

▶ **Peace of Mind *and*
Real Cash Benefits**



PERSONAL ACCIDENT EXPENSE PLUS
ACCIDENT/DISABILITY INSURANCE

AC

To the employees of:



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



PERSONAL ACCIDENT EXPENSE PLUS

ACCIDENT/DISABILITY INSURANCE
24-HOUR COVERAGE (ON/OFF THE JOB)

Policy A-33000-TX

AC

The Need

Accidents happen to all kinds of people every day. In 2012, 38.9 million people—about 1 out of 8—sought medical attention for an injury.*

What would the financial impact of an injury mean to your security? Are you prepared for medical debts in addition to everyday household expenditures and lost wages? Out-of-pocket expenses associated with an accident are unexpected and often burdensome; perhaps the accident itself could not have been prevented, but its impact on your finances and your well-being certainly can be reduced.

*Injury Facts, 2013 Edition, National Safety Council.



Aflac pays cash benefits directly to you, unless you choose otherwise. This means that you will have added financial resources to help with expenses incurred due to an injury, to help with ongoing living expenses, or to help with any purpose you choose. Aflac Personal Accident Expense Plus is designed to provide you with cash benefits throughout the different stages of care, regardless of the severity of the injury.

Aflac enables you to take charge and to help provide for an unpredictable future by paying cash benefits for accidental injuries. Your own peace of mind and the assurance that your family will have help financially are powerful reasons to consider Aflac.

THE PERSONAL ACCIDENT EXPENSE PLUS INSURANCE POLICY HAS:

- 1** No deductibles and no copayments.
- 2** No lifetime limit—policy won't terminate based on number or dollar amount of claims paid.
- 3** No network restrictions—you choose your own medical treatment provider.
- 4** No coordination of benefits—we pay regardless of any other insurance.

Aflac herein means American Family Life Assurance Company of Columbus.

BENEFIT	BENEFIT AMOUNT	ADDITIONAL BENEFIT INFORMATION
WELLNESS	\$60 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. Family members include your spouse and Dependent Children of either you or your spouse. Benefits include and are payable for annual physical examinations, mammograms, Pap smears, eye examinations, immunizations, flexible sigmoidoscopies, ultrasounds, prostate-specific antigen tests (PSAs), and blood screenings. This benefit will become available following each anniversary of the policy's Effective Date and is payable only once each 12-month period. Service must be under the supervision of or recommended by a physician, and a charge must be incurred.
<p>Aflac will pay the following benefits as applicable if a Covered Person's death, dismemberment, or Injury is caused by a covered accident. Death, dismemberment, or Injury must be independent of disease or bodily infirmity, or of any cause other than a covered accident. A covered death, dismemberment, or Injury must also occur while coverage is in force and is subject to the limitations and exclusions.</p>		
ACCIDENT EMERGENCY TREATMENT	\$120 Named Insured/ Spouse \$70 Dependent Children	Payable if a Covered Person receives treatment for Injuries sustained in a covered accident. This benefit is payable for treatment by a physician, for X-rays, or for treatment received in a hospital emergency room. Treatment must be received within 72 hours of the accident for benefits to be payable. This benefit is payable once per 24-hour period and only once per covered accident, per Covered Person.
ACCIDENT FOLLOW-UP TREATMENT	\$25 for one treatment per day, up to a maximum of six treatments per covered accident, per Covered Person	Payable if a Covered Person receives emergency treatment for Injuries sustained in a covered accident and later requires additional treatment over and above emergency treatment administered in the first 72 hours following the accident. The treatment must begin within 30 days of the covered accident or discharge from the hospital. Treatments must be furnished by a physician in a physician's office or in a hospital on an outpatient basis. The Accident Follow-Up Treatment Benefit is not payable for the same visit that the Physical Therapy Benefit is paid.
INITIAL ACCIDENT HOSPITALIZATION	\$1,000 once per period of Hospital Confinement and only once per calendar year, per Covered Person	Payable if a Covered Person requires Hospital Confinement for treatment of Injuries sustained in a covered accident. Confinements must start within 30 days of the accident.
ACCIDENT HOSPITAL CONFINEMENT	\$200 per day up to 365 days per covered accident, per Covered Person	Payable if a Covered Person requires Hospital Confinement for treatment of Injuries sustained in a covered accident. Confinements must start within 30 days of the accident.
INTENSIVE CARE UNIT CONFINEMENT	An additional \$400 per day for up to 15 days per covered accident, per Covered Person	Payable for each day a Covered Person receives the Accident Hospital Confinement Benefit and is confined in an intensive care unit. Confinements must start within 30 days of the accident.

BENEFIT	BENEFIT AMOUNT	ADDITIONAL BENEFIT INFORMATION
<p>ACCIDENT SPECIFIC-SUM INJURIES</p>	<p>\$25–\$10,000 (according to the policy) for:</p> <ul style="list-style-type: none"> • Dislocations • Tendons & Ligaments • Burns • Skin grafts • Ruptured disc/Torn knee cartilage • Eye injuries • Lacerations • Internal injuries • Fractures • Concussions • Coma • Paralysis • Emergency dental work • Partial amputations • Exploratory surgery • Torn rotator cuffs 	<p>Payable for treatment received by a Covered Person for Injuries sustained in a covered accident. We will pay for no more than two dislocations per covered accident, per Covered Person. Benefits are payable for only the first dislocation of a joint. Torn, ruptured, or severed tendons, ligaments, ruptured discs, or torn knee cartilage must be treated by a physician and repaired through surgery within one year after a covered accident. If a dislocation is reduced with local anesthesia or no anesthesia by a physician, we will pay 25 percent of the amount shown for the closed reduction dislocation. Burns must be treated by a physician within 72 hours after a covered accident. If a Covered Person receives a skin graft for a covered burn, we will pay 25 percent of the burn benefit amount that we paid for the burn involved. Lacerations requiring sutures must be repaired within 72 hours after the accident and repaired under the attendance of a physician. Only the highest single benefit will be paid for Injuries sustained in a covered accident. We will pay 25 percent of the benefit amount shown for the closed reduction of chip fractures and other fractures not reduced by open or closed reduction. We will pay for no more than two fractures per covered accident, per Covered Person. The duration of the paralysis must be a minimum of three months, and this benefit will be payable once per Covered Person. Coma must last at least 30 days.</p>
<p>PHYSICAL THERAPY</p>	<p>\$25 per treatment for one treatment per day, up to a maximum of six treatments per covered accident, per Covered Person</p>	<p>Payable if a Covered Person receives emergency treatment for Injuries sustained in a covered accident and later a physician advises the Covered Person to seek treatment from a physical therapist. Physical therapy must be for Injuries sustained in a covered accident and must start within 30 days of the covered accident or discharge from the hospital. The treatment must take place within six months after the accident. The Physical Therapy Benefit is not payable for the same visit the Accident Follow-Up Treatment Benefit is paid.</p>
<p>APPLIANCES</p>	<p>\$100 once per covered accident, per Covered Person</p>	<p>Payable if a physician advises a Covered Person to use a medical appliance as an aid in personal locomotion for Injuries sustained in a covered accident. Benefits are payable for the following types of appliances: a wheelchair, a leg brace, a back brace, a walker, and/or a pair of crutches.</p>

The policy has limitations and exclusions that may affect benefits payable.

This brochure is for illustrative purposes only. Refer to the policy and outline of coverage for complete details, definitions, limitations, and exclusions.

BENEFIT	BENEFIT AMOUNT	ADDITIONAL BENEFIT INFORMATION												
PROSTHESIS	\$500 once per covered accident, per Covered Person	Payable if a Covered Person requires use of a prosthetic device as a result of Injuries sustained in a covered accident. This benefit is not payable for hearing aids, wigs, or any dental aids, to include false teeth.												
BLOOD & PLASMA	\$100 once per covered accident, per Covered Person	Payable if a Covered Person requires blood and/or plasma for the treatment of Injuries sustained in a covered accident. This benefit does not pay for immunoglobulins.												
AMBULANCE	\$100 if a Covered Person requires ambulance transportation \$500 if a Covered Person requires air ambulance transportation	Payable if a Covered Person requires ambulance transportation or air ambulance transportation to a hospital or emergency center for Injuries sustained in a covered accident. Ambulance transportation must be within 72 hours of the covered accident. A licensed professional ambulance company must provide the ambulance service.												
TRANSPORTATION	\$300 per trip, up to three trips per calendar year, per Covered Person	Payable per trip to a hospital if a Covered Person requires special treatment and confinement in a hospital for Injuries sustained in a covered accident. If the treatment is for a Dependent Child and commercial travel is necessary, the Dependent Child's parent or legal guardian who travels with the Dependent Child will also receive this benefit. Only one person will be paid to travel with the Dependent Child. This benefit is not payable for transportation to any hospital located within a 100-mile radius from the site of the accident or the residence of the Covered Person. The local attending physician must prescribe the treatment and the treatment must not be available locally. This benefit is not payable for transportation by ambulance or air ambulance to the hospital.												
FAMILY LODGING	\$100 per night, limited to one motel/hotel room per night, up to 30 days per covered accident	Payable for one motel/hotel room for a member of the immediate family who accompanies a Covered Person who requires Hospital Confinement for the treatment of Injuries sustained in a covered accident. This benefit is payable only during the same period of time the injured Covered Person is confined to the hospital. The hospital and motel/hotel must be more than 100 miles from the residence of the Covered Person.												
ACCIDENTAL-DEATH	<table border="1"> <thead> <tr> <th></th> <th>Common-Carrier Accidents</th> <th>Other Accidents</th> </tr> </thead> <tbody> <tr> <td>INSURED</td> <td>\$100,000</td> <td>\$25,000</td> </tr> <tr> <td>SPOUSE</td> <td>\$ 50,000</td> <td>\$10,000</td> </tr> <tr> <td>CHILD</td> <td>\$ 15,000</td> <td>\$ 5,000</td> </tr> </tbody> </table>		Common-Carrier Accidents	Other Accidents	INSURED	\$100,000	\$25,000	SPOUSE	\$ 50,000	\$10,000	CHILD	\$ 15,000	\$ 5,000	<p>We will pay the applicable lump sum benefit indicated for the accidental death of a Covered Person. Death must occur as a result of Injuries sustained in a covered accident and must occur within 90 days of such accident.</p> <p>Please see the Terms You Need to Know section of this brochure for more details about Common-Carrier Accidents and Other Accidents.</p>
	Common-Carrier Accidents	Other Accidents												
INSURED	\$100,000	\$25,000												
SPOUSE	\$ 50,000	\$10,000												
CHILD	\$ 15,000	\$ 5,000												

BENEFIT	BENEFIT AMOUNT	ADDITIONAL BENEFIT INFORMATION
ACCIDENTAL-DISMEMBERMENT	\$250-\$25,000	We will pay the applicable lump sum benefit indicated in the policy for dismemberment due to a covered accident. Dismemberment must occur within 90 days of the accident. Only the highest single benefit per Covered Person will be paid for accidental dismemberment. Benefits will be paid only once for any covered accident. If death and dismemberment result from the same accident, only the Accidental-Death Benefit will be paid. Loss of use does not constitute dismemberment, except for eye injuries resulting in loss of the eye or permanent loss of 80 percent of vision.
CONTINUATION OF COVERAGE	Waive all monthly premiums for up to two months	We will waive all monthly premiums 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 because of your leaving employment; and (5) You re-establish premium payments either 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. (<i>Payroll deduction</i> means your premium is remitted to Aflac for you by your employer through a payroll deduction process.)

WHAT IS NOT COVERED

LIMITATIONS AND EXCLUSIONS

We will not pay benefits for services rendered by a member of the immediate family of a Covered Person.

We will not pay benefits for an accident or sickness that is caused by or occurs as a result of a Covered Person's:

- Participating in any activity or event, including the operation of a vehicle, while under the influence of a controlled substance (unless administered by a physician and taken according to the physician's instructions) or while intoxicated (*intoxicated* means that condition as defined by the law of the jurisdiction in which the accident occurred);
- Driving any taxi for wage, compensation, or profit;
- Mountaineering using ropes and/or other equipment, parachuting, or hang gliding;
- Participating in any illegal activity that is defined as a felony (*felony* is as defined by the law of the jurisdiction in which the activity takes place); or being incarcerated in any type penal institution;
- Intentionally self-inflicting bodily injury or attempting suicide, while sane or insane;
- Having cosmetic surgery or other elective procedures that are not medically necessary, or having dental treatment except as a result of Injury;
- Being exposed to war or any act of war, declared or undeclared, or serving in any of the armed forces;
- Participating in any form of flight aviation other than as a fare-paying passenger in a fully licensed passenger-carrying aircraft;
- Participating in any sport or activity for wage, compensation, or profit, or racing any type vehicle in an organized event.

A hospital does not include any institution or part thereof used as a hospice unit, including any bed designated as a hospice or a swing bed; a convalescent home; a rest or nursing facility; an extended-care facility; a skilled nursing facility; or a facility primarily affording custodial or educational care, care or treatment for persons suffering from mental disease or disorders, care for the aged, or care for persons addicted to drugs or alcohol.

A physician does not include you, a member of your immediate family, or anyone who normally resides in your home or residence.

TERMS YOU NEED TO KNOW

Common-Carrier Accidents: accidents that occur on or after the Effective Date of coverage and while coverage is in force, directly involving a vehicle in which a Covered Person is a passenger at the time of the accident and which is duly licensed by proper authority to transport passengers for a fee. A common-carrier vehicle is limited to only an airplane, train, bus, trolley, or boat that operates on a regularly scheduled basis between predetermined points or cities. A taxi is not a common-carrier vehicle.

Covered Person: any person insured under the coverage type you applied for: individual (the insured listed in the Policy Schedule), husband-wife (the insured and spouse), one-parent family (the insured and Dependent Children), or two-parent family (the insured, spouse, and Dependent Children). Newborn children are automatically covered under the terms of the policy from the moment of birth. If coverage is for individual or husband-wife, and you desire uninterrupted coverage for a newborn child, you must notify Aflac in writing within 31 days of the birth of your child, and Aflac will convert the policy to one-parent family or two-parent family coverage and advise you of the additional premium due. Coverage shall include any other Dependent Child, regardless of age, who is incapable of self-sustaining employment by reason of mental retardation or physical handicap and who became so incapacitated while covered hereunder. *Dependent Children* are your natural children, stepchildren, or legally adopted children who are under age 26. Children born to Dependent Children of the insured or spouse are covered under the policy. Children for which you must provide medical support under a court order are also covered under the terms of the policy.

Effective Date: the date(s) coverage begins as shown in the Policy Schedule. The Effective Date is not the date you signed the application for coverage.

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 will continue in force.

Guaranteed-Renewable: the right to renew the policy by payment of the premium due on or before the renewal date. The policy is Guaranteed-Renewable for your lifetime, subject to Aflac's right to change premiums by class upon any renewal date.

Hospital Confinement: a 24-hour overnight stay of a Covered Person confined to a bed in a hospital as an inpatient, for which a charge is made. The Hospital Confinement must be on the advice of a physician and medically necessary. Benefits are also payable for confinement in hospitals operated by or for the United States government.

Injury: a bodily injury caused directly by an accident, independent of sickness, disease, bodily infirmity, or any other cause, occurring on or after the Effective Date of coverage and while coverage is in force. See the Limitations and Exclusions section for Injuries not covered by the policy.

Other Accidents: accidents that occur on or after the Effective Date of coverage and while coverage is in force that is not classified as a Common-Carrier Accident and that is not specifically excluded in the Limitations and Exclusions section.

PREMIUMS: Premiums are subject to change.

Risk Class: _____

	Annual	Semiannual	Quarterly	Monthly
Policy:				
A-33000-TX	\$_____	\$_____	\$_____	\$_____

Riders:

Off-the-Job Accident Disability Benefit Rider:

A-33050-TX	\$_____	\$_____	\$_____	\$_____
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On-the-Job Accident Disability Benefit Rider:

A-33051-TX	\$_____	\$_____	\$_____	\$_____
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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.

\$1000 ON-THE-JOB AND \$1000 OFF-THE-JOB ACCIDENT DISABILITY BENEFIT RIDERS SUMMARY PAGE

Riders A-33050-TX and A-33051-TX

ACR

Riders become a part of the policy and are subject to all policy provisions, unless otherwise stated.

WHAT WE WILL PAY

THROUGH AGE 69:

While coverage is in force, if you become Totally Disabled within 90 days of, and as a result of, a covered accident, we will pay you one-thirtieth of the benefit shown in the Policy Schedule for each day you remain Totally Disabled. Benefits are payable up to the benefit period you select, subject to the elimination period shown in the Policy Schedule.

AGE 70 AND ABOVE:

If you require hospital confinement as the result of a covered accident within 90 days of, and as a result of, a covered accident, we will pay you one-thirtieth of the benefit shown in the Policy Schedule times three for each day you are confined. Benefits are payable up to the benefit period you select, not subject to the elimination period shown in the Policy Schedule.

Benefits will be paid for only one disability at a time even if it is caused by more than one injury. Both the disability and hospital confinement benefits are not payable for the same day. Turning age 70 will not stop benefits otherwise payable. Successive periods of disability not separated by 180 days or more, if due to the same or a related condition, will be considered a continuation of the prior disability. Separate periods of disability due to unrelated causes will be considered a continuation of the prior disability unless they are separated by your returning to your job for at least one full day, during which you are performing the material and substantial duties of your job and are no longer qualified to receive disability benefits. We reserve the right to meet with you during the pendency of a claim or to use an independent consultant and a physician's statement to determine whether you are Totally Disabled. Totally disabled is defined as your continuing inability to perform the material and substantial duties of your job. You must also be under the care and attendance of a physician for your condition. If you have any other disability benefit in force with Aflac, only one disability benefit will be payable under the policy.

REFER TO THE POLICY, RIDERS, AND OUTLINE OF COVERAGE FOR COMPLETE DEFINITIONS, DETAILS, LIMITATIONS, AND EXCLUSIONS.

Underwritten by:
American Family Life Assurance Company of Columbus

Worldwide Headquarters | 1932 Wynnton Road | Columbus, Georgia 31999 | aflac.com



PRE-EXISTING CONDITIONS

Disability caused by a Pre-Existing Condition or re-injuries to a Pre-Existing Condition will not be covered unless it begins more than 12 months after the Effective Date of coverage. A Pre-Existing Condition is an 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.

EFFECTIVE DATE

The Effective Date of the rider is the Effective Date of the policy or the Effective Date of the rider as stated in the Policy Schedule, if later.

TERMINATION

The rider will terminate if the policy to which it is attached terminates, if the premiums for the rider are not paid, or upon your death.

WHAT IS NOT COVERED

LIMITATIONS AND EXCLUSIONS

- Aflac will not pay benefits for an accident that is caused by or occurs as a result of you being Totally Disabled while outside the territorial limits of the United States or, if outside the United States, the territorial limits of the place where the policy was issued.
- Aflac will not pay benefits for an accident that occurs while you are working at any job for pay or benefits (applicable to the Off-the-Job Disability Benefit Rider A-33050-TX only).
- Aflac will not pay benefits for an accident that occurs while you are not working at any job for pay or benefits (applicable to the On-the-Job Disability Benefit Rider A-33051-TX only).

Refer to the policy for limitations and exclusions.

Coverage is provided for Off-the-Job Accidents and On-the-Job Accidents only. The rider does not apply to the Spouse or dependents. An *Off-the-Job Accident* is an accident that occurs while you are not working at any job for pay or benefits. An *On-the-Job Accident* is an accident that occurs while you are working at any job for pay or benefits.



Accident Specific-Sum Injuries Benefit Amounts – Policy A-33000-TX

Aflac will pay \$25–\$10,000 for:

<p>Exploratory Surgeries Torn Knee Cartilages Lacerations Skin Grafts Burns</p>	<p>Torn Rotator Cuffs Dislocations Concussions Fractures</p>	<p>Tendons & Ligaments Internal Injuries Eye Injuries Comas</p>	<p>Ruptured Discs Emergency Dental Work Paralyses Partial Amputations</p>
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Payable for treatment received by a Covered Person for Injuries sustained in a covered accident. We will pay for no more than two dislocations per covered accident, per Covered Person. Dislocations reduced by local anesthesia or no anesthesia by a physician will be paid 25 percent of the amount shown for the closed reduction dislocations. Benefits are payable for only the first dislocation of a joint. Torn, ruptured, or severed tendons, ligaments, ruptured discs, or torn knee cartilages must be treated by a physician and repaired through surgery within one year after a covered accident. Burns must be treated by a physician within 72 hours after a covered accident. Lacerations requiring sutures must be repaired within 72 hours after the accident and repaired under the attendance of a physician. Only the highest single benefit will be paid for Injuries sustained in a covered accident. Chip fractures and other fractures not reduced by open or closed reduction pay 25 percent of the benefit amount shown for closed reduction. Chip fractures must be diagnosed by a physician within 14 days after the date of the accident. We will pay for no more than two fractures per covered accident, per Covered Person. Concussions must result in electroencephalogram abnormality for benefit to be payable. Partial amputations of fingers or toes must include at least one joint. Coma durations must be at least 30 days. The benefit for paralysis is payable for spinal cord injuries received in a covered accident that result in complete and total loss of use of two or more limbs for a period of not less than three months, and must be confirmed by an attending physician.

A. Dislocations Benefit (dislocations that are reduced under general anesthesia):

	Benefit		Benefit
1. Hip:		2.	Second-degree burns of at least 10% but not more than 25% of the body surface
open reduction	\$2,000		
closed reduction	500	3.	Second-degree burns of at least 25% but not more than 35% of the body surface
2. Knee or shoulder:			
open reduction	500	4.	Second-degree burns of more than 35% of the body surface
closed reduction	200	5.	Third-degree burns covering less than 3 square inches of the body surface
3. Collarbone:		6.	Third-degree burns covering at least 3 but not more than 6 square inches of the body surface
open reduction	800	7.	Third-degree burns covering at least 6 but not more than 10 square inches of the body surface
closed reduction	150	8.	Third-degree burns covering at least 10 but not more than 25 square inches of the body surface
4. Ankle or foot (excluding toes):		9.	Third-degree burns covering at least 25 but not more than 35 square inches of the body surface
open reduction	500	10.	Third-degree burns covering 35 or more square inches of the body surface
closed reduction	150		
5. Lower jaw:			
open reduction	500		
closed reduction	250		
6. Wrist or elbow:			
open reduction	400		
closed reduction	200		
7. Toe or finger:			
open reduction	100		
closed reduction	50		
B. Tendons and Ligaments Benefit:	500		

C. Burns:

1. Second-degree burns of less than:		100	
10% of the body surface			

D. Skin Grafts:

If a Covered Person receives a skin graft for a covered burn, we will pay 25% of the amount for the burn involved.

	Benefit		Benefit
E. Ruptured discs or torn knee cartilages:	\$ 500	8. Coccyx:	
		open reduction	\$ 200
		closed reduction	100
F. Eye injury with surgical repair (removal of foreign body by a physician):	250 50	9. Toe(s):	
		open reduction	200
		closed reduction	100
G. Lacerations requiring suture:		10. Vertebral processes:	
1. Single laceration less than 2 inches	50	open reduction	1,000
2. At least 2 inches but not more than 6 inches (total of all lacerations)	200	closed reduction	150
3. Over 6 inches (total of all lacerations)	400	11. Skull:	
4. Lacerations not requiring sutures and treated by a physician	25	depressed	1,500
		simple	500
H. Internal injuries resulting in open abdominal, hernia, or thoracic surgery:	1,000	J. Torn rotator cuffs with surgical repairs:	
		one	250
		more than one	500
I. Fractures (chip fractures and other fractures not reduced by open or closed reduction pay: 25% of the benefit amount shown for the closed reduction): We will pay for no more than two fractures per covered accident, per Covered Person.		K. Exploratory surgeries without surgical repair (i.e., arthroscopy):	250
1. Hip:		L. Concussion resulting in electroencephalogram abnormality:	200
open reduction	2,000	M. Emergency dental work:	
closed reduction	1,000	Broken teeth repaired with crown(s)	150
2. Leg:		Broken teeth resulting in extraction(s)	50
open reduction	1,000	N. Partial amputations of finger(s) or toe(s) (must include at least one joint):	100
closed reduction	500	O. Coma duration of at least 30 days:	10,000
3. Hand (excluding fingers), foot (excluding toes/heel), wrist, shoulder blade, forearm, ankle, elbow, kneecap, sternum or lower jaw:		P. Paralysis: If a Covered Person suffers paralysis as a result of a covered accident, we will pay the applicable benefit indicated below. The duration of the paralysis must be a minimum of three months.	
open reduction	500	1. Quadriplegia (paralysis of four limbs):	
closed reduction	250	Insured/Spouse	10,000
4. Vertebrae (body of), pelvis (excluding coccyx):		Children	5,000
open reduction	1,000	2. Paraplegia (paralysis of lower limbs):	
closed reduction	500	Insured/Spouse	5,000
5. Upper jaw, upper arm or face (excluding nose):		Children	2,500
open reduction	600	This benefit is payable once per Covered Person.	
closed reduction	300		
6. Rib or ribs:			
open reduction	1,000		
closed reduction	100		
7. Nose, heel or finger(s):			
open reduction	500		
closed reduction	100		



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.

PERSONAL ACCIDENT EXPENSE PLUS

(includes \$1,000 On-the-Job Disability and \$1,000 Off-the-Job Disability)

POLICY A-33000-TX; RIDERS A-33050-TX, A-33051-TX

Individual

Base: \$6.45
Off-the-Job: \$3.70
On-the-Job: \$2.50
Total: \$12.65

Husband & Wife Only

Base: \$9.40
Off-the-Job: \$3.70
On-the-Job: \$2.50
Total: \$15.60

One-Parent Family

Base: \$10.95
Off-the-Job: \$3.70
On-the-Job: \$2.50
Total: \$17.15

Two-Parent Family

Base: \$13.95
Off-the-Job: \$3.70
On-the-Job: \$2.50
Total: \$20.15

This rate sheet is intended to be used as an insert page for Personal Accident Expense Plus Brochure A33075LTXCOHR.

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

Underwritten by: American Family Life Assurance Company of Columbus



Application for Accident Insurance (A-33000 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 _____ DOB _____ Sex _____
Last First MI Month/Day/Year

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 _____ DOB _____ Sex _____
Last First MI Month/Day/Year

Address _____ Apt.# _____
Street or Post Office Box

City _____ State _____ ZIP _____

Home Telephone () _____ Business Telephone () _____ Best Time to Call _____

Name of Employer _____ City of Houston _____ Type of Business _____ Municipality _____

Job Duties _____ Job Title _____

Occupation Code _____ Occupation Class _____ A _____ Industry Code _____ A _____
 (Completed by worldwide headquarters) (Completed by associate/agent) (Completed by associate/agent)

Do you have another accident policy with AFLAC? Yes No
 If yes, is this a change of that coverage? Yes No If yes, give current policy number: _____

Is the purchase of this coverage intended to replace any other health insurance now in force? Yes No
 If yes, please read and sign the Replacement Notice, if applicable, provided by your associate/agent and provide policy number here: _____

TO BE COMPLETED BY AFLAC ASSOCIATE/AGENT

Billing Method:	Mode:	<input type="checkbox"/> 01 Monthly	Disability	Accident Disability
<input checked="" type="checkbox"/> Payroll Deduction	<input type="checkbox"/> 01 Weekly	<input type="checkbox"/> 03 Quarterly	Benefit Periods	Elimination Periods
	<input type="checkbox"/> 01 Biweekly	<input type="checkbox"/> 06 Semiannual	<input type="checkbox"/> 6 Months	<input checked="" type="checkbox"/> 0 Days
	<input checked="" type="checkbox"/> 01 Semimonthly	<input type="checkbox"/> 12 Annual	<input checked="" type="checkbox"/> 12 Months	<input type="checkbox"/> 7 Days

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

Billable Premium: \$ _____ Premium Collected: \$ _____ PR _____ Sit. Code: _____

CHECK COVERAGE DESIRED: Individual Two-Parent Family One-Parent Family Husband-Wife Only

Class: <input checked="" type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D	Total # of Units:	Premium:	
<input checked="" type="checkbox"/> Personal Accident Expense Policy:			<input type="checkbox"/> Pre-Tax or <input checked="" type="checkbox"/> After-Tax

The Disability Riders shown below do not apply to the spouse or dependents.

<input checked="" type="checkbox"/> Off-The-Job Accident Disability Rider:	10	3.70	<input type="checkbox"/> Pre-Tax or <input checked="" type="checkbox"/> After-Tax
<input checked="" type="checkbox"/> On-The-Job Accident Disability Rider:	10	2.50	
<input type="checkbox"/> Sickness Disability Rider: 14-Day Elimination Period			
Total Premium:			

PLEASE COMPLETE IF APPLYING FOR MORE THAN \$700 OF ANY ONE MONTHLY DISABILITY RIDER:

1. I certify that my annual income (without overtime, unless contractual) for my full-time job is: \$ _____
 I understand that this information will be verified at the time of claim.

PLEASE COMPLETE QUESTIONS 2 THROUGH 8 IF APPLYING FOR ANY DISABILITY RIDER:

2. Do you have a short-term disability policy with AFLAC? If yes, please complete the Supplemental Notification section at the end of this application and be aware that you cannot have this policy with the disability riders without cancelling your short-term disability policy with AFLAC. Yes No
3. Have you been charged with driving under the influence of alcohol or any narcotic within the last 12 months or been charged two or more times within the last five years? Yes No
4. Are you currently on leave or not working due to sickness, maternity or injury? Yes No
5. Are there any material or substantial duties of your job that you are unable to perform due to sickness, maternity or injury? Yes No
6. Do you work fewer than [30] hours per week in your primary (full-time) occupation with the employer listed on the first page of the application? Yes No
7. Is your current annual income less than [\$10,000], without overtime (unless contractual), for your primary occupation? Yes No
8. Within the last six weeks, have you taken prescribed pain medication for injury, disease or disorder of the back, neck or joint(s)? Yes No

If you answered "yes," to any one of Questions 3 through 8, you are not eligible for any disability rider coverage and, therefore, no disability rider will be issued.

PLEASE COMPLETE QUESTION 9 IF APPLYING FOR THE ON-THE-JOB DISABILITY RIDER:

9. Are you covered by workers' compensation or similar law in your full-time job? Yes No

If you answered "yes," you are not eligible for On-The-Job rider coverage and, therefore, this rider will not be issued.

PLEASE COMPLETE QUESTIONS 10 THROUGH 20 IF APPLYING FOR THE SICKNESS DISABILITY RIDER:

10. Has a member of the medical profession ever diagnosed you with or ever treated you for any of the following: Yes No
- | | |
|---|------------------------------|
| ♦ stroke or TIA | ♦ systemic lupus |
| ♦ heart valve replacement | ♦ chronic fatigue syndrome |
| ♦ vascular insufficiency (circulatory problems) | ♦ rheumatoid arthritis |
| ♦ insulin-dependent diabetes | ♦ multiple sclerosis |
| ♦ emphysema | ♦ Crohn's disease |
| ♦ chronic liver disease | ♦ regional enteritis/ileitis |
| ♦ chronic hepatitis (other than Type A) | ♦ diverticulosis |
| ♦ fibromyalgia | ♦ ulcerative colitis |
11. Have you ever been diagnosed with acquired immune deficiency syndrome (AIDS) by a member of the medical profession or have you ever tested positive for the human immunodeficiency virus (HIV)? Yes No
12. In the past five years, has a member of the medical profession diagnosed you with or treated you for cancer (other than non-melanoma skin cancers)? Yes No
13. In the past 24 months, has surgery been performed for any of the following or has a member of the medical profession diagnosed you with or treated you for any of the following: Yes No
- | | | |
|----------------------------|-------------------------------|-------------------------------|
| ♦ heart attack | ♦ coronary bypass surgery | ♦ drug or alcohol abuse |
| ♦ congestive heart failure | ♦ sciatica | ♦ kidney disease |
| ♦ angina | ♦ carpal tunnel syndrome | (not including kidney stones) |
| ♦ coronary angioplasty | (unless surgically corrected) | |
14. Has a member of the medical profession ever diagnosed you with or treated you for any of the following: Yes No
- | | |
|-----------------------|--|
| ♦ psychotic disorders | ♦ bipolar affective disorder (manic depressive syndrome) |
| ♦ eating disorders | ♦ delusional (paranoid) disorders |
| ♦ schizophrenia | ♦ somatoform disorders (psychosomatic illness) |
| ♦ anxiety disorders | |

If you answered "yes" to any one of Questions 10 through 14, you are not eligible for Sickness Disability rider coverage and, therefore, this rider will not be issued.

15. Have you received disability benefits or claimed workers' compensation in the last five years? Yes No
16. In the past 12 months, have you missed five consecutive days or 10 total days of work due to your sickness or injury (not related to pregnancy)? Yes No

17. In the past 12 months, have you been confined in a hospital as an inpatient (not including confinement due to pregnancy)? Yes No
18. In the past year, have you been confined in a hospital or mental health facility as an inpatient? Yes No
19. In the past 12 months, has a member of the medical profession diagnosed you with or treated you for any of the following: Yes No
- ♦ chronic bronchitis
 - ♦ asthma
 - ♦ back, neck or joint injury or disorder
 - ♦ hypertension
20. Are you currently taking any medications for the treatment of mental illness? Yes No

If you answered "yes" to any one of Questions 15 through 20, you must complete Item 21 and provide details in Item 22.

21. **Within the last six weeks, have you been prescribed any medication by a physician or taken any prescription medication (not including prescription contraceptives)?** Yes No
 If yes, please provide complete information below.

Medication Name	Dosage and Frequency	Nature of Illness

Your Physician's Name: _____ Phone Number: _____
If no regular physician, physician last seen

Address _____

Date last seen by physician: _____ Reason for last visit: _____

22. (Details to Questions 15 – 20)

	Condition(s)	Onset (mo/yr)	Surgery Performed? (yes/no/date)	Name and Address of Physician and Hospital
Question 15				
Question 16				
Question 17				
Question 18				

Question 19				
Question 20				

APPLICANT'S STATEMENTS AND AGREEMENTS

23. I understand that the Effective Date of the policy will be the date recorded in the Policy Schedule by AFLAC Worldwide Headquarters.
24. I acknowledge receipt of, if applicable:
- | | |
|--|---|
| <input type="checkbox"/> Replacement Notice | <input type="checkbox"/> Guide to Health Insurance for People with Medicare |
| <input type="checkbox"/> Outline of Coverage | <input type="checkbox"/> Fair Credit Reporting Notice |
25. 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) AFLAC is not bound by any statement made by me, or any associate/agent of AFLAC, unless written herein; (3) the associate/agent cannot change the provisions of the policy or waive any of its provisions either orally or in writing; (4) the policy together with this application and endorsements or riders, if any, is the entire contract of insurance; and (5) no change to the policy will be valid until approved by AFLAC's secretary and president and noted in or attached to the policy.

NOTICE OF INFORMATION PRACTICES

To issue an insurance policy, AFLAC may need to obtain additional information about you and any other persons proposed for insurance. Some information will come from you and some may come from other sources. That information and any other subsequent information collected by AFLAC may in some circumstances be disclosed to third parties without your specific consent. You have the right to access and correct the information collected about you except information that relates to a claim or to a civil or criminal proceeding. If you wish to have a more detailed explanation of our information practices, please submit a written request to our worldwide headquarters. This notice applies only in Arizona, California, Connecticut, Georgia, Illinois, Maine, Massachusetts, Minnesota, Nevada, New Jersey, North Carolina, Ohio, Oregon and Virginia.

**SUPPLEMENTAL NOTIFICATION
COMPLETE IF YOU ARE REPLACING/TERMINATING EXISTING AFLAC DISABILITY COVERAGE.**

I, _____, am applying for AFLAC's policy with disability benefits. I currently have disability benefits under AFLAC short-term disability policy number _____. I understand that I must cancel my existing AFLAC short-term disability policy in order to purchase this policy.

- Please cancel my short-term disability policy so that this accident policy with disability benefits can be issued.

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

I authorize the following to give information (as defined below) to American Family Life Assurance Company of Columbus (AFLAC) or any person or entity acting on its part: any medical professional, medical care institution, insurer (including AFLAC, with respect to other AFLAC coverages), reinsurer, government agency (including departments of public safety and motor vehicle departments), the Medical Information Bureau, consumer reporting agency or employer. "Information" means facts or opinions relating to my past, present, or future physical or mental health or condition (excluding psychotherapy notes), employment, other insurance coverage, driving record, or any other medical or non-medical facts that AFLAC deems appropriate to determine eligibility for insurance or to evaluate a claim for benefits during the time this authorization is valid. I also authorize AFLAC to give information to the Medical Information Bureau. I understand that any disclosure of health information to AFLAC for the purpose of determining eligibility for coverage other than health plan coverage means the information may no longer be protected by federal privacy regulations. I further understand, however, that such information may be re-disclosed only in accordance with other applicable laws or regulations.

I understand that this information will be used by AFLAC for enrollment or to determine eligibility for insurance or for underwriting or risk rating (where applicable) purposes and, should coverage be issued, the information may be used to contest a claim for benefits or the issuance of the policy itself during the contestability period provided in the policy.

I understand that AFLAC is conditioning the issuance of coverage on the provision of this authorization, and that, while I may refuse to sign this authorization, my refusal to do so could result in coverage not being issued.

I understand that I may revoke this authorization at any time, except to the extent that (1) AFLAC has taken action in reliance on this authorization, or (2) other law provides AFLAC with the right to contest a claim under the policy or the policy itself. My revocation must be submitted in writing to AFLAC, Policy Service, 1932 Wynnton Road, Columbus, GA 31999.

Unless otherwise revoked, I agree that this authorization will expire on the earlier of the date AFLAC notifies me of its declination of my application for coverage or, if a policy is issued, two years from the policy effective date.

I agree that a copy of this authorization is as valid as the original.

Form A-90072

I understand that the premium amount listed on this application represents the premium amount that my employer will remit to AFLAC on my behalf; and I further understand that this amount, because of my employer's billing/payroll practices, could differ from the amount being deducted from my paycheck or the premium amount quoted to me by my associate/agent.

I have read, or had read to me, the completed application and realize that policy issuance is based upon statements and answers provided herein 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 realize that any material misrepresentation therein may result in loss of coverage under the policy.

Signed and Dated at _____ Houston, Texas _____ on _____
City and State Date

Applicant's Signature (X) _____

Beneficiary (your estate unless otherwise indicated) _____
(Relationship)

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

**MAKE CHECK OR MONEY ORDER PAYABLE TO AFLAC.
FOR INFORMATION, CALL TOLL-FREE 1-800-99-AFLAC (1-800-992-3522).**

For policies that provide benefits for expenses incurred for an accidental injury only

**IMPORTANT NOTICE TO PERSONS ON MEDICARE:
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE.**

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses that result from accidental injury. 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
- * 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 senior insurance counseling program.



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).



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

Page 2

[] 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: _____



aflac.com/social || 1.800.99.AFLAC (1.800.992.3522)

