox"/> \$13.50	<input type="checkbox"/> \$14.95	<input type="checkbox"/> \$18.95	<input type="checkbox"/> \$24.95
Named Insured & Spouse	<input type="checkbox"/> \$17.60	<input type="checkbox"/> \$21.45	<input type="checkbox"/> \$29.45	<input type="checkbox"/> \$42.45
Two-Parent Family	<input type="checkbox"/> \$21.15	<input type="checkbox"/> \$22.95	<input type="checkbox"/> \$30.45	<input type="checkbox"/> \$43.45

This rate sheet is intended to be used as an insert page for Voluntary Indemnity Plan Brochure A44275LTXCOHR.

The rates shown are for illustration purposes only; they do not imply coverage.

Underwritten by: American Family Life Assurance Company of Columbus



APPLICATION FOR HOSPITAL INDEMNITY INSURANCE (A-44000 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 Applicant

Applicant's Name _____ Last _____ First _____ MI _____ DOB _____ Month/Day/Year Sex _____

Applicant's SS# _____ - _____ - _____ Dependent Children Yes No
 (Write spouse's name below if you are applying for family coverage; if no spouse or spouse is not to be covered, put N/A in space below.)

Spouse's Name _____ Last _____ First _____ MI _____ DOB _____ Month/Day/Year Sex _____

Address _____ Street or Post Office Box _____ Apt.# _____

City _____ State _____ ZIP _____

Home Telephone () _____

Policyowner's Name _____ Relationship to Applicant _____
 (if other than applicant)

Address _____ Street or Post Office Box _____ Apt.# _____ Owner's SS# _____ - _____ - _____

City _____ State _____ ZIP _____

Name of Employer _____ City of Houston _____

Do you have any other hospital indemnity coverage with AFLAC? Yes No If yes, this must be a conversion of that coverage. Provide current policy number and see Item #13.
 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:

<input type="checkbox"/> Individual	<input type="checkbox"/> One-Parent Family	<input type="checkbox"/> Named Insured-Spouse Only
<input type="checkbox"/> Two-Parent Family		

Level 1: Policy Series A-44100	<input type="checkbox"/> DHIP7D	<input type="checkbox"/> DHIP8D	<input type="checkbox"/> DHIP9D	<input checked="" type="checkbox"/> Pre-tax <input type="checkbox"/> After-tax
*Level 2: Policy Series A-44200	<input type="checkbox"/> DHIP7E	<input type="checkbox"/> DHIP8E	<input type="checkbox"/> DHIP9E	

Optional Rider:

Initial Hospitalization (Series A-44150 - \$250)	<input type="checkbox"/> DHIP7F	<input type="checkbox"/> DHIP8F	<input type="checkbox"/> DHIP9F
Initial Hospitalization (Series A-44250 - \$500)	<input type="checkbox"/> DHIP7G	<input type="checkbox"/> DHIP8G	<input type="checkbox"/> DHIP9G

Billing Method: Payroll Deduction

Mode: 01 Semimonthly 06 Semiannual
 01 Weekly 01 Monthly 12 Annual
 01 Biweekly 03 Quarterly

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

Billable Premium: \$ _____ Premium Collected: \$ _____ PR _____ 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 physician recommended hospitalization? Yes No
2. Has anyone to be covered been confined in a hospital for 14 or more hours within the last 36 months because of any of the following? (Check all that apply.) Yes No

- | | | |
|---|--|--|
| <input type="checkbox"/> angina | <input type="checkbox"/> heart surgery | <input type="checkbox"/> transient ischemic attack (TIA) |
| <input type="checkbox"/> congestive heart failure | <input type="checkbox"/> stroke | <input type="checkbox"/> cerebral vascular insufficiency |
| <input type="checkbox"/> heart attack | <input type="checkbox"/> internal cancer | <input type="checkbox"/> peripheral vascular disease |

3. Has anyone to be covered been confined in a hospital for 14 or more hours within the last 12 months because of any of the following? (Check all that apply.) Yes No

- | | |
|---|--|
| <input type="checkbox"/> emphysema | <input type="checkbox"/> Parkinson's disease |
| <input type="checkbox"/> sickle-cell anemia | <input type="checkbox"/> chronic liver disease |
| <input type="checkbox"/> asthma | <input type="checkbox"/> chronic obstructive pulmonary disease |

4. Has anyone to be covered ever been treated or diagnosed by a member of the medical profession as having any of the following? (Check all that apply.) Yes No

- | | |
|--|---|
| <input type="checkbox"/> Alzheimer's disease | <input type="checkbox"/> end-stage renal disease |
| <input type="checkbox"/> senile dementia | <input type="checkbox"/> kidney failure |
| <input type="checkbox"/> systemic lupus | <input type="checkbox"/> insulin-dependent diabetes |

5. Has anyone to be covered ever been treated or diagnosed by a member of the medical profession as having AIDS or has anyone to be covered ever tested positive for the human immunodeficiency virus (HIV) or HTLV-III (antibodies to human T-lymphotropic virus Type III)? Yes No

6. If Question 1, 2, 3, 4 or 5 is answered "yes," the name and the relationship of the person(s) must be shown in the following space. Any person(s) so named will not be covered under the policy. _____

7. List all hospital indemnity policies you currently have in force and provide the daily benefit amount. _____

APPLICANT'S STATEMENTS AND AGREEMENTS:

8. 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.
9. I understand that the policy I am applying for will not cover any person who has attained age 71 prior to the Effective Date of the policy.
10. I acknowledge receipt of, if applicable:
- | | |
|---|---|
| <input type="checkbox"/> Fair Credit Reporting Notice | <input type="checkbox"/> Replacement Notice |
| <input type="checkbox"/> Outline of Coverage | <input type="checkbox"/> Guide To Health Insurance for People with Medicare |
11. **I understand that coverage is not provided for health conditions for which symptoms were evident or for which medical advice or treatment was recommended or received within the 12-month period before the Effective Date of coverage unless loss begins six months after the Effective Date of coverage.**
12. I understand that: (a) the insurance I am applying for will be issued based solely upon the written answers to questions and information asked for in this application; (b) AFLAC is not bound by any statement made by me, the applicant, or any associate/agent of AFLAC unless written herein; (c) the associate/agent cannot change the provisions of the policy or waive any of its provisions either orally or in writing; (d) the policy together with this application, endorsements, benefit agreements and riders, if any, is the entire contract of insurance; and (e) no change to the policy will be valid until approved by AFLAC's secretary and president, and noted in or attached to the policy.

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).

DISCLOSURE STATEMENT

**AMERICAN FAMILY LIFE ASSURANCE COMPANY OF COLUMBUS
(herein referred to as Aflac)**

Worldwide Headquarters • Columbus, Georgia 31999
A Stock Company

Applicant's Name: _____

Policy Number: _____

THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES.

MINIMUM ESSENTIAL COVERAGE DEFINITION

The type of coverage an individual needs to have to meet the individual responsibility requirement under the Affordable Care Act. This includes individual market policies, job-based coverage, Medicare, Medicaid, CHIP, TRICARE and certain other coverage.

I certify, by signing below, that I am covered by a major medical policy or other coverage that satisfies the minimum essential coverage under the Affordable Care Act.

Applicant's Signature

Date



Accident/Hospital Indemnity Wellness Benefit Claim Form

If you are interested in filing your claim online, register using aflac.com/smartclaim.

- Benefits of filing your claim online include faster claim processing time and receiving claim communications by email.

Please read all instructions.

Failure to follow these instructions could delay the processing of your claim.

Your Aflac policy provides a Wellness Benefit. To receive your Wellness Benefit, complete the form by following the instructions provided. Please check your policy for specific details on this benefit.

- Do not include receipts, statements or other claim documentation with this form.
- Do not write on form except as instructed.
- Please sign, date and mail or fax the completed form to the Aflac address/fax number shown below.
- Please use black or blue ink only and print legibly when completing this form in its entirety.
- Mark only wellness exam box(es) for test(s) that you had performed.
- Failure to complete all sections may result in a delay in processing this claim.
- Some types of tests and/or treatment listed may not be covered by your policy.

Please keep a copy of this completed form for your records. Please print a separate form for each additional family member or call 1-800-99-AFLAC (1-800-992-3522) to request additional forms. Claims for all other benefits covered under this policy must be filed separately using the claim forms available at aflac.com or by calling 1-800-99-AFLAC (1-800-992-3522).

Accident/Hospital Indemnity Wellness Benefit Claim Form

Policy Number:

All Fields are required.

Policyholder Information:

Last Name Suffix First Name MI

Date of Birth (mm/dd/yy) / / Telephone Number where we can reach you - -

Home Address

City State Zip Code

Check box if this is permanent address change.

Patient Information:

Last Name First Name Date of Birth (mm/dd/yy) / /

Sex: Male Female
 Relationship: Primary Policyholder Spouse Dependent Child

Treatment and Physician Information

Treatment Date: M M D D Y Y Y Y
 Mammogram Date: M M D D Y Y Y Y
 Pap Smear Date: M M D D Y Y Y Y

- | | | |
|---|--|---|
| <input type="checkbox"/> Annual Physical | <input type="checkbox"/> Blood Screening | <input type="checkbox"/> Dental Exam |
| <input type="checkbox"/> Ultrasound | <input type="checkbox"/> Immunizations | <input type="checkbox"/> Flexible Sigmoidoscopy |
| <input type="checkbox"/> PSA (blood test for prostate cancer) | <input type="checkbox"/> Eye Exam | |
| <input type="checkbox"/> Pap Smear | <input type="checkbox"/> Mammogram | |

Physician's Phone Number: - -

Physician's Name

Physician's Street Address

Physician's City State: Zip:

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime, and subjects such person to criminal and civil penalties.

The Provider listed above is authorized to validate the information I have provided.

 POLICYHOLDER/PATIENT SIGNATURE FAMILY RELATIONSHIP, IF NOT POLICYHOLDER DATE



REQUEST FOR CHANGE

Fax No.: 706.317.6446

EMPLOYEE NO: _____ Requested Date of Change: ____/____/____
Employee Name _____ Social Security Number: ____-____-____
 First M.I. Last
Current Mailing Address: _____ (CHECK IF THIS IS AN ADDRESS CHANGE ONLY [])
City: _____ State: _____ ZIP Code: _____
Department: _____ Work Phone: (____) ____-____ Cell or Home Phone: (____) ____-____

POLICY: [] Personal Accident Expense Policy (A-33000 series)
 [] Voluntary Indemnity Policy (A-44000 series) (Hospital Indemnity)
 [] Personal Cancer Protector Policy (A-59000 series)

PLEASE MAKE THE FOLLOWING CHANGES:

Full Name (First, M, Last) _____ Date of Birth _____ Relationship _____
[] **ADDITIONS** _____
ONLY _____
Reason: [] Marriage [] Divorce [] Other _____ Date of Event: ____/____/____
Type of Coverage now desired: [] Individual [] Named Insured/Spouse (not available with the Cancer) [] One-Parent Family
[] Two-Parent Family

Answer questions on Page 2

Full Name (First, M, Last) _____ Date of Birth _____ Relationship _____
[] **DELETIONS** _____
ONLY _____
Reason: [] Divorce [] Other: _____ Date of Event: ____/____/____
Type of Coverage now desired: [] Individual [] Named Insured/Spouse [] One-Parent Family [] Two-Parent Family

Answer questions on Page 2

[] **NAME CHANGE** Name shown on policy: _____
ONLY Change name to: _____
Reason: [] Marriage [] Divorce [] Other: _____ Date of Event: ____/____/____
Type of Coverage now desired: [] Individual [] Individual & Spouse [] One-Parent Family [] Two-Parent Family

[] **CANCELLATION** The insured/owner on the above-mentioned policy, wish to cancel the Aflac policy and/or policies I have
ONLY checked above.



REQUEST FOR CHANGE

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[] BENEFICIARY Change my primary beneficiary to the following designated person.

CHANGE ONLY

Last Name First M.I. Relationship Age

IMPORTANT: READ BEFORE SIGNING & PLEASE ANSWER THE APPROPRIATE QUESTIONS FOR ALL ADDITIONS

CANCER POLICY/QUESTION REQUIRED FOR ADDITIONS:

To the best of my knowledge no one to be ADDED under the terms of my CANCER policy has ever been diagnosed or treated for cancer of any type or form.

HOSPITAL INDEMNITY POLICY/ QUESTIONS REQUIRED FOR ADDITIONS:

- (1) Is anyone to be covered currently confined in a hospital or nursing home, or has hospitalization been recommended by a physician? [] Yes [] No
(2) Has anyone to be covered been confined in a hospital or nursing home within the last 24 months because of internal cancer, heart surgery, heart attack, stroke or congestive heart failure? [] Yes [] No
(3) Has anyone to be covered been confined in a hospital or a nursing home with the past 12 months for chronic liver disease, emphysema, chronic bronchitis, or Parkinson's disease? [] Yes [] No
(4) Has anyone to be covered ever been treated for or diagnosed as having Alzheimer's disease, senile dementia, systemic lupus, kidney failure, insulin dependent diabetes, acquired immune deficiency syndrome (AIDS) or AID-related complex (ARC)? [] Yes [] No
(5) If Question 1, 2, 3, or 4 was checked YES the person's name and relationship must be shown in the following space. ANY PERSON(S) SO NAMED WILL NOT BE COVERED UNDER THE POLICY.

Name Relationship Name Relationship

Policyholder Signature: _____ Date: ____/____/____

BENEFITS OFFICE ONLY:

AUTHORIZED BY: _____ Date: ____/____/____

(Aflac Policy Administrator)

Agent Name: _____

Agent Writing No: _____

Date: _____



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