



Personal Accident Indemnity Plan

Field Sales Guide

For Training Purposes Only

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Table of Contents

1	Introduction	11
2	Policy Benefits	
	Base PAI Policy	15
	Wellness	16
	Accident Emergency Treatment	16
	Accident Follow-Up Treatment	17
	Initial Accident Hospitalization	17
	Accident Hospital Confinement	18
	Intensive Care Unit Confinement	18
	Accident Specific-Sum	19
	Major Diagnostic Exam	19
	Physical Therapy	19
	Rehabilitation Unit	20
	Appliances	20
	Prosthesis	21
	Blood/Plasma/Platelets	21
	Ambulance	22
	Transportation	22
	Family Lodging	23
	Accidental-Death	23
	Accidental-Dismemberment	24
	Continuation of Coverage	24
	Chart Comparing Benefits of PAE and PAI	25–26
	Sample Policy	27–43
3	Disability Riders	
	Totally Disabled	47
	Base Pay Earnings	47
	Successive Periods of Disability	48
	Pregnancy and Childbirth	49
	Ten-Month Maternity Exclusion	49
	Pre-Existing Condition Provisions	50
	Benefit Periods and Elimination Period	50
	Disability Riders	51–52
	Summary of Rider Provisions	53
	Disability Income Annual Salary Replacement	54
	Aflac Associates and Disability	55
	Taxation of Disability Benefits	56
	Sample Disability Riders	57–73
4	Administrative Guidelines	
	Eligibility	77
	Advanced Effective Date	77
	Portability	77

Table of Contents

	Mode	77
	Existing Accident Disability Coverage	78
	Request for Change	78
	Transmittals	78
	Insurance Program Acknowledgment Form	78
	Privacy Practices	78
	Sample Privacy Practices Form	79
	Privacy and Aflac Associates	81
5	Setting Up the Account	
	SmartApp®	85
	SIC Approvals	85
	Industry Classifications	85–86
	SIC Request Form	87
6	Completing the Application	
	How to Complete the Application	91
	Four Types of Applications	91–96
	Conversions	97
	Sample Applications	98
	Payroll	99–104
	Payroll Base	105–107
	Nonpayroll	108–111
	Associate Only	112–115
7	Leave With Applicant	
	Replacement Notice	119
	Outline of Coverage	119
8	Personal Accident Indemnity Plan Codes	
	Base	123
	Optional Rider Plan Codes	124
9	Personal Accident Indemnity Premium Rates	
	Types of Coverage	127
	Base Accident Coverage – Payroll	127
	Optional Disability Riders – Payroll	128–129
	Base Accident Coverage – Direct and Association	130
	Rate Calculation Example	131
10	Commissions	
	New Associate	135
	Veteran Associate	135
	New Associate and Nonsoliciting Broker	136
	Veteran Associate and Nonsoliciting Broker	136

Table of Contents

11	Sales Support Materials	
	Brochure	139
	Rider Insert Page	139
	Mailer	139
12	Claims	
	Accident and Disability Claim Form	144–145
	Continuing Disability Claim Form	146
13	Off-the-Job Personal Accident Indemnity	
	Sample Policy	151–167
14	Off-the-Job Personal Accident Indemnity Plan Codes	
	Base	171
15	Off-the-Job Personal Accident Indemnity Premium Rates	
	Types of Coverage	175
16	Review of the Consultative Sales Process	
	Principles of Buyers' Decisions	179
	The Five Buying Decisions	179
	The Nine Acts or Steps of a Sale	180
17	Marketing PAI and Off-the-Job PAI	
	New Accounts	183
	First Buying Decision	184
	Second Buying Decision	185
	Third Buying Decision	185
	Fourth Buying Decision	185
	Fifth Buying Decision	185
	Business Survey	186–187
18	TFBRS (Tie Back, Feature, Benefit, Reaction Questions)	
	TFBRS	191
	Employer TFBRS	192–193
	Employee TFBRS	194–196
19	Underwriting Process	
	Underwriting Process	199
	Disability Underwriting Guidelines for Associates	200–204
20	Industry Classification Guide	
	Industry Classification Chart	207–210
21	Glossary of Medical Terms	
	Medical Terms	213–215

Table of Contents

22	List of Forms for Selling PAI	
	Forms219–220
23	List of Forms for Selling Off-the-Job PAI	
	Forms223–224
24	State Disability227

Preface

This manual is designed to serve as a reference guide to associates for Aflac's new Personal Accident Indemnity (PAI) product. Many of the forms, plan benefits, policy benefits, policy provisions, etc., will vary from state to state. For each state in which an associate is licensed to sell Aflac products, it is the associate's responsibility to review each state introduction packet for state variations. Keep this in mind when marketing multi-state accounts.

Good Luck and Good Selling!



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Table of Contents

1	Introduction	11
2	Policy Benefits	
	Base PAI Policy	15
	Wellness	16
	Accident Emergency Treatment	16
	Accident Follow-Up Treatment	17
	Initial Accident Hospitalization	17
	Accident Hospital Confinement	18
	Intensive Care Unit Confinement	18
	Accident Specific-Sum	19
	Major Diagnostic Exam	19
	Physical Therapy	19
	Rehabilitation Unit	20
	Appliances	20
	Prosthesis	21
	Blood/Plasma/Platelets	21
	Ambulance	22
	Transportation	22
	Family Lodging	23
	Accidental-Death	23
	Accidental-Dismemberment	24
	Continuation of Coverage	24
	Chart Comparing Benefits of PAE and PAI	25–26
	Sample Policy	27–43
3	Disability Riders	
	Totally Disabled	47
	Base Pay Earnings	47
	Successive Periods of Disability	48
	Pregnancy and Childbirth	49
	Ten-Month Maternity Exclusion	49
	Pre-Existing Condition Provisions	50
	Benefit Periods and Elimination Period	50
	Disability Riders	51–52
	Summary of Rider Provisions	53
	Disability Income Annual Salary Replacement	54
	Aflac Associates and Disability	55
	Taxation of Disability Benefits	56
	Sample Disability Riders	57–73
4	Administrative Guidelines	
	Eligibility	77
	Advanced Effective Date	77
	Portability	77

Table of Contents

	Mode	77
	Existing Accident Disability Coverage	78
	Request for Change	78
	Transmittals	78
	Insurance Program Acknowledgment Form	78
	Privacy Practices	78
	Sample Privacy Practices Form	79
	Privacy and Aflac Associates	81
5	Setting Up the Account	
	SmartApp®	85
	SIC Approvals	85
	Industry Classifications	85–86
	SIC Request Form	87
6	Completing the Application	
	How to Complete the Application	91
	Four Types of Applications	91–96
	Conversions	97
	Sample Applications	98
	Payroll	99–104
	Payroll Base	105–107
	Nonpayroll	108–111
	Associate Only	112–115
7	Leave With Applicant	
	Replacement Notice	119
	Outline of Coverage	119
8	Personal Accident Indemnity Plan Codes	
	Base	123
	Optional Rider Plan Codes	124
9	Personal Accident Indemnity Premium Rates	
	Types of Coverage	127
	Base Accident Coverage – Payroll	127
	Optional Disability Riders – Payroll	128–129
	Base Accident Coverage – Direct and Association	130
	Rate Calculation Example	131
10	Commissions	
	New Associate	135
	Veteran Associate	135
	New Associate and Nonsoliciting Broker	136
	Veteran Associate and Nonsoliciting Broker	136

Table of Contents

11	Sales Support Materials	
	Brochure	139
	Rider Insert Page	139
	Mailer	139
12	Claims	
	Accident and Disability Claim Form	144–145
	Continuing Disability Claim Form	146
13	Off-the-Job Personal Accident Indemnity	
	Sample Policy	151–167
14	Off-the-Job Personal Accident Indemnity Plan Codes	
	Base	171
15	Off-the-Job Personal Accident Indemnity Premium Rates	
	Types of Coverage	175
16	Review of the Consultative Sales Process	
	Principles of Buyers' Decisions	179
	The Five Buying Decisions	179
	The Nine Acts or Steps of a Sale	180
17	Marketing PAI and Off-the-Job PAI	
	New Accounts	183
	First Buying Decision	184
	Second Buying Decision	185
	Third Buying Decision	185
	Fourth Buying Decision	185
	Fifth Buying Decision	185
	Business Survey	186–187
18	TFBRS (Tie Back, Feature, Benefit, Reaction Questions)	
	TFBRS	191
	Employer TFBRS	192–193
	Employee TFBRS	194–196
19	Underwriting Process	
	Underwriting Process	199
	Disability Underwriting Guidelines for Associates	200–204
20	Industry Classification Guide	
	Industry Classification Chart	207–210
21	Glossary of Medical Terms	
	Medical Terms	213–215

Table of Contents

22	List of Forms for Selling PAI	
	Forms219–220
23	List of Forms for Selling Off-the-Job PAI	
	Forms223–224
24	State Disability227

Section 1

Introduction

Aflac reached a milestone in 2000 when in-force premiums for accident policies exceeded those of cancer. This reflected our growth from a cancer insurer in the 1950s to a leading voluntary benefits insurer, offering a variety of products to fill the gaps of today's major medical coverage. Accident continues to be our top-selling product, accounting for almost 34 percent of new business in the first half of 2002. Its companion product, short-term disability, is also popular, with just over 18 percent of new business this year. Together, accident and disability have composed over half of our sales for the past five years.

Both the Revised Personal Short-Term Disability and the Personal Accident Expense plans were introduced in 1997. While they continued to experience phenomenal growth, it was time to revisit these core products to ensure that we remained competitive with updated products that met our customers' needs, and also to allow us to expand our market niche. Based on suggestions from the field, we have developed the Personal Accident Indemnity plan.

Section 2

Policy Benefits

The base Personal Accident Indemnity (PAI) policy:

- Provides 24-hour coverage for death, dismemberment, or injury sustained in a covered accident that occurs on or off the job.
- Pays a set indemnity amount as specified in the policy.
- Is guaranteed-issue on payroll only. (Direct has a couple of knock-out questions.)
- Has two levels. Level 2 benefits are approximately 25 percent greater than Level 1.

The base Personal Accident Indemnity policy does not pay benefits for sickness.

Sickness is defined as:

a disease, disorder, infection, or any other abnormal physical condition that is not caused by an injury that is first manifested or treated more than 30 days after the effective date of coverage and while coverage is in force. ***Sickness*** includes diseases or conditions resulting from insect bites or infestations by microorganisms. If the disease or disorder is first manifested or treated within the first 30 days after the effective date of coverage, any resulting disability will not be covered unless it begins more than 12 months after the effective date of coverage.

Example: Mary contracts West Nile virus as a result of being bitten by a mosquito. The policy is designed to pay for accidental injuries, not for sickness. Therefore, no indemnity benefits would be payable. (Note: If Mary had purchased the Sickness Disability Rider and was disabled due to West Nile virus, she would be eligible for disability benefits due to sickness.)

Injury is defined as:

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. (Review the Limitations and Exclusions section for injuries not covered in the policy.)

Read the policy for a complete description of the policy benefits. Benefits and features will vary by state—please refer to your specific state product introduction package.

Wellness Benefit

After this policy has been in force for 12 months, Aflac will pay **\$60** for the insured or any one family member to undergo a covered routine examination or other covered preventive testing during the following policy year. This benefit is payable only once per policy during each 12-month period following the policy anniversary date.

The following services will be covered: Annual physical examinations, dental exams, mammograms, Pap smears, eye examinations, immunizations, flexible sigmoidoscopies, prostate-specific antigen tests (PSAs), ultrasounds, and blood screenings.



The Wellness Benefit is not payable for a procedure performed during the **first** policy year. Aflac will mail automated letters to remind policyholders when they are eligible for the Wellness Benefit.

The following benefits are payable if a covered person's death, dismemberment, or injury is caused by an accident, subject to the limitations and exclusions.

Accident Emergency Treatment Benefit

Aflac will pay the following benefit for treatment by a physician, for X-rays, or for treatment received in a hospital emergency room:

	Insured and Spouse	Child
Level 1	\$120	\$70
Level 2	\$120	\$70

- Treatment must be received within 72 hours of the accident.
- Benefit is payable once per 24-hour period.
- Benefit is payable once per covered accident, per covered person.

Accident Follow-Up Treatment Benefit

Aflac will pay the following benefit when a covered person requires additional treatment over and above emergency treatment administered in the first 72 hours following the accident:

	Follow-Up Treatment
Level 1	\$25 per treatment
Level 2	\$35 per treatment

- Treatment must start within 30 days of the accident or discharge from the hospital.
- Treatment must be performed in a hospital or physician's office on an outpatient basis.
- Benefit is limited to one treatment per day, up to a maximum of six treatments per covered accident, per covered person.



The Accident Follow-Up Treatment Benefit is not payable for the same visit that the Physical Therapy Benefit is paid.

Initial Accident Hospitalization Benefit

Aflac will pay the following benefit when a covered person is confined in a hospital for **24 hours** or more, or admitted directly to an intensive care unit for treatment of injuries:

	Initial Accident Hospital Confinement	Initial Accident Intensive Care Unit Confinement
Level 1	\$1,000	\$1,500
Level 2	\$1,000	\$2,000

- Confinement must start within 30 days of the accident.
- Benefit is payable once per hospital confinement or intensive care unit period.
- Benefit is payable once per calendar year, per covered person.

This benefit will be paid in addition to the hospital and ICU confinement benefits.

Accident Hospital Confinement Benefit

Aflac will pay the following benefit if a covered person is confined in a hospital for at least **18 hours** for treatment of injuries:

	Hospital Confinement
Level 1	\$200 per day
Level 2	\$250 per day

- Confinement must start within 30 days of the accident.
- Benefit is payable up to 365 days per covered accident, per covered person.



The Accident Hospital Confinement Benefit and Rehabilitation Unit Benefit will not be paid on the same day. The highest eligible benefit will be paid.

Intensive Care Unit Confinement Benefit

Aflac will pay the following additional benefit for each day a covered person is confined in an intensive care unit while the person is receiving the Accident Hospital Confinement Benefit:

	Intensive Care Unit Confinement
Level 1	\$400 per day
Level 2	\$400 per day

- Confinement must start within 30 days of the accident.
- Benefit is payable up to 15 days per covered accident, per covered person.

Example: Due to injuries sustained in a car accident, George is admitted directly to an intensive care unit. He stays in ICU for three days and then is transferred to a regular hospital room for seven days. He has a Level 2 Personal Accident Indemnity Policy. How much would the policy pay?

\$2,000		Initial Accident Hospitalization Benefit
\$2,500	\$250/day x 10 days (7 days confinement in regular room plus 3 days in ICU)	Accident Hospital Confinement Benefit
<u>\$1,200</u>	\$400/day in ICU x 3 days	Intensive Care Unit Confinement Benefit
\$5,700	TOTAL + any other applicable policy benefits	

Accident Specific-Sum Benefit

Aflac will pay benefits for the treatments listed, if a covered person receives treatment for injuries in a covered accident. See sample policy on page 27.

Major Diagnostic Exams Benefit

Aflac will pay the following benefit when a covered person requires a CT (computerized tomography) scan, an MRI (magnetic resonance imaging), or an EEG (electroencephalogram) for an injury sustained in a covered accident:

	Major Diagnostic Test
Level 1	\$150
Level 2	\$200

- Exams must be performed in a hospital, physician's office, or ambulatory surgical center.
- Benefit is limited to one payment per calendar year, per covered person.

The PAI Major Diagnostic Test Benefit pays for **three exams**. The **PSI** (Personal Sickness Indemnity) Major Diagnostic Test Benefit pays for **seven exams** (CT Scan, MRI, EEG, plus four additional tests).

	Physical Therapy
Level 1	\$25 per treatment
Level 2	\$35 per treatment



The Accident Follow-Up Treatment Benefit is not payable for the same visit that the Physical Therapy Benefit is paid.

Rehabilitation Unit Benefit

Aflac will pay the following benefit for each day of rehabilitation confinement when a person is confined in a hospital and is transferred to a bed in a rehabilitation unit of a hospital:

	Rehabilitation Unit Confinement
Level 1	\$100 per day
Level 2	\$150 per day

- Benefit is limited to 30 days per covered person, per period of hospital confinement.
- Benefit is payable up to 60 days per calendar year.

Appliances Benefit

Aflac will pay the following benefit when a covered person requires use of a medical appliance as an aid in personal locomotion as a result of injuries sustained in a covered accident:

	Appliances
Level 1	\$100
Level 2	\$125

- Benefit is payable for crutches, wheelchairs, leg braces, back braces, and walkers.
- Benefit is payable once per covered accident, per covered person.

Prosthesis Benefit

Aflac will pay the following benefit when a covered person requires use of a prosthetic device as a result of injuries sustained in a covered accident:

	Prosthetic Device
Level 1	\$500
Level 2	\$750

- Benefit is not payable for hearing aids, wigs, or any dental aids, including false teeth.
- Benefit is payable once per covered accident, per covered person.

Blood/Plasma/Platelets Benefit

Aflac will pay the following benefit when a covered person requires blood/plasma and/or platelets for treatment of injuries sustained in a covered accident:

	Blood/Plasma/Platelets
Level 1	\$100
Level 2	\$200

- Benefit is not payable for immunoglobulins.
- Benefit is payable once per covered accident, per covered person.

Ambulance Benefit

Aflac will pay the following benefit when a covered person requires transportation to a hospital or emergency center for injuries sustained in a covered accident:

	Ambulance	Air Ambulance
Level 1	\$150	\$1,000
Level 2	\$200	\$1,500

- Ambulance transportation must be provided within 72 hours of the covered accident.
- Transportation must be provided by a licensed professional ambulance company.

Transportation Benefit

Aflac will pay the following benefit when a covered person requires special treatment and confinement in a hospital for injuries sustained in a covered accident. A local physician must prescribe the treatment, and the treatment cannot be available locally.

	Transportation
Level 1	\$400 per round trip
Level 2	\$600 per round trip

- Benefit is not payable for ambulance or air ambulance transportation.
- Benefit is not payable for transportation within a 100-mile radius of the accident scene or residence of the covered person.
- Benefit is payable for up to three round trips per calendar year, per covered person.

If treatment is for a dependent child and commercial travel is necessary, the dependent child's parent or legal guardian who travels with the child will also receive this benefit.

Example:	Dependent Child	\$ 600
	Parent	<u>\$ 600</u>
	TOTAL	\$1,200

Family Lodging Benefit

Aflac will pay the following Family Lodging Benefit per night for one motel/hotel room for one member of the immediate family to accompany the covered person when a covered person requires confinement in a hospital or emergency center for injuries sustained in a covered accident:

	Family Lodging
Level 1	\$100 per night
Level 2	\$125 per night

- Benefit is payable only during the time the insured is hospital-confined.
- Hospital and lodging must be more than 100 miles from the residence of the covered person.
- Benefit is payable up to 30 days per covered accident.

Accidental-Death Benefit

Aflac will pay the following lump-sum benefit for accidental death. Death must occur as a result of injuries and must occur within 90 days of the covered accident.

		Insured	Spouse	Child
Level 1	Common Carrier Accident	\$100,000	\$100,000	\$15,000
	Other Accidents	\$25,000	\$25,000	\$7,500
Level 2	Common Carrier Accidents	\$150,000	\$150,000	\$25,000
	Other Accidents	\$40,000	\$40,000	\$12,500

Accidental-Dismemberment Benefit

If a dismemberment occurs as a result of injuries within 90 days of the covered accident, Aflac will pay the applicable lump-sum benefit:

		Insured	Spouse	Child
Level 1	Both arms and both legs	\$25,000	\$25,000	\$7,500
	Two eyes, feet, hands, arms, or legs	\$25,000	\$25,000	\$7,500
	One eye, foot, hand, arm, or leg	\$6,250	\$6,250	\$1,875
	One or more fingers and/or one or more toes	\$1,250	\$1,250	\$500
		Insured	Spouse	Child
Level 2	Both arms and both legs	\$40,000	\$40,000	\$12,500
	Two eyes, feet, hands, arms, or legs	\$40,000	\$40,000	\$12,500
	One eye, foot, hand, arm, or leg	\$10,000	\$10,000	\$3,750
	One or more fingers and/or one or more toes	\$2,000	\$2,000	\$625

The highest single benefit per covered accident will be paid once for any covered accident.

Continuation Of Coverage

Aflac will waive all monthly premiums due for the policy and riders for up to two months if the named insured meets all of the following conditions:

1. The policy has been in force for at least six months.
2. Aflac has received premiums for at least six consecutive months.
3. The premiums have been paid through payroll deduction, and the named insured leaves the employer for any reason.
4. The named insured or the employer notifies Aflac in writing within 30 days of the date the premium payments cease due to leaving employment.
5. The named insured re-establishes premium payments through:
 - (a) A new employer's payroll deduction process.
 - (b) Direct payment to Aflac.

The named insured will again become eligible to receive this benefit after re-establishing premium payments through payroll deduction for a period of at least six months and after Aflac receives premiums for at least six consecutive months.

PERSONAL ACCIDENT EXPENSE VERSUS PERSONAL ACCIDENT INDEMNITY

Benefits	PAE			PAI Level 1			PAI Level 2		
Wellness	\$60 after 12 months premiums			\$60 after 12 months in force; added dental exams			\$60 after 12 months in force; added dental exams		
Accidental Death	Insured	Spouse	Child	Insured	Spouse	Child	Insured	Spouse	Child
Common Carrier	\$100,000	50,000	15,000	\$100,000	100,000	15,000	\$150,000	150,000	25,000
Other Accidents	\$ 25,000	10,000	5,000	\$ 25,000	25,000	7,500	\$ 40,000	40,000	12,500
Accidental Dismemberment	Insured	Spouse	Child	Insured	Spouse	Child	Insured	Spouse	Child
Both arms and both legs	\$25,000	10,000	5,000	\$25,000	25,000	7,500	\$40,000	40,000	12,500
Two eyes, feet, hands, arms or legs	25,000	10,000	5,000	25,000	25,000	7,500	40,000	40,000	12,500
One eye, foot, hand, arm or leg	6,250	2,500	1,250	6,250	6,250	1,875	10,000	10,000	3,750
One or more fingers and/or toes	1,250	500	250	1,250	1,250	500	2,000	2,000	625
Initial hospitalization, 24 hours	\$1000			\$1000 for regular admission \$1500 if admitted directly to ICU			\$1000 for regular admission \$2000 if admitted directly to ICU		
Daily hospital confinement	\$200 for 24 hours, up to 365 days			\$200 for 18 hours, up to 365 days			\$250 for 18 hours, up to 365 days		
ICU confinement	\$400, up to 15 days			\$400, up to 15 days			\$400, up to 15 days		
Accident Emergency Treatment	Insured	Spouse	Child	Insured	Spouse	Child	Insured	Spouse	Child
	\$120	120	70	\$120	120	70	\$120	120	70
Follow-up visits	\$25, up to 6			\$25, up to 6			\$35, up to 6		
Physical therapy visits	\$25, up to 6			\$25, up to 10			\$35, up to 10		
Dislocations	Open	Closed		Open	Closed		Open	Closed	
Hip	\$2000	500		\$2000	500		\$2500	625	
Knee, shoulder	500	200		500	200		625	250	
Collar bone	800	150		800	150		1000	200	
Ankle, foot	500	150		500	150		625	200	
Lower jaw	500	250		500	250		625	325	
Wrist or elbow	400	200		400	200		500	250	
Toe or finger	100	50		100	50		125	65	
Burns (new policy in sq. cm.)									
2 nd degree, less than 10% (20 sq. cm.)	\$ 100			\$ 100			\$ 125		
2 nd , 10 – 25% (20 – 40 sq. cm.)	200			200			250		
2 nd , 25 – 35% (40 – 65 sq. cm.)	500			400			500		
2 nd , 35%+ (65 – 160 sq. cm.)	1,000			600			750		
2 nd , 160 - 225 sq. cm.				800			1,000		
2 nd , 225 sq. cm. +				1,000			1,250		
3 rd , less than 3 sq. in. (20 sq. cm.)	200			200			250		
3 rd , 3 – 6 sq. in. (20 – 40 sq. cm.)	500			500			625		
3 rd , 6 – 10 sq. in. (40 – 65 sq. cm.)	1,000			1,000			1,250		
3 rd , 10 –25 sq. in. (65 – 160 sq. cm.)	3,000			3,000			3,750		
3 rd , 25 – 35 sq. in. (160 – 225 sq. cm.)	7,000			7,000			8,750		
3 rd , 35 sq. in. + (225 sq. cm. +)	10,000			10,000			12,500		
Skin grafts	25% of burn benefit			50% of burn benefit			50% of burn benefit		
Tendons & Ligaments	\$500			\$500			\$625		
Ruptured disc/torn knee cartilage	\$500			\$500			\$625		
Torn rotator cuff	\$250, one \$500, more than one			\$500, one or more			\$625, one or more		
Eye injury	\$ 50, foreign body removal 250, surgical repair			\$ 50, foreign body removal 250, surgical repair			\$ 65, foreign body removal 300, surgical repair		
Lacerations with sutures									
Less than 2 inches (5 cm)	\$ 50			\$ 50			\$ 65		
2 – 6 inches (5 – 15 cm)	200			200			250		
Over 6 inches (15 cm)	400			400			500		
No sutures	25			25			35		
Internal injuries resulting in open abdominal, hernia or thoracic surgery	\$1000			\$1000; added cranial and open exploratory surgery			\$1250; added cranial and open exploratory surgery		

Bold indicates the benefits that have been increased compared to the Personal Accident Expense.
Shading indicates the Level 2 benefits that are higher than the Level 1 benefits.

Benefits	PAE		PAI Level 1		PAI Level 2	
	Open	Closed	Open	Closed	Open	Closed
Fractures						
Hip	\$2000	1000	\$2000	1000	\$2500	1250
Leg	1000	500	1000	500	1250	625
Hand, wrist, elbow, forearm	500	250	500	250	625	325
Shoulder blade	500	250	500	250	625	325
Foot, ankle, kneecap	500	250	500	250	625	325
Sternum (PAI) lower jaw	500	250	500	250	625	325
Vertebrae (body of), pelvis, sternum (PAI)	1000	500	1000	500	1250	625
Upper jaw, upper arm, face	600	300	600	300	750	375
Rib or ribs	1000	100	1000	100	1250	125
Nose, heel or finger(s)	500	100	500	100	625	125
Coccyx	200	100	200	100	250	125
Toe(s)	200	100	200	100	250	125
Vertebral processes	1000	150	1000	150	1250	200
Skull	depressed- \$1500, simple - \$500		depressed- \$1500, simple - \$500 Pay all fractures per bone, up to maximum of 2 (instead of one benefit for multiple fractures of ribs fingers or toes)		depressed- \$1875, simple - \$625 Pay all fractures per bone, up to maximum of 2 (instead of one benefit for multiple fractures of ribs fingers or toes)	
Chip Fractures	25% of fracture benefit		25% of fracture benefit		25% of fracture benefit	
Concussion	\$200 with EEG		\$50 with no diagnostic test		\$50 with no diagnostic test	
Exploratory surgery w/o repair (i.e., arthroscopy)	\$250		\$250		\$300	
Emergency dental work:						
Crown(s)	\$150		\$150		\$200	
Extraction(s)	50		50		65	
Partial amputation of finger(s), toe(s), must involve one joint	\$100		Deleted as a separate benefit; will pay as open fracture		Deleted as a separate benefit; will pay as open fracture	
Coma, after 30 days	\$10,000		\$10,000; After 7 days		\$12,500; After 7 days	
Paralysis, after 3 months	Insured/Spouse	Child	Same benefit for all covered persons:			
Quadriplegia	\$10,000	5000	Quad - \$10,000		Quad - \$12,500	
Paraplegia	5,000	2500	Para - \$ 5,000		Para - \$6,250	
			After 30 days		After 30 days	
Appliance	\$100		\$100		\$125	
Prosthesis	\$500		\$500		\$750	
Ambulance	\$100 ground 500 air		\$ 150 ground 1000 air		\$ 200 ground 1500 air	
Transportation	\$300 per trip, up to 3 per year		\$400 per trip, up to 3 per year		\$600 per trip, up to 3 per year	
Lodging	\$100 per night, up to 30 days per acc		\$100 per night, up to 30 days per acc		\$125 per night, up to 30 days per acc	
Blood and plasma	\$100		\$100; added platelets		\$200; added platelets	
Continuation of coverage	After 6 months, waive up to 2 months		After 6 months, waive up to 2 months		After 6 months, waive up to 2 months	
New Benefits:						
Major diagnostic exam (MRI, CT scan, etc.)	None		\$150, 1 per person per year		\$200, 1 per person per year	
Rehabilitation confinement	None		\$100, up to 30 days per accident, 60 days per year		\$150, up to 30 days per accident, 60 days per year	
Misc. surgery requiring general anesthesia	None		\$250; 1 per 24-hour period		\$300; 1 per 24-hour period	

Bold indicates the benefits that have been increased compared to the Personal Accident Expense. Shading indicates the Level 2 benefits that are higher than the Level 1 benefits.

*Sample Personal Accident
Indemnity Policy
(Series A-34200 Level 2)*

There are two levels of Personal Accident Indemnity plans available: Form A-34100 (Level 1) and Form A-34200 (Level 2). We will use Form A-34200 for illustrative purposes in this manual.

This is a sample base policy to be used for training purposes only. **Benefits, limitations, and exclusions may vary by state; please refer to your specific state introduction packet for complete details.**

ACCIDENT-ONLY POLICY

This is an accident-only policy;
it does not pay benefits for Sickness.

IMPORTANT: This is a limited policy.
Read it carefully with the Outline of Coverage, if applicable.

In this policy, you, the Insured as shown in the Policy Schedule, are referred to as "you," "your," or "yours." **American Family Life Assurance Company of Columbus (AFLAC)**, a stock company, is referred to as "we," "our," "us," or "AFLAC."

CONSIDERATION

We promise to insure you for the benefits described in this policy. We make this promise in consideration of the application for this policy and the payment of all premiums when due.

YOUR RIGHT TO EXAMINE THIS POLICY

It is important to us that you are satisfied with this policy and that it meets your insurance needs. If you are not satisfied, you may return it within 30 days after you receive it. Send it to our associate (duly licensed agent) or to AFLAC Worldwide Headquarters, 1932 Wynnton Road, Columbus, Georgia 31999. You will receive a full refund of all premiums paid, and your policy will be void from its Effective Date. If you return the policy, please note in writing: "This policy is returned for cancellation and refund of premium."

IMPORTANT NOTICE: Please read your application attached to this policy. This policy is issued on the basis that the information shown on the application is correct and complete to the best of your knowledge and belief. Carefully check the application. Write to us within 30 days of the date you receive this policy if any information shown on it is not correct or complete. Incorrect information can result in the denial of a claim or termination of this policy. No associate (duly licensed agent) may change this policy or waive any of its provisions.

THIS POLICY IS GUARANTEED-RENEWABLE FOR YOUR LIFETIME, SUBJECT TO OUR RIGHT TO CHANGE PREMIUMS BY CLASS UPON ANY RENEWAL DATE.

We agree that this policy will never be restricted by the addition of any rider without your consent, nor will renewal be refused because of any change in a covered person's health or physical condition. You are guaranteed the right to renew this policy for your lifetime by the payment of premiums at the rate in effect at the beginning of each term. We may change the established premium rate, but only if the rate is changed for all policies of this class. While this policy is in force, no change will be made in your class because of the age, sex, or physical condition of any covered person(s). "Class" means all policies of this form number and premium classification in your state that are then in force. If the established premium rate changes, we will notify you in writing at your last known address at least 30 days before the change becomes effective.

American Family Life Assurance Company of Columbus (AFLAC)
Worldwide Headquarters: 1932 Wynnton Road, Columbus, Georgia 31999
Call toll-free 1-800-99-AFLAC (1-800-992-3522).

INDEX

Insured.....	Policy Schedule
Definitions	Part 1
Limitations and Exclusions	Part 2
Right of Conversion	Part 3
Uniform Provisions.....	Part 4
Benefits.....	Part 5

Policy Schedule

INSURED: John A. Doe

POLICY NUMBER: 111-2222

TYPE OF COVERAGE: Individual

COVERAGE: XXXXXX
 AAABBB

MODE OF PAYMENT: Monthly

DISABILITY BENEFIT PERIOD:

ELIMINATION PERIOD:

Accident:
Sickness:
Rider:

Accident:
Sickness:
Rider:

PREMIUMS

Policy: \$XX
Rider: \$XX

EFFECTIVE DATES

Policy: XX/XX/XX
Riders: XX/XX/XX

In witness whereof, AFLAC's president and secretary signed this policy in Columbus, Georgia, as of the policy Effective Date shown in the Policy Schedule.

ABCD

Joey M. Loudermilk, Secretary

ABCD

Daniel P. Amos, President

This policy is a contract between you and AFLAC.

READ YOUR POLICY CAREFULLY.

Part 1
DEFINITIONS

- A. ACCIDENTAL-DEATH OR -DISMEMBERMENT:** death or Dismemberment caused by an accident that occurs on or after the Effective Date of coverage and while coverage is in force, independent of disease, bodily infirmity, or any other cause. See the Limitations and Exclusions section for death or Dismemberment not covered by this policy.
- B. AMBULATORY SURGICAL CENTER:** a facility, licensed as such, that provides surgical services on an outpatient basis. This does not include a Physician's or dentist's office, clinic, or other such location.
- C. COMA:** a continuous state of profound unconsciousness, diagnosed or treated after the Effective Date of this policy, lasting for a period of seven or more consecutive days, characterized by the absence of: 1) spontaneous eye movements, 2) response to painful stimuli, and 3) vocalization. The condition must require intubation for respiratory assistance.
- D. CHIP FRACTURE:** a Fracture in which a piece of the bone is broken off near a joint at a place where a ligament is usually attached. It must be diagnosed by a Physician through the use of an X-ray.
- E. 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 a proper authority to transport passengers for a fee. Common-carrier vehicles are limited to airplanes, trains, buses, trolleys, and boats that operate on a regularly scheduled basis between predetermined points or cities. **A taxi is not a common-carrier vehicle.**
- F. DISLOCATION:** a completely separated joint. It must be diagnosed as a Dislocation by a Physician within 72 hours after the date of the accident. The Dislocation must require correction by a Physician. It can be corrected by open or closed Reduction.
- G. DISMEMBERMENT OR LOSS OF (with or without reattachment):** (1) Arm - actual severance above the elbow; (2) Leg - actual severance above the knee; (3) Hand - actual severance above the wrist; (4) Foot - actual severance above the ankle; (5) Finger - actual severance at the joint (proximate to the first interphalangeal joint) where it is attached to the hand; (6) Toe - actual severance at the joint (proximate to the first interphalangeal joint) where it is attached to the foot; and (7) Eye - loss of the eye or permanent loss of vision such that central visual acuity cannot be corrected to better than 20/200. **Loss of use does not constitute Dismemberment, except as stated above in (7) Eye.**
- H. EFFECTIVE DATE:** the date shown in the Policy Schedule. The Effective Date of the policy is **not** the date you signed the application for coverage.
- I. FRACTURE:** a break in a bone that can be seen by X-ray. It must be diagnosed as a Fracture by a Physician within 14 days after the date of the accident. The Fracture must require correction by a Physician. It can be corrected by open or closed Reduction.

- J. HOSPITAL:** a legally operated institution licensed by the state in which it is located that maintains and uses a laboratory, X-ray equipment and an operating room on its premises or in facilities available to it on a prearranged, written, contractual basis. The institution must also have permanent and full-time facilities for the care of overnight-resident bed patients under the supervision of one or more licensed Physicians, provide 24-hour-a-day nursing service by or under the supervision of a registered professional nurse, and maintain the patients' written histories and medical records on the premises. The term "Hospital" also includes Ambulatory Surgical Centers and satellite emergency centers. The term "Hospital" does not include any institution or part thereof used as a Rehabilitation Unit; 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.
- K. HOSPITAL CONFINEMENT:** a stay of a covered person confined to a bed in a Hospital for which a room 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.
- L. IMMEDIATE FAMILY:** anyone related to you in the following manner: your spouse; brothers or sisters (includes stepbrothers and stepsisters); children (includes stepchildren); parents (includes stepparents); grandchildren; father-in-law or mother-in-law; and spouses, as applicable, of any of these.
- M. 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 this policy.
- N. INTENSIVE CARE UNIT (ICU):** a specifically designated facility of the Hospital that provides the highest level of medical care and that is restricted to those patients who are critically ill or injured. Such facilities must be separate and apart from the surgical recovery room and from rooms, beds, and wards customarily used for patient confinement. The ICU must be permanently equipped with special lifesaving equipment for the care of the critically ill or injured, and the patients must be under constant and continual observation by nursing staffs assigned exclusively to the ICU on a full-time basis. These units must be listed as Intensive Care Units in the current edition of the American Hospital Association Guide or be eligible to be listed therein. This guide lists three types of facilities that meet this definition: (1) Intensive Care Units, (2) Cardiac Intensive Care Units, and (3) Infant (Neonatal) Intensive Care Units.
- O. OTHER ACCIDENTS:** accidents that occur on or after the Effective Date of coverage and while coverage is in force that are not classified as Common-Carrier Accidents and that are not specifically excluded in the Limitations and Exclusions section.
- P. PARALYSIS:** 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 30 days. Your Paralysis must be confirmed by your attending Physician.

- Q. PERIOD OF HOSPITAL CONFINEMENT:** a time period of Hospital Confinement that starts while this policy is in force. If the confinement follows a previously covered confinement, it will be deemed a continuation of the first confinement unless the later confinement is the result of an entirely unrelated Injury or the confinements are separated by 30 days or more.
- R. PHYSICAL THERAPIST (also known as "Physiotherapist"):** a licensed specialist in physical therapy.
- S. PHYSICIAN:** a legally qualified person, other than a member of your Immediate Family, who is licensed as a Physician by the state to treat the type of condition for which a claim is made.
- T. PROSTHETIC DEVICE/PROSTHESIS:** an artificial device designed to replace a missing part of the body.
- U. REHABILITATION UNIT:** a unit of a Hospital providing coordinated multidisciplinary physical restorative services to inpatients under the direction of a Physician who is knowledgeable and experienced in rehabilitative medicine. Beds must be set up and staffed in a unit specifically designated for this service.
- V. REDUCTION:** open (surgical) or closed (manipulative) repair of a Fracture or Dislocation.
- W. SICKNESS:** a disease, disorder, infection, or any other abnormal physical condition that is not caused by an Injury that is first manifested or treated more than 30 days after your Effective Date of coverage and while coverage is in force. "Sickness" includes diseases or conditions resulting from insect bites or infestations by microorganisms. If you purchase the Optional Sickness Disability Rider Series A-34052, and the disease or disorder is first manifested or treated within the first 30 days after your Effective Date of coverage, any resulting disability will not be covered unless it begins more than 12 months after the Effective Date of coverage.
- X. TYPE OF COVERAGE:** see your Policy Schedule to determine the Type of Coverage issued: Individual, Named Insured/Spouse Only, One-Parent Family, or Two-Parent Family.
- (1) **Individual:** coverage for only you (the Insured listed in the Policy Schedule).
- (2) **Named Insured/Spouse Only:** coverage for only you (the Insured) and your spouse.
- (3) **One-Parent Family:** coverage for you (the Insured) and all of your dependent children (or those of your spouse) who are unmarried and under age 19. "Dependent children" are your natural children, stepchildren, or legally adopted children who are unmarried, who are under age 19, and who qualify as legal dependents for tax exemption purposes under the United States Internal Revenue Service Tax Code. Coverage of a dependent child will be extended to age 23 if he/she is enrolled as a full-time student in a post secondary institution of higher learning for five calendar months in that calendar year; or, if not enrolled, would have been eligible to enroll and was prevented from enrolling due to Sickness or Injury. Children born to dependent children of the Named Insured or spouse are not covered under this policy.
- (4) **Two-Parent Family:** coverage for you (the Insured), your spouse, and all of your dependent children (or those of your spouse) who are unmarried and under age 19. Dependent children are your natural children, stepchildren, or legally adopted children who are unmarried, who are under age 19, and who qualify as legal dependents for tax exemption purposes under the United States Internal Revenue Service Tax Code. Coverage of a

dependent child will be extended to age 23 if he/she is enrolled as a full-time student in a post secondary institution of higher learning for five calendar months in that calendar year; or, if not enrolled, would have been eligible to enroll and was prevented from enrolling due to Sickness or Injury. Children born to dependent children of the Insured or the Insured's spouse are not covered under this policy.

Persons covered under Individual, Named Insured/Spouse, One-Parent Family, or Two-Parent Family coverage are referred to as "covered persons." Newborn children are automatically covered under the terms of the policy from the moment of birth, and adopted children are covered from the date of petition. If Individual or Named Insured/Spouse coverage is issued and you desire uninterrupted coverage for a newborn or adopted child, you must notify AFLAC within 31 days of the child's birth or the date of petition for adoption. Upon notification, AFLAC will convert this policy to One-Parent Family or Two-Parent Family coverage and advise you of the additional premium due. If One-Parent Family or Two-Parent Family coverage is in force, it is not necessary for you to notify AFLAC of the birth of your child or the date of petition for adoption, and an additional premium payment is not required. If you wish any other person to be covered after the Effective Date of the policy, you must apply for such coverage, and that person must be added by endorsement. Insurance for persons added by endorsement becomes effective on the date specified on the endorsement.

The insurance on any dependent child will terminate on the policy anniversary date following the child's 19th birthday (23rd if a full-time student), the child's marriage, or at the time the child no longer qualifies as a legal dependent for tax exemption purposes under the United States Internal Revenue Service Tax Code, whichever occurs first. Termination will be without prejudice to any prior claim. AFLAC's acceptance of premium after such date will be considered as premium for only the remaining persons who qualify as covered persons under the policy. Coverage provided under any One-Parent Family or Two-Parent Family contract will include any other unmarried 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 before age 19. Proof of such incapacity and dependency must be furnished to AFLAC by you within 31 days of the dependent child's 19th birthday. Proof of continued incapacity and dependency must be furnished at AFLAC's request, but not more often than annually, after the two-year period following the child's 19th birthday.

Part 2

LIMITATIONS AND EXCLUSIONS

- A. We will not pay benefits for services rendered by a member of the Immediate Family of a covered person.**
- B. We will not pay benefits for an accident or Sickness that is caused by or occurs as a result of a covered person's:**
 - 1. 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);
 - 2. Driving any taxi for wage, compensation, or profit;

3. Mountaineering using ropes and/or other equipment; parachuting; or hang gliding;
4. Participating in, or attempting to participate in, an illegal activity that is defined as a felony, whether charged or not ("felony" is as defined by the law of the jurisdiction in which the activity takes place); or being incarcerated in any type penal institution;
5. Intentionally self-inflicting bodily Injury or attempting suicide, while sane or insane;
6. Having cosmetic surgery or other elective procedures that are not medically necessary, or having dental treatment except as a result of Injury;
7. Being exposed to war or any act of war, declared or undeclared;
8. Actively serving in any of the armed forces, or units auxiliary thereto, including the National Guard or Army Reserve;
9. Participating in any form of flight aviation other than as a fare-paying passenger in a fully licensed, passenger-carrying aircraft;
10. Participating in any sport or sporting activity for wage, compensation, or profit, including officiating or coaching; or racing any type vehicle in an organized event.

Part 3 **RIGHT OF CONVERSION**

A. Dissolution of Marriage:

If you and your spouse dissolve your marriage by a valid decree of dissolution of marriage and your spouse was covered under Named Insured/Spouse Only or Two-Parent Family coverage, coverage for your spouse will terminate. Your ex-spouse can apply for and receive, without evidence of insurability, a policy in his/her occupation class providing coverage not greater than the terminated coverage. To obtain the policy, your ex-spouse must apply to AFLAC within 60 days following the entry of the decree of dissolution of marriage and pay the appropriate premium. Conversion rights do not apply to Off-the-Job Accident Disability Rider Series A-34050, On-the-Job Accident Disability Rider Series A-34051 and Sickness Disability Rider Series A-34052. If your ex-spouse is covered under the Spouse Off-the-Job Rider Series A-34053, this rider will terminate. However, the spouse rider will convert to the Off-the-Job Rider Series A-34050 for the same amount of coverage as provided in the Spouse Off-the-Job Rider Series A-34053. If additional coverage is desired, additional underwriting will be required.

If such dissolution of marriage occurs, the Named Insured under this policy at the time of the dissolution will retain that status. Any covered dependents may be insured under either policy, but not both.

B. Death:

In the event of your death, your spouse (if covered hereunder) will become the Named Insured and coverage will continue in the same occupation class. Conversion rights do not apply to Off-the-Job Accident Disability Rider Series A-34050, On-the-Job Accident Disability Rider Series A-34051 and Sickness Disability Rider Series A-34052. If your spouse is covered under the Spouse Off-the-Job Rider Series A-34053, this rider will terminate. However, the spouse rider will convert to the Off-the-Job Rider Series A-34050 for the same amount of coverage as provided in the Spouse Off-the-Job Rider Series A-34053. If additional coverage is desired, additional underwriting will be required.

C. Termination of Dependency:

A dependent child covered under this policy who has reached his or her 19th birthday or who has married and desires to continue coverage as the Insured under a separate policy may do so by notifying AFLAC of the request in writing. The child will have the right to continue coverage as an Insured on a separate equivalent policy in his/her occupation class without a requirement for evidence of insurability and without interruption in coverage, provided AFLAC receives written notification of the request before 30 days after the policy anniversary date following the dependent's 19th birthday or marriage. Conversion rights do not apply to Off-the-Job Accident Disability Rider Series A-34050, On-the-Job Accident Disability Rider Series A-34051 and Sickness Disability Rider Series A-34052.

Part 4 **UNIFORM PROVISIONS**

- A. ENTIRE CONTRACT; CHANGES:** This policy, together with the application, endorsements, benefit agreements, riders, and attached papers, if any, constitutes the entire contract of insurance. No change in this policy is valid until approved in writing by the secretary and president of AFLAC at our worldwide headquarters. Any such change must be noted on or attached hereto. No associate (duly licensed agent) has the authority to change this policy or to waive any of its provisions.
- B. TIME LIMIT ON CERTAIN DEFENSES:** After two years from the Effective Date of this policy, any misstatements, except fraudulent misstatements, made by you in the application shall not be used to void the policy or to deny a claim for care commencing after the expiration of such two-year period.
- C. TERM:** The term of this policy begins at midnight, standard time, at the place where you reside on the Effective Date shown in the Policy Schedule. It ends at midnight, at the same standard time, on the first renewal date. Each renewal term ends at midnight, at the same standard time, on the next following renewal date. Renewal dates are determined by the mode of payment. The mode of payment for the original term of this policy is shown in the Policy Schedule. An annual premium will maintain this policy in force for 12 months, semiannual for six months, quarterly for three months, and monthly for one month. Premium for a term is due on the first day of that term. If you fail to pay your premium by the end of the grace period, coverage under this policy will terminate.
- D. MISSTATEMENT OF AGE:** If an age has been misstated on the application, the benefits will be those the premium paid would have purchased at the correct age. We will refund all unearned premiums paid, less any benefits paid, if the misstated age at the time of application was outside the age limits for this policy.
- E. REINSTATEMENT:** You may request reinstatement of your policy from our associate (duly licensed agent) or from AFLAC. If your policy has lapsed for nonpayment of premium and we accept a later payment without requiring an application, your policy shall be reinstated. If we require a written application and provide you with a conditional receipt, your policy will be reinstated upon our approval of the application. If we do not notify you of our disapproval in writing within 45 days of the date of your application, your policy shall be deemed reinstated. The reinstated policy shall cover only loss resulting from accidental Injury that takes place after the date of reinstatement and loss resulting from Sickness (if you purchased Rider Form Series A-34052) that begins more than 10 days after the date of reinstatement. In all other

respects, the Insured and AFLAC shall have the same rights as provided under the policy immediately before the due date of the defaulted premium, subject to any provisions added in connection with the reinstatement. Any premium accepted in connection with a reinstatement will not be applied to any period prior to the date of reinstatement.

- F. 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.
- G. MISSTATEMENT OF OCCUPATION OR INCOME:** If your occupation has been misstated, the benefits will be those that the premiums paid would have purchased for your correct occupation. If your income has been misstated, the benefit payable will be that which would have been allowed for your true income level, and any overpayment of premium will be refunded.
- H. NOTICE OF CLAIM:** Written notice of claim must be given within 60 days after a covered loss starts or as soon as reasonably possible. The notice can be given to AFLAC at our worldwide headquarters or to your associate (duly licensed agent). The notice should include the name of the covered person and the policy number.
- I. CLAIM FORMS:** When we receive a notice of claim, we will send you forms for filing proof of loss. If the forms are not given to you within ten working days, you will meet the proof-of-loss requirements by giving us a written statement of the nature and extent of the loss within the time limit stated in the Proof of Loss provision.
- J. PROOF OF LOSS:** Written proof of loss must be furnished to AFLAC at our worldwide headquarters within 90 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate or reduce any claim if it was not reasonably possible to give proof within such time. However, such proof must be furnished as soon as reasonably possible and in no event (except in the absence of legal capacity) later than 15 months from the time proof is otherwise required.
- K. TIME OF PAYMENT OF CLAIMS:** All benefits payable under this policy will be paid immediately upon receipt of written proof of loss.
- L. PAYMENT OF CLAIMS:** All benefits will be payable to you unless assigned by you or by operation of law. Any accrued benefits unpaid at your death will be paid to your estate.
- M. LEGAL ACTIONS:** Any legal action may not be brought to recover on this policy within 60 days after written proof of loss has been furnished in accordance with the requirements of this policy. Any such action may not be brought after six years from the time written proof of loss is required to be furnished.
- N. CONFORMITY WITH STATE AND FEDERAL STATUTES:** Any provision of this policy that, on its Effective Date, is in conflict with the statutes of the state in which it was issued or with any federal statute is hereby amended to conform to the minimum requirements of such statutes.
- O. PHYSICAL EXAMINATIONS AND AUTOPSY:** AFLAC, at its own expense, shall have the right and opportunity to have a covered person examined by a Physician of our choice as often as it may be reasonably required during the pendency of a claim hereunder, and to have an autopsy performed in the case of death, where autopsy is not forbidden by law.
- P. CHANGE OF BENEFICIARY:** Unless you made the beneficiary designation in the attached application irrevocable, you have the right to make a change. The consent of the beneficiary

is not required to surrender the policy, assign benefits, or make any other changes to this policy.

- Q. ASSIGNMENT:** We will not assume responsibility for determining the validity of an assignment of your benefits to a provider of services. No such assignment of benefits will be recognized until we receive notice that you have specifically assigned the benefits of your AFLAC policy at our worldwide headquarters.
- R. OTHER INSURANCE WITH AFLAC:** If a person is covered under more than one accident only policy, only one AFLAC policy chosen by you, your beneficiary, or your estate, as the case may be, will be effective. We will pay benefits under the policies for claims that may have been incurred since their respective Effective Dates. We will also return all premiums paid for the canceled policies from the date of duplication, less any benefits paid under these policies from such date.

Part 5 **BENEFITS**

Benefit A is a preventive benefit; the death, Dismemberment, or Injury of a covered person is not required for this benefit to be payable.

- A. WELLNESS BENEFIT:** After this policy has been in force for 12 months, we will pay \$60 (sixty dollars) if you or any one family member undergoes routine examinations or other preventive testing during the following policy year. Services covered are: annual physical examinations, dental exams, mammograms, Pap smears, eye examinations, immunizations, flexible sigmoidoscopies, prostate-specific antigen tests (PSAs), ultrasounds, and blood screenings. This benefit will become available following each anniversary of the policy's Effective Date for service received during the following policy year and is payable only once per policy each 12-month period following your policy anniversary date. Eligible family members are your spouse and the dependent children of either you or your spouse. Service must be under the supervision of or recommended by a Physician, received while your policy is in force, and a charge must be incurred.

We will pay the following benefits as applicable if a covered person's death, Dismemberment, or Injury is caused by a covered accident that occurs on or off the job. Death, Dismemberment, or Injury must be independent of disease or bodily infirmity, or of any cause other than a covered accident. A covered accident must also occur while coverage is in force and is subject to the limitations and exclusions.

- B. ACCIDENT EMERGENCY TREATMENT BENEFIT:** If a covered person receives treatment for Injuries sustained in a covered accident, we will pay the following benefit for treatment received. This benefit is payable for treatment by a Physician, X-rays, or 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.

<u>Insured</u>	<u>Spouse</u>	<u>Child</u>
\$120	\$120	\$70

- C. ACCIDENT FOLLOW-UP TREATMENT BENEFIT:** 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, we will pay \$35 (thirty-five dollars) per treatment for such follow-up treatment. We will pay for one treatment per day for up to a maximum of six treatments per covered

accident, per covered person. 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. **This benefit is not payable for the same visit that the Physical Therapy Benefit is paid.**

D. INITIAL ACCIDENT HOSPITALIZATION BENEFIT: When a covered person is confined to a Hospital for at least 24 hours for Injuries sustained in a covered accident, we will pay an Initial Accident Hospitalization Benefit of \$1,000 (one thousand dollars), or we will pay \$2,000 (two thousand dollars) if the covered person is admitted directly to an Intensive Care Unit. This benefit is payable only once per Hospital or Intensive Care Unit Confinement and only once per calendar year, per covered person. Confinements must start within 30 days of the accident.

E. ACCIDENT HOSPITAL CONFINEMENT BENEFIT: When a covered person is confined to a Hospital for at least 18 hours for treatment of Injuries sustained in a covered accident, we will pay \$250 (two hundred fifty dollars) for each day of Hospital Confinement for which a covered person is charged for a room. We will pay this benefit up to 365 days per covered accident, per covered person. Confinements must start within 30 days of the accident.

The Accident Hospital Confinement Benefit and the Rehabilitation Unit Benefit will not be paid on the same day. The highest eligible benefit will be paid.

F. INTENSIVE CARE UNIT CONFINEMENT BENEFIT: While a covered person is receiving the Accident Hospital Confinement Benefit, we will pay an additional \$400 (four hundred dollars) for each day the covered person is confined and charged for a room in an Intensive Care Unit. This Intensive Care Unit Confinement Benefit is payable for up to 15 days per covered accident, per covered person. Confinements must start within 30 days of the accident.

G. ACCIDENT SPECIFIC-SUM INJURIES BENEFITS: If a covered person receives treatment for Injuries sustained in a covered accident, we will pay the following benefit for the treatment listed.

1. Dislocation (reduced under general anesthesia):

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.

	Benefit:	
	Open Reduction	Closed Reduction
a. Hip	\$2,500	\$625
b. Knee or shoulder	\$625	\$250
c. Collar bone	\$1,000	\$200
d. Ankle or foot (excluding toes)	\$625	\$200
e. Lower jaw	\$625	\$325
f. Wrist or elbow	\$500	\$250
g. Toe or finger	\$125	\$65

If a Dislocation is reduced with local anesthesia or no anesthesia by a Physician, we will pay 25% of the amount shown for the closed Reduction Dislocation.

2. Burns (treated by a Physician within 72 hours after a covered accident):

	Benefit:	
	2nd Degree	3rd Degree
Less than 20 square centimeters of the body surface	\$125	\$250
More than 20 but less than 40 square centimeters of the body surface	\$250	\$625
More than 40 but less than 65 square centimeters of the body surface	\$500	\$1,250
More than 65 but less than 160 square centimeters of the body surface	\$750	\$3,750
More than 160 but less than 225 square centimeters of the body surface	\$1,000	\$8,750
More than 225 square centimeters of the body surface	\$1,250	\$12,500

3. Skin Grafts:

If a covered person receives one or more skin grafts for a covered burn, we will pay a total of 50% of the Burn benefit amount we paid for the burn involved.

4. Eye Injury:

Benefit:

Surgical repair	\$300
Removal of foreign body by a Physician	\$65

5. Lacerations requiring sutures (must be repaired within 72 hours after the accident and repaired under the attendance of a Physician):

Benefit:

Laceration(s) not requiring sutures and treated by a Physician	\$35
Single laceration less than 5 centimeters	\$65
Lacerations at least 5 centimeters but not more than 15 centimeters (total of all lacerations)	\$250
Lacerations over 15 centimeters (total of all lacerations)	\$500

6. Fractures:

We will pay 25% of the benefit amount shown for the closed Reduction for 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.

Benefit:

	Open Reduction	Closed Reduction
a. Hip	\$2,500	\$1,250
b. Leg	\$1,250	\$625
c. Hand (excluding fingers)	\$625	\$325
d. Foot (excluding toes/heel)	\$625	\$325
e. Wrist, elbow, ankle, or kneecap	\$625	\$325
f. Shoulder blade or forearm	\$625	\$325
g. Lower jaw	\$625	\$325
h. Vertebrae (body of), pelvis (excluding coccyx), or sternum	\$1,250	\$625
i. Upper jaw, upper arm, or face (excluding nose)	\$750	\$375
j. Rib	\$1,250	\$125
k. Nose, heel, or finger	\$625	\$125
l. Coccyx	\$250	\$125

m. Toe	\$250	\$125
n. Vertebral processes	\$1,250	\$200
o. Skull		
depressed	\$1,875	
simple	\$625	

7. Concussion (brain):

Benefit:
\$50

8. Emergency dental work:

Benefit:

Broken teeth repaired with crowns	\$200
Broken teeth resulting in extractions	\$65

We will pay for no more than one dental benefit per covered accident, per covered person.

9. Coma duration of at least 7 days:

Benefit:
\$12,500

10. 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 30 days.

Benefit:

Quadriplegia (Paralysis of four limbs)	\$12,500
Paraplegia (Paralysis of lower limbs)	\$6,250

This benefit will be payable once per covered person.

11. Surgical Procedures:

Treatment must be performed within one year of a covered accident. Two or more surgical procedures performed through the same incision will be considered one operation and benefits will be paid based upon the most expensive procedure.

Benefit:

Repair of:	
Tendons and/or ligaments	\$625
Torn Rotator Cuffs	\$625
Ruptured discs	\$625
Torn knee cartilages	\$625
Arthroscopy without surgical repair	\$300
Open abdominal (including exploratory laparotomy), cranial, hernia, or thoracic surgery	\$1,250

Miscellaneous surgery requiring general anesthesia that is not covered by any other specific-sum Injury benefit (Only one miscellaneous surgery benefit is payable per 24-hour period even though more than one surgical procedure may be performed.):

Benefit:
\$300

H. MAJOR DIAGNOSTIC EXAMS: If a covered person requires one of the following exams for Injuries sustained in a covered accident and a charge is incurred, we will pay \$200 (two hundred dollars): CT (computerized tomography) scan, MRI (magnetic resonance imaging), or EEG (electroencephalogram). These exams must be performed in a Hospital, a Physician's office, or an Ambulatory Surgical Center. This benefit is limited to one payment per calendar year, per covered person. No lifetime maximum.

I. PHYSICAL THERAPY BENEFIT: 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, we will pay \$35 (thirty-five dollars) per treatment. 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. We will pay for one treatment per day for up to a maximum of 10 treatments per covered accident, per covered person. The treatment must take place within six months after the accident. **This benefit is not payable for the same visit that the Accident Follow-Up Treatment Benefit is paid.**

J. REHABILITATION UNIT BENEFIT: When a covered person is confined in a Hospital and is transferred to a bed in a Rehabilitation Unit of a Hospital for a covered Injury, we will pay \$150 (one hundred fifty dollars) per day for each day you are charged for a room. This benefit is limited to 30 days for each covered person per Period of Hospital Confinement and is limited to a calendar year maximum of 60 days. No lifetime maximum.

The Accident Hospital Confinement Benefit and the Rehabilitation Unit Benefit will not be paid on the same day. The highest eligible benefit will be paid.

K. APPLIANCES BENEFIT: If, as a result of Injuries sustained in a covered accident, a covered person requires, as advised by a Physician, the use of a medical appliance as an aid in personal locomotion, we will pay \$125 (one hundred twenty-five dollars). Benefits include and are payable for crutches, wheelchairs, leg braces, back braces, and walkers. This benefit is payable once per covered accident, per covered person.

L. PROSTHESIS BENEFIT: If a covered person requires use of a Prosthetic Device as a result of Injuries sustained in a covered accident, we will pay \$750 (seven hundred fifty dollars). This benefit is not payable for hearing aids, wigs, or any dental aids to include false teeth. This benefit is payable once per covered accident, per covered person.

M. BLOOD/PLASMA/PLATELETS BENEFIT: If a covered person requires blood/plasma and/or platelets for the treatment of Injuries sustained in a covered accident, we will pay \$200 (two hundred dollars). This benefit does not pay for immunoglobulins and is payable only one time per covered accident, per covered person.

N. AMBULANCE BENEFIT: If a covered person requires ambulance transportation to a Hospital or emergency center for Injuries sustained in a covered accident, we will pay \$200 (two hundred dollars). Ambulance transportation must be within 72 hours of the covered accident. We will pay \$1,500 (fifteen hundred dollars) for transportation provided by an air ambulance. A licensed professional ambulance company must provide the ambulance service.

O. TRANSPORTATION BENEFIT: If a covered person requires special treatment and confinement in a Hospital for Injuries sustained in a covered accident, we will pay \$600 (six hundred dollars) per round trip. This benefit is not payable for transportation by ambulance or air ambulance to the Hospital. 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 such dependent child). The local attending Physician must prescribe the treatment, and the treatment must not be available locally. This benefit is not payable for transportation to any Hospital located within a 100-mile radius of the site of the accident or residence of the covered person. This benefit is payable for up to three round trips per calendar year, per covered person.

P. FAMILY LODGING BENEFIT: If a covered person requires Hospital Confinement for the treatment of Injuries sustained in a covered accident, we will pay \$125 (one hundred twenty-five dollars) per night for one motel/hotel room for a member(s) of the Immediate Family to accompany the covered person. 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. This benefit is payable up to 30 days per covered accident.

Q. ACCIDENTAL-DEATH BENEFIT: We will pay the applicable lump-sum benefit indicated below for Accidental Death. Death must occur as a result of Injuries sustained in a covered accident and must occur within 90 days of such accident.

	<u>Insured</u>	<u>Spouse</u>	<u>Child</u>
Common-Carrier Accidents	\$150,000	\$150,000	\$25,000
Other Accidents	\$40,000	\$40,000	\$12,500

R. ACCIDENTAL-DISMEMBERMENT BENEFIT: We will pay the applicable lump-sum benefit indicated below for Dismemberment. Dismemberment must occur as a result of Injuries sustained in a covered accident and must occur within 90 days of the accident.

Dismemberment or complete loss of, with or without reattachment:

	<u>Insured</u>	<u>Spouse</u>	<u>Child</u>
Both arms and both legs	\$40,000	\$40,000	\$12,500
Two eyes, feet, hands, arms, or legs	\$40,000	\$40,000	\$12,500
One eye, foot, hand, arm, or leg	\$10,000	\$10,000	\$3,750
One or more fingers and/or one or more toes	\$2,000	\$2,000	\$625

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.

S. CONTINUATION OF COVERAGE BENEFIT: 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. Your 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 through:
 - (a) your new employer's payroll deduction process or
 - (b) direct payment to AFLAC.

You will again become eligible to receive this benefit after:

1. You re-establish your premium payments through payroll deduction for a period of at least six months, and
2. 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.

Section 3

Disability Riders

The riders pay a monthly disability benefit to an insured who becomes totally disabled as a result of a covered accident and/or a covered sickness. To understand how the disability riders provide coverage, a few definitions and provisions must be reviewed.

Totally Disabled

The disability riders define ***totally disabled*** as:

Your continuing inability to perform the material and substantial duties of your full-time job. You must also be under the care and attendance of a physician for your condition. If you are unable to perform the material and substantial duties of your full-time job but are able to work at any job, you will continue to be considered totally disabled as long as your earnings are less than 80 percent of your base pay earnings at the time you became totally disabled. If you return to work at any job and are earning 80 percent or more of your predisability base pay earnings, you will no longer be considered totally disabled.

Disability insurance is intended to replace lost income. Aflac will continue to provide benefits to an insured who has been given modified job duties and/or reduced work hours because of a disability, as long as this has resulted in a substantial cut in pay. However, **Aflac will no longer provide benefits to policyholders who continue to receive full or near full pay while working under such conditions.** This change will be beneficial to Aflac accounts to help ensure that employees return to full job duties as soon as medically possible. In order to remain objective, Aflac has set “less than 80 percent of base pay earnings” (defined below) as an indicator of disability.

Base Pay Earnings

The disability riders define ***base pay earnings*** as:

Your gross salary or wages for your full-time job. This does not include variable pay such as overtime (unless contractual), bonuses, or other incentives. If you are self-employed, the term ***base pay earnings*** means your business’s gross income minus the allowable business deductions from that business. (For tax purposes, ***base pay earnings*** is referred to as ***net earnings***.)

Successive Periods of Disability

The disability riders define *successive periods of disability* as:

Separate periods of disability, if caused by the same or a related condition and not separated by 180 days or more, are considered a continuation of the prior disability. Separate periods of disability resulting from unrelated causes are considered a continuation of the prior disability unless they are separated by the insured's returning to work at a full-time job for **14** working days, during which he or she is performing the material and substantial duties of the job and is no longer qualified to receive disability benefits.

With a continuation of a prior disability, the elimination period and benefit period do not start over.

Example:

Assume a three-month benefit period and a 0/7 elimination period and the following periods of disability: disabled six weeks due to accident, back to work for one week, disabled five days due to sickness, back to work for three days, disabled eight weeks due to new accident.

Claims for the Personal Disability Income Protector would be paid as follows:

First Accident	Sickness	Second Accident
42 days paid	5 days paid	43 days paid
0 elimination period for accident (6 weeks x 7 days = 42 days)	Returned to work for less than 14 days; elimination period already satisfied. (Therefore, all 5 days paid)	Returned to work for less than 14 days; elimination period already satisfied. Remaining 43 days are paid and the 90-day benefit period is satisfied.

By requiring 14 working days instead of one day back at work between unrelated disabilities, it is more difficult to begin a new benefit period, but easier to satisfy an elimination period.

In the past, if a policyholder returned to work for one day and then suffered an unrelated disability, the benefit period and elimination period started over. Aflac will now consider unrelated disabilities to fall under the same benefit period and elimination period unless the policyholder returns to full job duties for at least 14 working days.

Pregnancy and Childbirth

The Sickness Disability Rider contains the following provision for pregnancy and childbirth:

Disability due to pregnancy and childbirth is payable to the same extent as a covered sickness. After this policy has been in force ten months, the maximum benefit period allowed for childbirth is **six weeks** for noncesarean delivery and **eight weeks** for cesarean delivery, **less the elimination period chosen**, unless you furnish proof that you remain disabled beyond these time frames.

Aflac treats maternity as a sickness. Before any benefits are payable, the woman must first satisfy her elimination period. Then, the benefit period and the disability benefits begin. Typically the standard disability length, as set by physicians and the insurance industry, is six weeks for noncesarean delivery and eight weeks for cesarean delivery.

NOTE: The elimination period is not subtracted from the benefit period. The elimination period is satisfied first, and then benefits are payable for the remaining time she is considered disabled, up to the benefit period chosen.

Ten-Month Maternity Exclusion

Most states have a **ten-month maternity exclusion** that excludes:

Giving birth within the first ten months of the effective date of the policy as a result of a normal pregnancy, including cesarean (complications of pregnancy will be covered to the same extent as a sickness).

Therefore, disability due to pregnancy and childbirth is excluded if the birth occurs within ten months of the effective date of the policy (as a result of a normal pregnancy). Complications of pregnancy are not excluded for the first ten months. If a woman is totally disabled due to complications of pregnancy, she will be eligible for disability benefits under the Sickness Disability Rider.

Some states do not have the ten-month maternity exclusion. Please refer to your specific state introduction packet for complete details. **However, all states are subject to the rider pre-existing condition limitation provision.** (In most states, the pre-existing condition provision is 12 months before and 12 months after the effective date of coverage.)

Pre-Existing Condition Provision

The disability riders define *pre-existing condition* as:

A sickness or 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. Disability caused by a pre-existing condition or injuries to a pre-existing condition will not be covered unless it begins more than **12 months** after the effective date of coverage.

Benefit Periods and Elimination Periods

Benefit period: The maximum number of days after the elimination period, if any, when Aflac will pay disability benefits.

Elimination Period: Length of time between the start of the disability and the time that benefit payments begin.

Disability Riders

Four disability riders are available with the Personal Accident Indemnity plan:

1. Off-the-Job Accident Disability Rider
2. Spouse Off-the-Job Accident Disability Rider
3. On-the-Job Accident Disability Rider
4. Sickness Disability Rider

The following stipulations apply to the four disability riders:

- They are available on a payroll basis only.
- They are available to occupational classes A, B, and C, and E for applicants ages 18–64.
- **Exception:** The On-the-Job Disability Rider is available to occupational classes A, B, and C only, except for Aflac associates (occupational class E).
- Employees in occupational class E must be employed for over 12 months to be eligible for the disability riders.
- They are not allowed with government allotment accounts.
- They are portable to direct at a payroll rate, if one monthly premium has been paid through payroll deduction. However, after a policy is placed on direct billing, upgrades or downgrades cannot be made to the disability riders. The disability riders may be dropped, but no other changes are permitted.
- Aflac associates (occupational class E) can purchase PAI and the disability riders on a direct basis, or they may use payroll rates through the 00316 account. Associates purchasing the On-the-Job Accident Disability Rider must use the C rate for this rider only, as E rated accounts are not eligible for this rider. See the Aflac Associates and Disability section for more information.

Disability benefits will be paid based on employment and age at the time of the disability. The insured must be working at a full-time job 30 or more hours per week and earning at least \$10,000 per year.

Off-the-Job Accident Disability Rider (primary insured only)

- This rider is available for applicant ages 18–64.
- It is available on payroll only.
- Applicants may purchase a minimum of **one unit (\$100)** and a maximum of **20 units (\$2,000)** of disability coverage.
- This rider has a **0- or seven-day elimination period** and a **six- or twelve-month benefit period**.
- This rider is available to associates on Account 00316 with an E occupational classification.

Spouse Off-the-Job Accident Disability Rider

- This rider is available to applicant ages 18–64.
- It is available on payroll only.
- There is one premium rate for the Spouse Disability Rider, regardless of the insured's or spouse's occupation.
- The spouse must be working at a full-time job 30 or more hours per week, earning at least \$10,000 per year.
- The applicant may purchase a minimum of **one unit (\$100)** and a maximum of **seven units (\$700)** of disability coverage.
- The rider has a **0-day elimination period** and a **six-month benefit period**.
- The spouse must be covered under the base policy (but the named insured does not have to purchase a disability rider).
- This rider cannot be added to an Individual or a One-Parent Family policy.

On-the-Job Accident Disability Rider

- This rider is available to applicants ages 18–64.
- It is available on payroll deduction only.
- This rider is not available to persons covered by workers' compensation.
- It is available for the primary insured only.
- Applicants may purchase a minimum of **one unit (\$100)** and a maximum of **ten units (\$1,000)**.
- This rider has a **0- or seven-day elimination period** (for disability due to accident) and a **six- or twelve-month benefit period**.
- This rider is available to associates on Account 00316 with an E occupational classification.
- This rider is not available on payroll for any class E accounts other than Account 00316.

Sickness Disability Rider

- This rider is age banded for applicants 18–49 and 50–64.
- It is available on payroll deduction only.
- This rider is available for the primary insured only.
- Applicants may purchase a minimum of **one unit (\$100)** and a maximum of **20 units (\$2,000)**.
- There is a **14-day elimination period and six- or twelve-month benefit period**.
- It has a **30-day waiting period**. If the disease or disorder is first manifested or treated within the first 30 days after the effective date of coverage, any resulting disability will not be covered unless it begins more than 12 months after the effective date of coverage.
- This rider is subject to a **pre-existing condition provision**. The pre-existing condition provision states, "Disability or hospitalization caused by 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 a sickness for which, within the 12-month period before the effective date of coverage, medical advice, consultation, or treatment was recommended or received, or symptoms existed that would ordinarily cause a prudent person to seek diagnosis, care, or treatment."
- This rider is not available to associates.
- This rider is guaranteed-renewable (Individual Disability policy Personal Disability Income Protector is guaranteed-renewable to age 70).

Summary of Rider Provisions

	Elimination Period (days)	Benefit Period (months)	Minimum Coverage	Maximum Coverage	Available to 00316	Age Banded
Off-the-Job Accident Disability Rider (Primary insured)	0 or 7	6 or 12	1 unit (\$100)	20 units (\$2,000)	Yes	No
Off-the-Job Accident Disability Rider (Spouse)	0	6	1 unit (\$100)	7 units (\$700)	No	No
On-the-Job Accident Disability Rider	0 or 7	6 or 12	1 unit (\$100)	10 units (\$1,000)	Yes	No
Sickness Disability Rider	14	6 or 12	1 unit (\$100)	20 units (\$2,000)	No	Yes 18–49, 50–64



Riders selected must have the same benefit period and elimination period. Exception: The Sickness Disability Rider is available only with a 14-day elimination period.

Example:

The primary insured is purchasing both the Off-the-Job and On-the-Job Accident Disability Riders. Both riders must have the same 0- or seven-day elimination period and six- or twelve-month benefit period. The primary insured cannot have a 0-day elimination period and six-month benefit period on one rider and a seven-day elimination period and six-month benefit period on the other rider.

Disability Income Annual Salary Replacement

The disability coverage has minimum and maximum benefits. The Disability Limits Chart (Form M-1019) lists the specific minimums and maximums for payroll sales.

PAI Disability Income Annual Salary Replacement Limits	
Maximum Monthly Disability Benefit Amount	Minimum Annual Income
\$ 700	\$10,000
\$ 800	\$17,000
\$ 900	\$19,000
\$1,000	\$22,000
\$1,100	\$25,000
\$1,200	\$27,000
\$1,300	\$29,000
\$1,400	\$32,000
\$1,500	\$34,000
\$1,600	\$36,000
\$1,700	\$39,000
\$1,800	\$41,000
\$1,900	\$43,000
\$2,000	\$45,000
One Unit = \$100	
Minimum of \$100 (1 unit) for all Riders	
Maximum for Riders	
Off-the-Job Accident Disability	\$2,000
On-the-Job Accident Disability	\$1,000
Sickness Disability	\$2,000
Spouse Off-the-Job Accident Disability	\$ 700

The maximum disability for Aflac associates is limited to:

Off-the-Job Accident Disability **\$1,500 (15 units)**

On-the-Job Accident Disability **\$1,000 (10 units)**

Refer to the next page for Aflac associate disability guidelines.

Aflac Associates and Disability

Aflac associates may purchase disability subject to the following guidelines:

1. The associate must have been an Aflac associate for a minimum of two years.
2. Income verification must be provided with the application in the form of two years of self-employment tax returns. The income to be counted will include the amounts from:
 - Form 1040, line 7 (wages, salaries, and tips).
 - Form 1040, line 12 (business income or loss).
 - Schedule E, line 31 (partnership and S corporation income or loss).
3. The Sickness Disability Rider and the Spouse Accident Disability Rider are not available to Aflac associates.
4. The maximum monthly disability benefit amount (subject to standard income and under writing requirements) is limited to:
 - Off-the-Job Accident Disability – \$1,500 (15 units).
 - On-the-Job Accident Disability – \$1,000 (10 units).
5. Aflac associates receive an E occupational classification and may use payroll rates through the 00316 account. This represents significant savings over the previous use of C classification on a direct basis.
6. Aflac associates purchasing the On-the-Job Accident Disability Rider must use the C rate for this rider only, as E rated accounts are not eligible for this rider.
7. Aflac associates can purchase PAI and the disability riders on a direct basis or through the 00316 account.
8. The associate-only application (**Form A-34004**) should be used for Aflac associates applying for PAI.

Taxation of Disability Benefits



If the Personal Accident Indemnity policy is offered as an employer-paid benefit or paid with pre-tax premiums, the disability benefits under the riders payable at the time of claim are subject to certain tax requirements.

Pre-tax and after-tax premium payment can be interchangeable between base plan and the disability riders on paper applications. However, all the riders must be either pre-tax or after-tax.

On SmartApp®, if the base plan is purchased after-tax, all the riders will default to after-tax. The spouse rider is sold only on after-tax basis.

1. When we receive a disability claim and determine that the premiums were paid by the employer or paid on a pre-tax basis, **Aflac will reduce the amount of the claim by the applicable FICA (Social Security and Medicare) tax percentage.**
2. Aflac will deposit the claimant's portion of the FICA tax with the IRS.
3. Aflac will notify the employer of the amount of the claim payment and the employer's matching portion of the FICA tax.
4. Benefits will be subject to FICA, FUTA, and Medicare taxes if paid during the calendar month the employee last works for the employer, or in the six calendar months thereafter. Such benefits may also be subject to state unemployment tax.
5. The employer must add the employee's claim benefit amount to the employee's W-2 at year-end or prepare 1099 forms for employees who received disability benefits. Aflac will provide the employer with quarterly reports of total claim payments and furnish an annual report by January 15 of the following year.

Disability Riders
(Series A-34400)

These are sample disability riders to be used for training purposes only. **Benefits, limitations, and exclusions may vary by state; please refer to your specific state introduction packet for complete details.**

AMERICAN FAMILY LIFE ASSURANCE COMPANY OF COLUMBUS (AFLAC)

Worldwide Headquarters: Columbus, Georgia 31999

A Stock Company

This **OFF-THE-JOB ACCIDENT DISABILITY BENEFIT RIDER** is a part of the policy and is subject to all policy provisions unless modified herein. **This rider applies to the Insured only, as shown in the Policy Schedule.**

Part 1

EFFECTIVE DATE

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

Part 2

PRE-EXISTING CONDITIONS

Disability or hospitalization caused by a Pre-existing Condition or reinjuries 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 symptoms existed that would ordinarily cause a prudent person to seek diagnosis, care, or treatment.

Part 3

DEFINITIONS

(for the purposes of this rider)

A. ACTIVITIES OF DAILY LIVING (ADLs): activities used in measuring levels of personal functioning capacity. Normally, these activities are performed without Direct Personal Assistance, allowing personal independence in everyday living.

The ADLs are:

- (1) Continence: Maintaining control of urination and bowel movements, including your ability to use ostomy supplies or other devices such as catheters;
- (2) Transferring: Moving between a bed and a chair, or a bed and a wheelchair;
- (3) Dressing: Putting on and taking off all necessary items of clothing, and/or medically necessary braces and artificial limbs usually worn;
- (4) Toileting: Getting to and from a toilet, getting on and off a toilet, and performing associated personal hygiene; and
- (5) Eating: Performing all major tasks of getting food into the body.

B. BASE PAY EARNINGS: your gross salary or wages for your Full-Time Job. This does not include variable pay such as overtime (unless contractual), bonuses, or other incentives. If you are self-employed, the term "Base Pay Earnings" means your business's gross income minus the allowable business deductions from that business. (For tax purposes, Base Pay Earnings is referred to as "net earnings.")

- C. BENEFIT PERIOD:** the maximum number of days after the Elimination Period, if any, for which you can be paid benefits for any one or Successive Periods of Disability. Each new Benefit Period is subject to a new Elimination Period. See the Policy Schedule for the Benefit Period you selected. For the purposes of this calculation, a "month" is defined as 30 days for which benefits are paid. See definition of "Successive Periods of Disability."
- D. DIRECT PERSONAL ASSISTANCE:** direct physical assistance from another party required to help you perform an ADL, each and every time you perform that activity, because of an inability to perform the entire activity alone with the supports and mechanical aids that are normally available to you.
- E. ELIMINATION PERIOD:** the number of consecutive days at the beginning of your period of total disability for which no benefits are payable. See the Policy Schedule for the Elimination Period you selected. Each new Benefit Period is subject to a new Elimination Period.
- F. FULL-TIME JOB:** a job at which you work 30 or more hours per week for pay or benefits.
- G. 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 and the Pre-existing Conditions sections for Injuries not covered by this policy.
- H. OFF-THE-JOB ACCIDENT:** an Injury that occurs while you are not working at any job for pay or benefits.
- I. SUCCESSIVE PERIODS OF DISABILITY:** separate periods of disability, if caused by the same or a related condition and not separated by 180 days or more, are considered a continuation of the prior disability. Separate periods of disability resulting from unrelated causes are considered a continuation of the prior disability unless they are separated by your returning to work at a Full-Time Job for 14 working days, during which you are performing the material and substantial duties of this job and are no longer qualified to receive disability benefits.
- J. TOTALLY DISABLED:** your continuing inability to perform the material and substantial duties of your Full-Time Job. You must also be under the care and attendance of a Physician for your condition. If you are unable to perform the material and substantial duties of your Full-Time Job but are able to work at any job, you will continue to be considered Totally Disabled as long as your earnings are less than 80% of your Base Pay Earnings at the time you became Totally Disabled. If you return to work at any job and are earning 80% or more of your predisability Base Pay Earnings, you will no longer be considered Totally Disabled.

Part 4

LIMITATIONS AND EXCLUSIONS

- A.** We will not pay benefits for a disability that is being treated outside the territorial limits of the United States or, if outside the United States, the territorial limits of the place where your policy was issued.
- B.** Refer to your policy for additional Limitations and Exclusions.

Part 5

BENEFITS

A. Working Full Time: While you are working at a Full-Time Job and while this coverage is in force, we will insure you as follows:

- 1. Through Age 69:** If your covered Off-the-Job Accident causes you to become Totally Disabled within 90 days of your last treatment for your covered Off-the-Job Accident, we will pay you one-thirtieth of the benefit shown in the Policy Schedule for each day you remain Totally Disabled. This benefit is payable up to the Benefit Period you selected and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled Term and the definitions of "Benefit Period" and "Successive Periods of Disability."
- 2. Age 70 and above:** If you require Hospital Confinement within 90 days of your last treatment for your covered Off-the-Job Accident, we will pay you one-thirtieth of the benefit shown in the Policy Schedule times three for each day you are confined. This benefit is payable up to the Benefit Period you selected and is not subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled Term and the definitions of "Benefit Period" and "Successive Periods of Disability."

B. Not Working Full Time: If you are not working at a Full-Time Job and coverage is in force, we will insure you as follows:

- 1. Through Age 69:** If your covered Off-the-Job Accident causes you to be unable to perform two or more ADLs, as certified by your Physician, and you require Direct Personal Assistance to perform such ADLs, we will pay you one-thirtieth of the benefit shown in the Policy Schedule for each day you cannot perform such ADLs. Such inability must occur within 90 days of your last treatment for your covered Off-the-Job Accident. This benefit is payable up to the Benefit Period you selected and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled Term and the definitions of "Benefit Period" and "Successive Periods of Disability."
- 2. Age 70 and above:** If you require Hospital Confinement within 90 days of your last treatment for your covered Off-the-Job Accident, we will pay you one-thirtieth of the benefit shown in the Policy Schedule times three for each day you are confined. This benefit is payable up to the Benefit Period you selected and is not subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled Term and the definitions of "Benefit Period" and "Successive Periods of Disability."

Benefits will be paid for only one disability at a time, even if it is caused by more than one Injury. Benefits are not payable for Items A1, A2, B1, or B2 for the same day. Turning age 70 will not stop benefits otherwise payable. **We reserve the right to meet with you during the pendency of a claim or to use an independent consultant and Physician's statement to determine whether you are Totally Disabled, or whether you are unable to perform two or more ADLs and require Direct Personal Assistance. You must be under the care and attendance of a Physician for these benefits to be payable. Benefits will cease on the date of your death.**

IF YOU HAVE ANY OTHER DISABILITY BENEFIT IN FORCE WITH US, ONLY ONE DISABILITY BENEFIT IS PAYABLE.

Part 6 TERMINATION

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

In witness whereof, AFLAC, at its worldwide headquarters, has caused this rider to be signed by its secretary and president in the city of Columbus, Georgia.

ABCD

Joey M. Loudermilk, Secretary

ABCD

Daniel P. Amos, President

AMERICAN FAMILY LIFE ASSURANCE COMPANY OF COLUMBUS (AFLAC)

Worldwide Headquarters: Columbus, Georgia 31999

A Stock Company

This **ON-THE-JOB ACCIDENT DISABILITY BENEFIT RIDER** is a part of the policy and is subject to all policy provisions unless modified herein. **This rider applies to the Insured only, as shown in the Policy Schedule.**

Part 1

EFFECTIVE DATE

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

Part 2

PRE-EXISTING CONDITIONS

Disability or hospitalization caused by a Pre-existing Condition or reinjuries 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 symptoms existed that would ordinarily cause a prudent person to seek diagnosis, care, or treatment.

Part 3

DEFINITIONS

(for the purposes of this rider)

A. ACTIVITIES OF DAILY LIVING (ADLs): activities used in measuring levels of personal functioning capacity. Normally, these activities are performed without Direct Personal Assistance, allowing personal independence in everyday living.

The ADLs are:

- (1) Continence: Maintaining control of urination and bowel movements, including your ability to use ostomy supplies or other devices such as catheters;
- (2) Transferring: Moving between a bed and a chair, or a bed and a wheelchair;
- (3) Dressing: Putting on and taking off all necessary items of clothing, and/or medically necessary braces and artificial limbs usually worn;
- (4) Toileting: Getting to and from a toilet, getting on and off a toilet, and performing associated personal hygiene; and
- (5) Eating: Performing all major tasks of getting food into the body.

B. BASE PAY EARNINGS: your gross salary or wages for your Full-Time Job. This does not include variable pay such as overtime (unless contractual), bonuses, or other incentives. If you are self-employed, the term "Base Pay Earnings" means your business's gross income minus the allowable business deductions from that business. (For tax purposes, Base Pay Earnings is referred to as "net earnings.")

- C. BENEFIT PERIOD:** the maximum number of days after the Elimination Period, if any, for which you can be paid benefits for any one or Successive Periods of Disability. Each new Benefit Period is subject to a new Elimination Period. See the Policy Schedule for the Benefit Period you selected. For the purposes of this calculation, a "month" is defined as 30 days for which benefits are paid. See definition of "Successive Periods of Disability."
- D. DIRECT PERSONAL ASSISTANCE:** direct physical assistance from another party required to help you perform an ADL, each and every time you perform that activity, because of an inability to perform the entire activity alone with the supports and mechanical aids that are normally available to you.
- E. ELIMINATION PERIOD:** the number of consecutive days at the beginning of your period of total disability for which no benefits are payable. See the Policy Schedule for the Elimination Period you selected. Each new Benefit Period is subject to a new Elimination Period.
- F. FULL-TIME JOB:** a job at which you work 30 or more hours per week for pay or benefits.
- G. 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 and the Pre-existing Conditions sections for Injuries not covered by this policy.
- H. ON-THE-JOB ACCIDENT:** an Injury that occurs while you are working at any job for pay or benefits.
- I. SUCCESSIVE PERIODS OF DISABILITY:** separate periods of disability, if caused by the same or a related condition and not separated by 180 days or more, are considered a continuation of the prior disability. Separate periods of disability resulting from unrelated causes are considered a continuation of the prior disability unless they are separated by your returning to work at a Full-Time Job for 14 working days, during which you are performing the material and substantial duties of this job and are no longer qualified to receive disability benefits.
- J. TOTALLY DISABLED:** your continuing inability to perform the material and substantial duties of your Full-Time Job. You must also be under the care and attendance of a Physician for your condition. If you are unable to perform the material and substantial duties of your Full-Time Job but are able to work at any job, you will continue to be considered Totally Disabled as long as your earnings are less than 80% of your Base Pay Earnings at the time you became Totally Disabled. If you return to work at any job and are earning 80% or more of your predisability Base Pay Earnings, you will no longer be considered Totally Disabled.

Part 4

LIMITATIONS AND EXCLUSIONS

- A.** We will not pay benefits for a disability that is being treated outside the territorial limits of the United States or, if outside the United States, the territorial limits of the place where your policy was issued.
- B.** Refer to your policy for additional Limitations and Exclusions.

Part 5

BENEFITS

A. Working Full Time: While you are working at a Full-Time Job and while this coverage is in force, we will insure you as follows:

1. **Through Age 69:** If your covered On-the-Job Accident causes you to become Totally Disabled within 90 days of your last treatment for your covered On-the-Job Accident, we will pay you one-thirtieth of the benefit shown in the Policy Schedule for each day you remain Totally Disabled. This benefit is payable up to the Benefit Period you selected and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled Term and the definitions of "Benefit Period" and "Successive Periods of Disability."
2. **Age 70 and above:** If you require Hospital Confinement within 90 days of your last treatment for your covered On-the-Job Accident, we will pay you one-thirtieth of the benefit shown in the Policy Schedule times three for each day you are confined. This benefit is payable up to the Benefit Period you selected and is not subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled Term and the definitions of "Benefit Period" and "Successive Periods of Disability."

B. Not Working Full Time: If you are not working at a Full-Time Job and coverage is in force, we will insure you as follows:

1. **Through Age 69:** If your covered On-the-Job Accident causes you to be unable to perform two or more ADLs, as certified by your Physician, and you require Direct Personal Assistance to perform such ADLs, we will pay you one-thirtieth of the benefit shown in the Policy Schedule for each day you cannot perform such ADLs. Such inability must occur within 90 days of your last treatment for your covered On-the-Job Accident. This benefit is payable up to the Benefit Period you selected and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled Term and the definitions of "Benefit Period" and "Successive Periods of Disability."
2. **Age 70 and above:** If you require Hospital Confinement within 90 days of your last treatment for your covered On-the-Job Accident, we will pay you one-thirtieth of the benefit shown in the Policy Schedule times three for each day you are confined. This benefit is payable up to the Benefit Period you selected and is not subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled Term and the definitions of "Benefit Period" and "Successive Periods of Disability."

Benefits will be paid for only one disability at a time, even if it is caused by more than one Injury. Benefits are not payable for Items A1, A2, B1, or B2 for the same day. Turning age 70 will not stop benefits otherwise payable. **We reserve the right to meet with you during the pendency of a claim or to use an independent consultant and Physician's statement to determine whether you are Totally Disabled, or whether you are unable to perform two or more ADLs and require Direct Personal Assistance. You must be under the care and attendance of a Physician for these benefits to be payable. Benefits will cease on the date of your death.**

IF YOU HAVE ANY OTHER DISABILITY BENEFIT IN FORCE WITH US, ONLY ONE DISABILITY BENEFIT IS PAYABLE.

Part 6 **TERMINATION**

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

In witness whereof, AFLAC, at its worldwide headquarters, has caused this rider to be signed by its secretary and president in the city of Columbus, Georgia.

ABCD

Joey M. Loudermilk, Secretary

ABCD

Daniel P. Amos, President

AMERICAN FAMILY LIFE ASSURANCE COMPANY OF COLUMBUS (AFLAC)

Worldwide Headquarters: Columbus, Georgia 31999

A Stock Company

This **SICKNESS DISABILITY BENEFIT RIDER** is a part of the policy and is subject to all policy provisions unless modified herein. **This rider applies to the Insured only, as shown in the Policy Schedule.**

Part 1
EFFECTIVE DATE

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

Part 2
PRE-EXISTING CONDITIONS

Disability or hospitalization caused by 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 a Sickness for which, within the 12-month period before the Effective Date of coverage, medical advice, consultation, or treatment was recommended or received, or symptoms existed that would ordinarily cause a prudent person to seek diagnosis, care, or treatment.

Part 3
DEFINITIONS
(for the purposes of this rider)

A. ACTIVITIES OF DAILY LIVING (ADLs): activities used in measuring levels of personal functioning capacity. Normally, these activities are performed without Direct Personal Assistance, allowing personal independence in everyday living.

The ADLs are:

- (1) Continence: Maintaining control of urination and bowel movements, including your ability to use ostomy supplies or other devices such as catheters;
- (2) Transferring: Moving between a bed and a chair, or a bed and a wheelchair;
- (3) Dressing: Putting on and taking off all necessary items of clothing, and/or medically necessary braces and artificial limbs usually worn;
- (4) Toileting: Getting to and from a toilet, getting on and off a toilet, and performing associated personal hygiene; and
- (5) Eating: Performing all major tasks of getting food into the body.

B. BASE PAY EARNINGS: your gross salary or wages for your Full-Time Job. This does not include variable pay such as overtime (unless contractual), bonuses, or other incentives. If you are self-employed, the term "Base Pay Earnings" means your business's gross income minus the allowable business deductions from that business. (For tax purposes, Base Pay Earnings is referred to as "net earnings.")

- C. BENEFIT PERIOD:** the maximum number of days after the Elimination Period, if any, for which you can be paid benefits for any one or Successive Periods of Disability. Each new Benefit Period is subject to a new Elimination Period. See the Policy Schedule for the Benefit Period you selected. For the purposes of this calculation, a "month" is defined as 30 days for which benefits are paid. See definition of "Successive Periods of Disability."
- D. DIRECT PERSONAL ASSISTANCE:** direct physical assistance from another party required to help you perform an ADL, each and every time you perform that activity, because of an inability to perform the entire activity alone with the supports and mechanical aids that are normally available to you.
- E. ELIMINATION PERIOD:** the number of consecutive days at the beginning of your period of total disability for which no benefits are payable. See the Policy Schedule for the Elimination Period you selected. Each new Benefit Period is subject to a new Elimination Period.
- F. FULL-TIME JOB:** a job at which you work 30 or more hours per week for pay or benefits.
- G. SUCCESSIVE PERIODS OF DISABILITY:** separate periods of disability, if caused by the same or a related condition and not separated by 180 days or more, are considered a continuation of the prior disability. Separate periods of disability resulting from unrelated causes are considered a continuation of the prior disability unless they are separated by your returning to work at a Full-Time Job for 14 working days, during which you are performing the material and substantial duties of this job and are no longer qualified to receive disability benefits.
- H. TOTALLY DISABLED:** your continuing inability to perform the material and substantial duties of your Full-Time Job. You must also be under the care and attendance of a Physician for your condition. If you are unable to perform the material and substantial duties of your Full-Time Job but are able to work at any job, you will continue to be considered Totally Disabled as long as your earnings are less than 80% of your Base Pay Earnings at the time you became Totally Disabled. If you return to work at any job and are earning 80% or more of your predisability Base Pay Earnings, you will no longer be considered Totally Disabled.

Part 4 **LIMITATIONS AND EXCLUSIONS**

- A. We will not pay benefits for a disability that is being treated outside the territorial limits of the United States or, if outside the United States, the territorial limits of the place where your policy was issued.**
- B. We will not pay benefits for a disability that is caused by or occurs as a result of your:**
1. Becoming Totally Disabled due to any of the following: bipolar affective disorder (manic depressive syndrome), delusional (paranoid) disorders, psychotic disorders, somatoform disorders (psychosomatic illness), eating disorders, schizophrenia, anxiety disorders, depression, stress, or post-partum depression. This policy will pay, however, for covered disabilities resulting from Alzheimer's disease, or similar forms of senility or senile dementia, first manifested while coverage is in force;
 2. Giving birth within the first ten months of the Effective Date of this rider as a result of a normal pregnancy, including cesarean (complications of pregnancy will be covered to the same extent as a Sickness); or

3. Donating an organ within the first 12 months of the Effective Date of this rider.
- C. Refer to your policy for additional Limitations and Exclusions.

Part 5

BENEFITS

- A. **Working Full Time:** While you are working at a Full-Time Job and while this coverage is in force, we will insure you as follows:
1. **Through Age 69:** If your covered Sickness causes you to become Totally Disabled within 90 days of your last treatment for your covered Sickness, we will pay you one-thirtieth of the benefit shown in the Policy Schedule for each day you remain Totally Disabled. This benefit is payable up to the Benefit Period you selected and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled Term and the definitions of "Benefit Period" and "Successive Periods of Disability."
 2. **Age 70 and above:** If you require Hospital Confinement within 90 days of your last treatment for your covered Sickness, we will pay you one-thirtieth of the benefit shown in the Policy Schedule times three for each day you are confined. This benefit is payable up to the Benefit Period you selected and is not subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled Term and the definitions of "Benefit Period" and "Successive Periods of Disability."
- B. **Not Working Full Time:** If you are not working at a Full-Time Job and coverage is in force, we will insure you as follows:
1. **Through Age 69:** If you are unable to perform two or more ADLs within 90 days of your last treatment for your covered Sickness, as certified by your Physician, and you require Direct Personal Assistance to perform such ADLs, we will pay you one-thirtieth of the benefit shown in the Policy Schedule for each day you cannot perform such ADLs. This benefit is payable up to the Benefit Period you selected and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled Term and the definitions of "Benefit Period" and "Successive Periods of Disability."
 2. **Age 70 and above:** If you require Hospital Confinement within 90 days of your last treatment for your covered Sickness, we will pay you one-thirtieth of the benefit shown in the Policy Schedule times three for each day you are confined. This benefit is payable up to the Benefit Period you selected and is not subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled Term and the definitions of "Benefit Period" and "Successive Periods of Disability."

Disability due to pregnancy and childbirth is payable to the same extent as a covered Sickness. After this policy has been in force ten months, the maximum Benefit Period allowed for childbirth is six weeks for noncesarean delivery and eight weeks for cesarean delivery, less the Elimination Period, unless you furnish proof that you remain disabled, as defined above, beyond these time frames.

Benefits will be paid for only one disability at a time even if it is caused by more than one Sickness. Benefits are not payable for Items A1, A2, B1, or B2 for the same day. Turning age 70 will not stop benefits otherwise payable. **We reserve the right to meet with you during the pendency of a claim or to use an independent consultant and Physician's statement to**

determine whether you are Totally Disabled, or whether you are unable to perform two or more ADLs and require Direct Personal Assistance. You must be under the care and attendance of a Physician for these benefits to be payable. Benefits will cease on the date of your death.

IF YOU HAVE ANY OTHER DISABILITY BENEFIT IN FORCE WITH US, ONLY ONE DISABILITY BENEFIT IS PAYABLE.

Part 6
TERMINATION

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

In witness whereof, AFLAC, at its worldwide headquarters, has caused this rider to be signed by its secretary and president in the city of Columbus, Georgia.

ABCD

Joey M. Loudermilk, Secretary

ABCD

Daniel P. Amos, President

AMERICAN FAMILY LIFE ASSURANCE COMPANY OF COLUMBUS (AFLAC)

Worldwide Headquarters: Columbus, Georgia 31999

A Stock Company

This **SPOUSE OFF-THE-JOB ACCIDENT DISABILITY BENEFIT RIDER** is a part of the policy and is subject to all policy provisions unless modified herein. **This rider applies to the Insured's spouse only, as shown in the Policy Schedule.**

In this rider, you, the spouse, will be referred to as "you," "your," or "yours." **American Family Life Assurance Company of Columbus (AFLAC)**, a stock company, will be referred to as "we" or "AFLAC."

Part 1
EFFECTIVE DATE

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

Part 2
PRE-EXISTING CONDITIONS

Disability or hospitalization caused by a Pre-existing Condition or reinjuries 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 symptoms existed that would ordinarily cause a prudent person to seek diagnosis, care, or treatment.

Part 3
DEFINITIONS
(for the purposes of this rider)

A. ACTIVITIES OF DAILY LIVING (ADLs): activities used in measuring levels of personal functioning capacity. Normally, these activities are performed without Direct Personal Assistance, allowing personal independence in everyday living.

The ADLs are:

- (1) Contingence: Maintaining control of urination and bowel movements, including your ability to use ostomy supplies or other devices such as catheters;
- (2) Transferring: Moving between a bed and a chair, or a bed and a wheelchair;
- (3) Dressing: Putting on and taking off all necessary items of clothing, and/or medically necessary braces and artificial limbs usually worn;
- (4) Toileting: Getting to and from a toilet, getting on and off a toilet, and performing associated personal hygiene; and
- (5) Eating: Performing all major tasks of getting food into the body.

B. BASE PAY EARNINGS: your gross salary or wages for your Full-Time Job. This does not include variable pay such as overtime (unless contractual), bonuses, or other incentives. If you are self-employed, the term "Base Pay Earnings" means your business's gross income

minus the allowable business deductions from that business. (For tax purposes, Base Pay Earnings is referred to as "net earnings.")

- C. BENEFIT PERIOD:** the maximum number of days after the Elimination Period, if any, for which you can be paid benefits for any one or Successive Periods of Disability. Each new Benefit Period is subject to a new Elimination Period. See the Policy Schedule for the Benefit Period you selected. For the purposes of this calculation, a "month" is defined as 30 days for which benefits are paid. See definition of "Successive Periods of Disability."
- D. DIRECT PERSONAL ASSISTANCE:** direct physical assistance from another party required to help you perform an ADL, each and every time you perform that activity, because of an inability to perform the entire activity alone with the supports and mechanical aids that are normally available to you.
- E. ELIMINATION PERIOD:** the number of consecutive days at the beginning of your period of total disability for which no benefits are payable. See the Policy Schedule for the Elimination Period you selected. Each new Benefit Period is subject to a new Elimination Period.
- F. FULL-TIME JOB:** a job that you, the Insured's spouse, work at 30 or more hours per week for pay or benefits.
- G. 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 and the Pre-existing Conditions sections for Injuries not covered by this policy.
- H. OFF-THE-JOB ACCIDENT:** an Injury that occurs while you are not working at any job for pay or benefits.
- I. SUCCESSIVE PERIODS OF DISABILITY:** separate periods of disability, if caused by the same or a related condition and not separated by 180 days or more, are considered a continuation of the prior disability. Separate periods of disability resulting from unrelated causes are considered a continuation of the prior disability unless they are separated by your returning to work at a Full-Time Job for 14 working days, during which you are performing the material and substantial duties of this job and are no longer qualified to receive disability benefits.
- J. TOTALLY DISABLED:** your continuing inability to perform the material and substantial duties of your Full-Time Job. You must also be under the care and attendance of a Physician for your condition. If you are unable to perform the material and substantial duties of your Full-Time Job but are able to work at any job, you will continue to be considered Totally Disabled as long as your earnings are less than 80% of your Base Pay Earnings at the time you became Totally Disabled. If you return to work at any job and are earning 80% or more of your predisability Base Pay Earnings, you will no longer be considered Totally Disabled.

Part 4 **LIMITATIONS AND EXCLUSIONS**

whether you are Totally Disabled, or whether you are unable to perform two or more ADLs and require Direct Personal Assistance. You must be under the care and attendance of a Physician for these benefits to be payable. Benefits will cease on the date of your death.

IF YOU HAVE ANY OTHER DISABILITY BENEFIT IN FORCE WITH US, ONLY ONE DISABILITY BENEFIT IS PAYABLE.

Part 6
TERMINATION

This rider will terminate if the policy to which it is attached terminates, if the premiums for this rider are not paid, upon the dissolution of your marriage, upon the death of the Named Insured, or upon your death.

In witness whereof, AFLAC, at its worldwide headquarters, has caused this rider to be signed by its secretary and president in the city of Columbus, Georgia.

ABCD

Joey M. Loudermilk, Secretary

ABCD

Daniel P. Amos, President

whether you are Totally Disabled, or whether you are unable to perform two or more ADLs and require Direct Personal Assistance. You must be under the care and attendance of a Physician for these benefits to be payable. Benefits will cease on the date of your death.

IF YOU HAVE ANY OTHER DISABILITY BENEFIT IN FORCE WITH US, ONLY ONE DISABILITY BENEFIT IS PAYABLE.

Part 6
TERMINATION

This rider will terminate if the policy to which it is attached terminates, if the premiums for this rider are not paid, upon the dissolution of your marriage, upon the death of the Named Insured, or upon your death.

In witness whereof, AFLAC, at its worldwide headquarters, has caused this rider to be signed by its secretary and president in the city of Columbus, Georgia.

ABCD

Joey M. Loudermilk, Secretary

ABCD

Daniel P. Amos, President

Section 4

Administrative Guidelines

*Eligibility***The Personal Accident Indemnity base plan (no disability riders):**

- Is available to applicants ages **18–64**.
- Is available for occupational classes A, B, C, D, and E.
- Is not age banded.
- **Is available for purchase by the field force through the agents' account (00316).**
- Is available on payroll, direct, nonpayroll/association.
- Is available for purchase by government allotment accounts.
- Requires that both the spouse and the primary insured meet the age requirements to be covered.
- Can provide coverage for dependent children who are unmarried and under 19 years of age (23 for full-time students). Dependent age varies by state.
- Allows pre-tax premium deductions under Section 125 or on an after-tax basis.

Advanced Effective Date

- An advanced effective date up to 90 days from the enrollment date can be used.
- With any sales where the effective date is advanced more than 60 days, a **Statement of Understanding (Form A-13072)** must be completed and submitted with the application.

Portability

- The PAI is portable/transferable to direct, at a payroll rate, if one month's premium has been paid through payroll deduction when the employee leaves the payroll account. However, after a policy is placed on direct billing, upgrades or downgrades cannot be made to the disability riders. The disability riders may be dropped, but no other changes can be made.

Mode

- All payment billing modes (weekly, biweekly, semimonthly, monthly, quarterly, semiannual, and annual modes) are available on payroll only.

Existing Accident/Disability Coverage

- An applicant cannot have both an Aflac accident policy with disability rider(s) and an Aflac Short-Term Disability policy. If replacing existing Aflac disability coverage, answer Question 2 on the application yes and complete the supplemental notification at the end of the application.

Request For Change

- Use Form H-L0046 for any Personal Accident Indemnity changes.

Transmittals

- Use transmittal Form M-0018R. List the line of business on the transmittal as AD. If yes is answered to any of Questions **17** through **21** on the application, submit the business on a separate transmittal.

Insurance Program Acknowledgment Form

- Complete the standard Insurance Program Acknowledgment form (**M-0138**) on all new accounts, giving special attention to the Accident Disability section. Form **M-0135R** on SmartApp®.
- Complete Form M-0486 for all existing accounts if accident disability coverage has never been written. **If these forms, where applicable, are not received, the business will pend. If the existing account has been previously classified for disability coverage, do not submit Form M-0486.**
- New account authorizations can be faxed to (706) 320-4658.

Privacy Practices

- Form **A-90070** will be inserted in the policy packet.

AFLAC PRIVACY PRACTICES

Protecting the privacy and confidentiality of information about our customers is very important to American Family Life Assurance Company of Columbus and American Family Life Assurance Company of New York (collectively, "AFLAC"). Accordingly, we strive to comply with each of the following practices in everything we do:

- **We do not sell, rent, lease or otherwise disclose personal information of our customers for purposes unrelated to our products and services.** The personal information of our customers is of paramount importance to us. Therefore, we provide this information only to our employees, agents and third parties as required to allow them to help us develop and provide our insurance and employee benefit products and services.
- **We work to ensure information integrity and security.** We use technology tools and design our business practices to help ensure that the personal information of our customers is properly gathered, stored and processed. We also work to maintain the security of, and internal and external access to, the personal information of our customers through the use of technology and our business practices.
- **We expect our agents and employees to respect the personal information of our customers.** AFLAC has business policies and practices in place to help ensure that our employees and agents carry out these practices and otherwise protect personal information about our customers. Both employees and agents are subject to censure, dismissal, or termination for violation of these policies.

These Privacy Practices apply to our U.S. customers. Due to legal and cultural differences, our practices may vary outside the United States.

PRIVACY NOTICE

AFLAC and our agents provide this notice to let you know about the current privacy practices of AFLAC and our agents. **You do not need to do anything in response to this notice. This notice is merely to inform you about how we safeguard your information.**

Collection of Information

As part of AFLAC's normal underwriting and operating procedures, AFLAC (and our agents acting on our behalf) need to obtain information to determine an individual's eligibility for our products and services, and to perform our insurance functions. AFLAC and our agents may collect nonpublic personal information (which includes both nonpublic personal financial information and nonpublic personal health information) about AFLAC's customers, including:

- Information from our customers (including names, addresses, financial and health information).
- Information about the customers' transactions with AFLAC or our agents (including claims and payment information).
- Information from consumer reporting agencies (including creditworthiness and credit history); motor vehicle records agencies (including accident reports and violations); investigators (including information regarding general character and participation in hazardous activities); insurance support organizations such as the Medical Information Bureau, Inc. (including claims, and health and insurance application histories); and the customers' health care providers (including health history), employers (including salary and benefits information), and family members.

Disclosure of Information

AFLAC may disclose the nonpublic personal financial information we collect, as described above, as well as information about your transactions with us (such as your policy coverage, premiums, and payment history) to our agents or other third parties who perform services or functions on our behalf, including in some circumstances the marketing of AFLAC products. We may also disclose the nonpublic personal financial information we collect to other third parties as authorized by you, or as required or permitted by law.

Our agents will make disclosures of our customers' nonpublic personal financial information only while acting on AFLAC's behalf and, furthermore, will make such disclosures only as AFLAC itself is permitted to make.

Neither AFLAC nor our agents will use or share with other parties any nonpublic personal health information about AFLAC customers for any purpose other than disclosures for the performance of insurance functions by AFLAC or on our behalf, disclosures that are permitted or required by law, or disclosures that the customer has authorized.

Neither AFLAC nor our agents will further disclose any nonpublic personal information about a former customer of AFLAC other than as may be required or permitted by law.

Confidentiality and Security

AFLAC and our agents will safeguard, according to strict standards of security and confidentiality, any information we collect, receive or maintain about AFLAC's customers. AFLAC maintains administrative, technical, and physical safeguards to ensure the security and confidentiality of our customer information and records, to protect against anticipated threats or hazards to such records, and to protect against unauthorized access to or use of such information or records.

Internally, AFLAC limits access to our customers' information to only those employees who need access to the information to perform their job functions. Employees who misuse information are subject to disciplinary actions. Externally, we do not disclose customer information to any third parties unless we have previously informed the customer of the disclosure, have been authorized to do so by the customer, or are required or permitted to make the disclosure by law or our regulators.

NOTICE OF INFORMATION PRACTICES

Arizona, California, Connecticut, Georgia, Illinois, Maine, Massachusetts, Minnesota, Nevada, New Jersey, North Carolina, Ohio, Oregon, and Virginia require insurers and agents to describe their information practices in addition to providing a Privacy Notice. There is significant overlap between the two notices, but in general our Information Practices include the following: AFLAC may obtain information about you and any other persons proposed for insurance. Some of this 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. Residents of these states have the right to access and correct the information collected about them except information that relates to a claim or to a civil or criminal proceeding. They also have the right to receive the specific reason for an adverse underwriting decision in writing. If you wish to have a more detailed explanation of our information practices required by your state, please submit a written request to: AFLAC Worldwide Headquarters, ATTN: Client Services, 1932 Wynnton Road, Columbus, Georgia 31999.

NOTICE OF PRIVACY PRACTICES - PROTECTED HEALTH INFORMATION

If you would like a copy of AFLAC's Notice of Privacy Practices - Protected Health Information issued pursuant to the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), copies are available by sending a written request to: AFLAC Worldwide Headquarters, ATTN: Privacy Office, 1932 Wynnton Road, Columbus, Georgia 31999.

Privacy and Aflac Associates

You may ask yourself: What does representing Aflac as an associate have to do with privacy, ethics, and conduct? Everything! As an Aflac associate you will handle sensitive and confidential information about employers and employees on a daily basis. You will, in fact, be exposed to possible legal and insurance department actions if you violate someone's privacy or act in an unethical manner. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) refers to this as PHI, or Protected Health Information.

Information that may be considered private about employees:

- **Employee's and/or employee's family's health status (PHI)**
- **Employee's and/or employee's family's income or financial status**
- **Employee's and/or employee's family's participation level**
- **Employee's family status**
- **Employee's position within the company**
- **Employee's sexual preference**

Never give out PHI about an employee or his/her family members to anyone, including the employer. You may inform the employer about an employee's participation level as a whole in the new benefit plans. In addition, be careful not to leave paperwork on a desk or break room table so other employees can see it.

Information that may be considered private about employers:

- **Employer's and/or employer's family's health status**
- **Employer's and/or employer's family's income or financial status**
- **Employer's and/or employer's family's participation level**
- **Employer's family status**
- **Employer's position within the company**
- **Employer's sexual preference**

These examples may seem obvious, but they are easy to overlook. Another example is sharing claims information when you have paid a large claim within an account. It is tempting to share how great we are at paying claims, but be careful—that, too, is confidential information. Don't do it; the potential cost is too high!

Section 5

Setting Up the Account

SmartApp®

First and foremost, Aflac's Personal Accident Indemnity application is on SmartApp. If you haven't already done so, please attend a SmartApp certification class as soon as possible. SmartApp certification is a prerequisite to attending an Enrollment Certification Specialist workshop, which in turn is a prerequisite to working in many of the key accounts enrolled annually. In addition, the premium rates are on Premium Quote in SmartApp.

SmartApp applications are virtually the same as paper applications. Reviewing paper applications will assist you in learning the SmartApp applications.

SIC Approvals

Have you obtained SIC approval for the account, even on existing accounts?

To avoid delays in processing business, obtain your approval **before** quoting rates or writing business!

Industry Classifications

Industry classification is based on industry experience, economic trends, and Aflac's morbidity and lapse experience. The disability benefits are available for industry codes A, B, C, and E **only**. The **E** class represents former D industries that are eligible for disability coverage. Some entire industries will receive E classifications, while some D industries will be reviewed and assigned E ratings based on specific characteristics of an account. Some industries and groups still remain in the D classification and are ineligible for disability. For your reference, the new Industry Classification Manual indicates the D industries that cannot be considered for E classification.

Applicants in E industries must be employed with the group for at least one year before applying for any disability coverage. **A, B, and C rates are not available to any employees in a D or E account, regardless of job duties.**

The Industry Classification Manual (Form M-1042) must be used as several of the industries and guidelines have changed. This booklet is for the associate's use only. A copy of the book is located in Section 20 of this guide.

Review the guidelines in the Industry Classification Manual for important changes. The previous Industry Classification Manuals (Forms M-0480 and M-0812R) can no longer be used.

The significant changes are:

- **Health services** (all four-digit codes beginning with 80) are **moving from B to C**.
- **Governments** (all four-digit codes beginning with 91 are **no longer eligible for across-the-board A's**; however, individual applicants may still be eligible for A rates based on their job duties.

The following industries have been changed **from B to A**:

- **8711 – Engineering services**
- **8712 – Architectural services**
- **8721 – Accounting, auditing, and bookkeeping services**
- **8741 – Management services**
- **8742 – Management consulting services**
- **8748 – Business consulting services**

Before writing business, even on existing accounts, submit all SIC requests in writing to the SIC team. This can be done by any one of the following methods:

Via Internet: Complete and send the Payroll Industry Classification Request Form M-0988 located on the Aflac Web site (aflac.com) Associate Services section.

Via E-Mail: Send SIC requests only to SIC@Aflac.com. Include the following information: the associate's name, writing number, and the account's name, address, and telephone number. Any additional information (company profile, company Web site, etc.) that can help in the process should also be included.

Via Fax: Print the Form M-0988 located at the Aflac Web site (aflac.com) Associates Services section and fax to (706) 317-0783. Please note: This fax number is for SIC requests only.

Via Mail: Print the Form M-0988 located at the Aflac Web site (aflac.com) Associates Services section and mail it to Aflac Worldwide Headquarters, ATTN: SIC Team, 1932 Wynnton Road, Columbus, Georgia 31999.



Note: When submitting SIC requests for multi-state locations, please indicate that it is a multi-state account, what states are involved, and which is the domicile state.

PAYROLL INDUSTRY CLASSIFICATION REQUEST FORM

Date: _____
Associate name: _____ Writing number: _____
E-mail address: _____ Fax no.: _____

Required Information

SIC confirmations will be delayed unless this section is completed.

Business name: _____
Physical address (No P.O. boxes): _____
City: _____ State: _____ ZIP: _____
Telephone no. (No toll-free numbers): _____ Web site address (if available): _____
Number of employees: _____ If existing account, list account number: _____
Advise associate if existing account information is located? Yes ☐ No ☐
Type of business and what is produced (be descriptive): _____
Are there any other locations? Yes ☐ No ☐ If yes, complete the Profile.1 form.
Does the account have any subsidiaries? Yes ☐ No ☐ If yes, complete the Profile.1 form.
Has the company's name/address changed within the past year? Yes ☐ No ☐ If yes, provide previous name/ address: _____
Does the business have any secondary lines of business that should be considered? Yes ☐ No ☐ If yes, what are they? _____
Number of years in business? _____ Projected enrollment date: _____
PRODUCTS BEING OFFERED MUST BE INDICATED: PAE ☐ PSTD ☐ PAI ☐ PDIP ☐

Special Requirements

If you answer yes to either question below, the requested information must be submitted with this form.

Is this a NONPROFIT ORGANIZATION? Yes ☐ No ☐ If yes, the following information must be completed in full.

- ☐ Length of time in business? _____
- ☐ Are the employees W2 employees? _____
- ☐ Total number of employees? _____ How many employees are full time and eligible for benefits? _____
- ☐ Describe the nature/purpose of the nonprofit organization. _____
- ☐ Does the organization offer job training assistance and/or job placement? Yes ☐ No ☐ If yes, will trainees be offered AFLAC products? Yes ☐ No ☐
- ☐ Attach a list from the business showing the hire dates of all eligible employees and their years of service.

Is the business a PEO/STAFFING/LEASING COMPANY, TEMPORARY AGENCY, HOLDING COMPANY or FRANCHISE Yes ☐ No ☐ MULTI-STATE OR MULTI-LOCATION BUSINESS? Yes ☐ No ☐ If yes, the domicile state must be provided: _____

- ☐ If yes to any of the above, submit a list of all associated locations or contracted companies and list the PHYSICAL addresses, phone numbers (NO toll-free numbers), number of employees, business description/function, tax ID number and Web site (if available).

Fax this request to the SIC Unit at 1-706-317-0783, e-mail your request to SIC@aflac.com, or submit the online request form located on the Associate Services Web page at www.aflac.com.

WWHQ Use Only

SIC assigned: _____ Classification assigned: _____
Database record no. _____ Date assigned: _____

Fax this form to the SIC Unit at (706) 317-0783.
American Family Life Assurance Company of Columbus (AFLAC)
Worldwide Headquarters: Columbus, Georgia 31999

Section 6

Completing the Application

How to Complete the Application

Issuance of a PAI policy will be based on the information included on the application. As a field underwriter, you have the responsibility to ask every question on the application and record the applicant's answers accurately and completely. The applications must be completed in full and, if using paper applications, must be completed in black ink.

Four Types of Applications

There are four applications for the Personal Accident Indemnity policy:

- 1. Payroll application with disability riders (A-34001)**
This application may be used for all payroll business whether or not the applicant chooses the disability riders. If the riders are not selected, no underwriting questions need to be answered.
- 2. Payroll application for base accident coverage only (A-34001A)**
This application is used only if the disability riders are not being offered. There are no underwriting questions.
- 3. Nonpayroll base application (A-34002A)**
- 4. Nonpayroll application with disability riders for Aflac associates only (A-34004)**

Completing the Application

The following example was taken from a standard application. Underwriting questions may vary by state; please refer to your specific state introduction packet for complete details.

Name of Employer _____	Type of Business _____
Job Duties _____	
Job Title _____	
Occupation Class _____ (Completed by associate/agent)	Industry Code _____ (Completed by associate/agent)

Job Title and Job Duties are required fields on the application and they aren't the same thing! **Be specific. Indicate the employee's actual job title and give a short description of his or her specific job duties.**

EXAMPLE: CORRECT!!

Name of Employer _____ ABC COMPANY _____	Type of Business _____ Engineering _____
Job Duties _____ 80% administration _____	
Job Title _____ Receptionist _____	
Occupation Class _____ A _____ (Completed by associate/agent)	Industry Code _____ A _____ (Completed by associate/agent)

EXAMPLE: INCORRECT!!

Name of Employer _____ ABC COMPANY _____	Type of Business _____ Engineering _____
Job Duties _____ Administrative _____	
Job Title _____ Administrative _____	
Occupation Class _____ A _____ (Completed by associate/agent)	Industry Code _____ A _____ (Completed by associate/agent)

Print the actual amount the employer is billed in the Billable Premium section. The billable premium is what the group will remit to Aflac, not what will be deducted from the employees' checks. If the billable premium is not completed, the application will pend.

TO BE COMPLETED BY AFLAC ASSOCIATE/AGENT			
PAYROLL MODES:			Employee No. _____
1 01 Weekly	1 03 Quarterly	1 Pre-Tax	Dept. No. _____
1 01 Biweekly	1 06 Semiannual	1 After-Tax	Billable Premium \$ _____
1 01 Semimonthly	1 12 Annual		Premium Collected \$ _____
1 01 Monthly			Associate/Agent No. _____
1 01 28-Day			Sit. Code _____



INCORRECT PREMIUM IS ONE OF THE TOP REASONS THAT APPLICATIONS PEND!

If the application is for base coverage only (no disability riders), the applicant does not need to answer any underwriting questions.

Question 1:

1.	<p>I certify that my gross annual income [without overtime (unless contractual), bonuses, or other incentives] for my full-time job is \$ _____. If you are self-employed, your gross annual income is your net earnings.</p> <p>I understand that this information will be verified at the time of claim. Annual income must be \$10,000 or greater for coverage to be issued.</p>
1a.	<p>If applying for the Spouse Disability Rider, I further certify that my spouse's gross annual income [without overtime (unless contractual), bonuses, or other incentives] for his/her full-time job is \$ _____.</p> <p>If your spouse is self-employed, his/her gross annual income is his/her net earnings.</p> <p>Spouse's Employer _____ Spouse's Job Title _____</p>
1b.	<p>If your Industry Class is E, have you been employed for less than 12 months with the employer listed on the front page of this application?</p> <p style="text-align: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No N/A</p>

Question 1 is for the primary insured and income must be at least \$10,000 to be eligible.

Question 1a is for the spouse rider and income must be at least \$10,000 to be eligible. The income of the primary insured and spouse cannot be combined.

Question 1b applies to applicants with an E occupational classification only. If any other classification is selected, the N/A box should be marked. If an E classification is indicated and the question is answered yes, disability riders cannot be issued.

Completing the Application

Question 2:

2.	<p>Do you or does anyone to be covered have a Short-Term Disability policy with Aflac? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, please complete the Supplemental Notification section at the end of this application and be aware that you or anyone to be covered cannot have this policy with the disability riders without canceling your Short-Term Disability policy with Aflac.</p>
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If **Question 2** is answered yes, the applicant must complete the supplemental notification at the end of the application.

Question 3:

3.	<p>Do you or does anyone to be covered currently have disability coverage, that you purchased, that will remain in force which, combined with this applied-for coverage, exceeds 70 percent of your monthly gross (pre-tax) income? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
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Question 3 – If existing disability combined with the disability riders will exceed 70 percent of gross income, the application will be declined. This question refers only to disability coverage **that the individual** purchased. The question does not take into consideration employer-paid disability.

Disability insurance should replace no more than 70 percent of a person's income. Coverage is intended to help a policyholder continue financial obligations while out of work but also to provide an incentive to return to work as soon as medically possible.

Question 4–8:

4.	<p>Have you or has anyone to be covered 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? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
5.	<p>Are you or is anyone to be covered currently on leave or not working because of sickness, maternity, or injury? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
6.	<p>Are there any material or substantial duties of your job that you or anyone to be covered are unable to perform because of sickness, maternity, or injury? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
7.	<p>Do you or does anyone to be covered work fewer than [30] hours per week in your primary (full-time) occupation with the employer listed on the first page of the application? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
8.	<p>Within the last six weeks, have you or has anyone to be covered taken prescribed medication for the treatment of injury, disease, or disorder of the back, neck, or joints? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>

Questions 4–8 apply to anyone applying for disability and are knock-out questions. If answered yes, the applicant must indicate to whom the yes answer applies, and if it is the named insured, disability riders cannot be issued to the named insured. If it is the spouse, the spouse rider cannot be issued. The application will be declined, and a new application for eligible coverage must be submitted.

Question 9:

9.	Are you covered by workers' compensation or a similar law in your full-time job?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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Question 9 is required only if applying for the on-the-job rider. This is a knock-out question; if answered yes, the rider cannot be issued. The application will be declined and a new application for eligible coverage must be submitted.

Questions 10–16:

10.	Has a member of the medical profession ever diagnosed you with or ever treated you for any of the following: <div style="display: flex; justify-content: flex-end;"> <input type="checkbox"/> Yes <input type="checkbox"/> No </div> <div style="display: flex; flex-wrap: wrap;"> <div style="width: 50%;"> <ul style="list-style-type: none"> • Stroke or TIA (mini-stroke) • Heart valve replacement • Vascular insufficiency (circulatory problems) • Multiple sclerosis • Crohn's disease • Chronic hepatitis (other than Type A) • Fibromyalgia • Chronic obstructive pulmonary disease </div> <div style="width: 50%;"> <ul style="list-style-type: none"> • Psoriatic arthritis • Chronic liver disease • Muscular dystrophy • Systemic lupus • Chronic fatigue syndrome • Rheumatoid arthritis • Emphysema • Regional enteritis/ileitis • Ulcerative colitis • Cardiomyopathy • Pulmonary fibrosis </div> </div>
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 human immunodeficiency virus (HIV)? <div style="display: flex; justify-content: flex-end;"> <input type="checkbox"/> Yes <input type="checkbox"/> No </div>
12.	In the past five years, has a member of the medical profession diagnosed you with or treated you for cancer (other than nonmelanoma skin cancers)? <div style="display: flex; justify-content: flex-end;"> <input type="checkbox"/> Yes <input type="checkbox"/> No </div>
13.	Have you ever been diagnosed with or received treatment by a member of the medical profession for Type I diabetes, or Type II diabetes (1) diagnosed prior to age 30, or (2) with complications to include retinopathy, neuropathy, or nephropathy, or (3) with continued tobacco use, or (4) requiring the use of insulin within the past five years? <div style="display: flex; justify-content: flex-end;"> <input type="checkbox"/> Yes <input type="checkbox"/> No </div>
14.	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: <div style="display: flex; justify-content: flex-end;"> <input type="checkbox"/> Yes <input type="checkbox"/> No </div> <div style="display: flex; flex-wrap: wrap;"> <div style="width: 33%;"> <ul style="list-style-type: none"> • Heart attack • Congestive heart failure • Atrial fibrillation • Angina (heart-related chest pains) </div> <div style="width: 33%;"> <ul style="list-style-type: none"> • Coronary bypass surgery • Sciatica • Coronary angioplasty (or stents) • Carpal tunnel syndrome </div> <div style="width: 33%;"> <ul style="list-style-type: none"> • Drug or alcohol abuse • Kidney disease (not including kidney stones) </div> </div>
15.	In the past 12 months, have you received treatment in an emergency room or hospital by a member of the medical profession or missed ten total days of work for any of the following: <div style="display: flex; justify-content: flex-end;"> <input type="checkbox"/> Yes <input type="checkbox"/> No </div> <div style="display: flex; flex-wrap: wrap;"> <div style="width: 33%;"> <ul style="list-style-type: none"> • Chronic bronchitis • Asthma • Diverticulitis • Type II diabetes </div> <div style="width: 33%;"> <ul style="list-style-type: none"> • Hypertension (high blood pressure) • Joint replacement • Pancreatitis </div> <div style="width: 33%;"> <ul style="list-style-type: none"> • Seizures • Gastric bypass • Blood disorders </div> </div>
16.	Have you been advised by a physician to be hospitalized or to have surgery that has not yet been performed (excluding routine childbirth)? <div style="display: flex; justify-content: flex-end;"> <input type="checkbox"/> Yes <input type="checkbox"/> No </div>

Questions 10–16 are required only if applying for the sickness rider. These are knock-out questions; if answered yes, the rider cannot be issued. The application will be declined, and a new application for eligible coverage must be submitted.

Questions 17–21:

17.	Have you received disability benefits or claimed workers' compensation in the last five years? <input type="checkbox"/> Yes <input type="checkbox"/> No
18.	In the past 12 months, have you missed five consecutive days or ten total days of work because of your sickness or injury (not related to routine childbirth)? <input type="checkbox"/> Yes <input type="checkbox"/> No
19.	In the past 12 months, have you been confined in a hospital as an inpatient (not including confinement because of routine childbirth)? <input type="checkbox"/> Yes <input type="checkbox"/> No
20.	In the past 12 months, has a member of the medical profession diagnosed you with or treated you for any heart disease or disorder, excluding insignificant heart murmurs? <input type="checkbox"/> Yes <input type="checkbox"/> No
21.	In the past 12 months, has a member of the medical profession diagnosed you with or treated you for an injury, disease, or disorder of the back, the neck, or a joint? <input type="checkbox"/> Yes <input type="checkbox"/> No

Questions 17–21 are required if applying for **five** or more units of the sickness rider. If any questions are answered yes, **Questions 22** (prescription information), **23** (physician information), and **24** (details to questions) must also be completed and these applications will pend to Underwriting. If **Questions 17–21** are answered no, the policy may be issued.



Due to privacy issues, the **home** telephone number is not a required field on SmartApp®. However, a prompt appears on the application before **Question 23** to remind the associate to secure a home telephone number. This will expedite time if the applicant needs to be called.



If an application must be underwritten, hold the new Premium Deduction Authorization Card that lists the premium. Client Services will notify the associate listed on the application when the policy is ready to be released for issue. At that time, submit the PDA card to the payroll specialists to start deductions.

Conversions

- The new business application (**Form A-34001**) may also be used for conversions/upgrades.
- Any existing accident policy may be converted to the PAI policy.
- Complete the section on the application about other accident coverage and provide the insured's current policy number.
- In a divorce situation, the spouse of the primary insured may request a new policy with identical coverage at his or her own occupation code.
- Additional units of coverage may be added to any existing disability riders.
- The total number of units should be combined and premium calculated on the applicant's **attained age**.
- The section on the application about other disability coverage must be completed.
- Standard conversion commissions will be paid and production credit given to the converting associate and his or her hierarchy based on the incremental increase system.

SAMPLE APPLICATIONS
(Series A-34000)

This is a sample application to be used for training purposes only. **Underwriting questions may vary by state; please refer to your specific state introduction packet for complete details.**



Application for Accident Insurance (A-34000 Series) with disability riders
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 No. _____ - _____ - _____ Dependent Children ☐ Yes ☐ No
(Write spouse's name below if you are applying for family coverage; if no spouse or if spouse is not to be covered, put N/A in space below.)

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

Applicant's Address _____ Street or Post Office Box _____ Apt. No. _____

City _____ State _____ ZIP _____

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

Name of Employer _____ Type of Business _____

Job Duties _____

Job Title _____

Occupation Class _____ Industry Code _____
(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 the policy number here _____

TO BE COMPLETED BY AFLAC ASSOCIATE/AGENT

Billing Method: ☒ Payroll Deduction **Mode:** ☐ 01 Monthly ☐ 01 Weekly ☐ 01 Biweekly ☐ 01 Semimonthly ☐ 01 28-Day ☐ 03 Quarterly ☐ 06 Semiannual ☐ 12 Annual **Disability Benefit Period:** ☐ 6 Months ☐ 12 Months **Accident Disability Elimination Period:** ☐ 0 Days ☐ 7 Days

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

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

CHECK COVERAGE DESIRED: ☐ Individual ☐ Two-Parent Family ☐ One-Parent Family ☐ Named Insured/Spouse Only

Class: <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D <input type="checkbox"/> E	Total No. of Units	Premium	<input type="checkbox"/> Pre-Tax or <input type="checkbox"/> After-Tax
<input type="checkbox"/> Level 1 Policy Series A-34100			<input type="checkbox"/> Pre-Tax or <input type="checkbox"/> After-Tax
<input type="checkbox"/> Level 2 Policy Series A-34200			<input type="checkbox"/> Pre-Tax or <input type="checkbox"/> After-Tax

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

<input type="checkbox"/> Off-the-Job Accident Disability Rider			<input type="checkbox"/> Pre-Tax or <input type="checkbox"/> After-Tax
<input type="checkbox"/> On-the-Job Accident Disability Rider			
<input type="checkbox"/> Sickness Disability Rider 14-Day Elimination Period			<input type="checkbox"/> After-Tax

The Disability Rider shown below applies only to your spouse.

<input type="checkbox"/> Spouse Off-the-Job Accident Disability Rider 0 Day Elimination Period/ 6-Month Benefit Period			After-Tax Only
	Total Premium		

PLEASE COMPLETE QUESTIONS 1 THROUGH 8 IF APPLYING FOR ANY DISABILITY RIDER

1. I certify that my gross annual income (without overtime, unless contractual, bonuses or other incentives) for my full-time job is \$ _____. If you are self-employed, your gross annual income is your net earnings. I understand that this information will be verified at the time of claim. Annual income must be [\$10,000] or greater for coverage to be issued.
- 1a. If applying for the Spouse Disability Rider, I further certify that my spouse's gross annual income (without overtime, unless contractual, bonuses or other incentives) for his/her full-time job is \$ _____.
If your spouse is self-employed, his/her gross annual income is his/her net earnings.
Spouse's Employer _____ Spouse's Job Title _____
- 1b. If your Industry Class is E, have you been employed for less than 12 months with the employer listed on the front page of this application? ☐ Yes ☐ No ☐ N/A
2. Do you or does anyone to be covered have a short-term disability policy with AFLAC? ☐ Yes ☐ No
If yes, please complete the Supplemental Notification section at the end of this application and be aware that you or anyone to be covered cannot have this policy with the disability riders without canceling your short-term disability policy with AFLAC.
3. Do you or does anyone to be covered currently have disability coverage, that you purchased, that will remain in force which, combined with this applied-for coverage, exceeds 70% of your monthly gross (pre-tax) income? ☐ Yes ☐ No
4. Have you or has anyone to be covered 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
5. Are you or is anyone to be covered currently on leave or not working because of Sickness, maternity or Injury? ☐ Yes ☐ No
6. Are there any material or substantial duties of your job that you or anyone to be covered are unable to perform because of Sickness, maternity or Injury? ☐ Yes ☐ No
7. Do you or does anyone to be covered 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
8. Within the last six weeks, have you or has anyone to be covered taken prescribed medication for the treatment of Injury, disease, or disorder of the back, neck, or joints? ☐ Yes ☐ No

If you answered yes, to Question 1b or 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 indicate to which person any "yes" answer applies.

☐ Named Insured

☐ Spouse

The person indicated will not be covered by any disability rider.

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

9. Are you covered by workers' compensation or a 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 16 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 (mini-stroke) | • Systemic lupus |
| • Heart valve replacement | • Chronic fatigue syndrome |
| • Vascular insufficiency (circulatory problems) | • Rheumatoid arthritis |
| • Multiple sclerosis | • Psoriatic arthritis |
| • Emphysema | • Crohn's disease |
| • Chronic liver disease | • Regional enteritis/ileitis |
| • Chronic hepatitis (other than Type A) | • Ulcerative colitis |
| • Fibromyalgia | • Muscular dystrophy |
| • Chronic obstructive pulmonary disease | • Pulmonary fibrosis |
| • Cardiomyopathy | |
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 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 nonmelanoma skin cancers)? ☐ Yes ☐ No

13. Have you ever been diagnosed with or received treatment by a member of the medical profession for Type I diabetes; or Type II diabetes (1) diagnosed prior to age 30, or (2) with complications to include retinopathy, neuropathy, or nephropathy, or (3) with continued tobacco use, or (4) requiring the use of insulin within the past five years? ☐ Yes ☐ No
14. 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
 - Congestive heart failure
 - Coronary angioplasty (or stents)
 - Angina
 - Coronary bypass surgery
 - Sciatica
 - Carpal tunnel syndrome
 - Atrial fibrillation
 - Drug or alcohol abuse
 - Kidney disease
 - (not including kidney stones)
- (heart-related chest pains)
15. In the past 12 months, have you received treatment in an emergency room or Hospital by a member of the medical profession or missed ten total days of work for any of the following: ☐ Yes ☐ No
- Chronic bronchitis
 - Asthma
 - Diverticulitis
 - Type II diabetes
 - Hypertension (high blood pressure)
 - Joint replacement
 - Pancreatitis
 - Seizures
 - Gastric bypass
 - Blood disorders
16. Have you been advised by a Physician to be hospitalized or to have surgery that has not yet been performed (excluding routine childbirth)? ☐ Yes ☐ No

If you answered yes to any one of Questions 10 through 16, you are not eligible for Sickness Disability Rider coverage; therefore, this rider will not be issued.

IF YOU ARE APPLYING FOR MORE THAN 4 UNITS OF SICKNESS DISABILITY COVERAGE, PLEASE COMPLETE QUESTIONS 17 THROUGH 21. IF NOT, PROCEED TO ITEM 25.

17. Have you received disability benefits or claimed workers' compensation in the last five years? ☐ Yes ☐ No
18. In the past 12 months, have you missed five consecutive days or ten total days of work because of your Sickness or Injury (not related to routine childbirth)? ☐ Yes ☐ No
19. In the past 12 months, have you been confined in a Hospital as an inpatient (not including confinement because of routine childbirth)? ☐ Yes ☐ No
20. In the past 12 months, has a member of the medical profession diagnosed you with or treated you for any heart disease or disorder excluding insignificant heart murmurs? ☐ Yes ☐ No
21. In the past 12 months, has a member of the medical profession diagnosed you with or treated you for an Injury, disease, or disorder of the back, the neck, or a joint? ☐ Yes ☐ No

If you answered yes to any one of Questions 17 through 21, you must complete Items 22 and 23 and provide details in Item 24.

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

Medication Name	Dosage	Frequency	Date First Prescribed	Reason

23.

Your Physician's Name _____	Phone Number _____
(If no regular Physician, Physician last seen)	
Address _____	
Date Last Seen by Physician _____	Reason for Last Visit _____

Form A-34001

3

A34001.1

24. Details to Questions 17–21

	Medical Conditions	Onset (mo/yr)	Surgery Performed? (If yes, provide the type of procedure and date)
Question 17			
Question 18			
Question 19			
Question 20			
Question 21			

APPLICANT'S STATEMENTS AND AGREEMENTS

25. I understand that the Effective Date of the policy will be the date recorded in the Policy Schedule by AFLAC Worldwide Headquarters.
26. I acknowledge receipt of, if applicable:
- ☐ Replacement Notice ☐ *Guide to Health Insurance for People With Medicare*
- ☐ Outline of Coverage ☐ Fair Credit Reporting Notice
27. 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, endorsements, benefit agreements, riders, and attached papers, if any, constitutes 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 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

Form A-34001 4 A34001.1

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.

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

I 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.

Signed and Dated at _____ on _____
City and State Date

Applicant's Signature (X) _____

Beneficiary (your estate unless otherwise indicated) _____
Relationship

I certify that I personally saw the applicant when the application was written, and each question was asked of the applicant and answered as recorded. All answers above are correct to the best of my knowledge.

Associate/Agent 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.



Application for Accident Insurance (A-34000 Series) – base plan
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 No. _____ - _____ - _____ Dependent Children ☐ Yes ☐ No
(Write spouse's name below if you are applying for family coverage; if no spouse or if spouse is not to be covered, put N/A in space below.)
Spouse's Name _____ DOB _____ Sex _____
Last First MI Month/Day/Year
Applicant's Address _____ Apt. No. _____
Street or Post Office Box
City _____ State _____ ZIP _____
Home Telephone () _____ Business Telephone () _____ Best Time to Call _____

Name of Employer _____ Type of Business _____
Job Duties _____
Job Title _____
Occupation Class _____ Industry Code _____
(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 the policy number here _____

TO BE COMPLETED BY AFLAC ASSOCIATE/AGENT

Billing Method: ☒ Payroll Deduction **Mode:**
☐ 01 Weekly ☐ 01 Monthly
☐ 01 Biweekly ☐ 03 Quarterly
☐ 01 Semimonthly ☐ 06 Semiannual
☐ 01 28-Day ☐ 12 Annual
Employee No. _____ Dept. No. _____ Assoc./Agent No. _____
Billable Premium \$ _____ Premium Collected \$ _____ Sit. Code _____

CHECK COVERAGE DESIRED: ☐ Individual ☐ Two-Parent Family
☐ One-Parent Family ☐ Named Insured/Spouse Only

Class: <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D <input type="checkbox"/> E	Total No. of Units	Premium
<input type="checkbox"/> Level 1 Policy Series A-34100		<input type="checkbox"/> Pre-Tax or <input type="checkbox"/> After-Tax
<input type="checkbox"/> Level 2 Policy Series A-34200		<input type="checkbox"/> Pre-Tax or <input type="checkbox"/> After-Tax
	Total Premium	

APPLICANT'S STATEMENTS AND AGREEMENTS

1. I understand that the Effective Date of the policy will be the date recorded in the Policy Schedule by AFLAC Worldwide Headquarters.
2. I acknowledge receipt of, if applicable:
☐ Replacement Notice
☐ Outline of Coverage
☐ *Guide to Health Insurance for People With Medicare*
☐ Fair Credit Reporting Notice
3. 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, endorsements, benefit agreements, riders, and attached papers, if any, constitutes 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.

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

I 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.

Signed and Dated at _____ on _____
City and State Date

Applicant's Signature (X) _____

Beneficiary (your estate unless otherwise indicated) _____
Relationship

I certify that I personally saw the applicant when the application was written, and each question was asked of the applicant and answered as recorded. All answers above are correct to the best of my knowledge.

Associate/Agent 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.

Nonpayroll Base

Application for Accident Insurance (A-34000 Series) – base plan
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 No. _____ - _____ - _____ Dependent Children ☐ Yes ☐ No
(Write spouse's name below if you are applying for family coverage; if no spouse or if spouse is not to be covered, put N/A in space below.)

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

Applicant's Address _____ Apt. No. _____
Street or Post Office Box

City _____ State _____ ZIP _____

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

Name of Employer _____ Type of Business _____

Job Duties _____

Job Title _____

Occupation Class _____ Industry Code _____
(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 the policy number here _____

TO BE COMPLETED BY AFLAC ASSOCIATE/AGENT

Billing Method:
☐ Direct
☐ Emp. Nonpayroll/Assoc.
☐ Bank Draft (B/D, ACH)
☐ Credit Card (C/C)

Mode:
☐ 01 Monthly (B/D & C/C Only)
☐ 03 Quarterly
☐ 06 Semiannual
☐ 12 Annual

Card Name _____ Card No. _____ Expiration Date _____

I authorize American Family Life Assurance Company of Columbus (AFLAC) to charge my VISA/MASTERCARD/AMERICAN EXPRESS account in accordance with the premium rate that I have chosen. Premiums will be advanced by my bank until I cancel authorization in writing to AFLAC. Cancellation will be effective on the first day of the month following AFLAC's receipt of notice to cancel.

Signature _____ Date _____
Assoc./Agent No. _____ Sit. Code _____ Billable Premium \$ _____ Premium Collected \$ _____

CHECK COVERAGE DESIRED: ☐ Individual ☐ Two-Parent Family
☐ One-Parent Family ☐ Named Insured/Spouse Only

Class: <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D <input type="checkbox"/> E	Total No. of Units	Premium
<input type="checkbox"/> Level 1 Policy Series A-34100		
<input type="checkbox"/> Level 2 Policy Series A-34200		
	Total Premium	

PLEASE COMPLETE QUESTIONS 1 and 2

1. Have you or has anyone to be covered by this policy 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? If yes, please list the name and the relationship of each person on the line below. Any person so named will not be covered under the policy. ☐ Yes ☐ No

If a person so named is the primary insured, a policy will not be issued; therefore, do not submit this application.

2. In the past 12 months, has a member of the medical profession diagnosed you (or anyone to be covered) with or treated you for an Injury, disease, or disorder of the back, the neck, or a joint? ☐ Yes ☐ No

IF YOU ANSWERED YES TO QUESTION 2, YOU MUST COMPLETE ITEM 3 AND PROVIDE DETAILS IN ITEM 4.

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

Medication Name	Dosage	Frequency	Date First Prescribed	Reason

4. Details to Question 2

	Medical Conditions	Onset (mo/yr)	Surgery Performed? (If yes, provide the type of procedure and date)
Question 2			

APPLICANT'S STATEMENTS AND AGREEMENTS

5. I understand that the Effective Date of the policy will be the date recorded in the Policy Schedule by AFLAC Worldwide Headquarters.
6. I acknowledge receipt of, if applicable:
☐ Replacement Notice ☐ *Guide to Health Insurance for People With Medicare*
☐ Outline of Coverage ☐ Fair Credit Reporting Notice
7. 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, endorsements, benefit agreements, riders, and attached papers, if any, constitutes 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.

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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.

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.

Signed and Dated at _____ on _____
City and State Date

Applicant's Signature (X) _____

Beneficiary (your estate unless otherwise indicated) _____
Relationship

I certify that I personally saw the applicant when the application was written, and each question was asked of the applicant and answered as recorded. All answers above are correct to the best of my knowledge.

Associate/Agent Signature _____
Licensed Associate/Agent Date

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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

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- * other approved items and services

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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.

Associate Only

Application for Accident Insurance (A-34000 Series) with disability riders
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 No. _____ - _____ - _____ Dependent Children ☐ Yes ☐ No
(Write spouse's name below if you are applying for family coverage; if no spouse or if spouse is not to be covered, put N/A in space below.)
Spouse's Name _____ Last _____ First _____ MI _____ DOB _____ Month/Day/Year Sex _____
Applicant's Address _____ Street or Post Office Box _____ Apt. No. _____
City _____ State _____ ZIP _____
Home Telephone () _____ Business Telephone () _____ Best Time to Call _____

Name of Employer _____ Type of Business _____
Job Duties _____
Job Title _____
Occupation Class _____ (Completed by associate/agent) Industry Code _____ (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: ☐ Direct ☐ Bank Draft (B/D, ACH) ☐ Credit Card (C/C) ☐ Statement Deduction
Mode: ☐ 01 Monthly (B/D & C/C Only) ☐ 03 Quarterly ☐ 06 Semiannual ☐ 12 Annual
Disability Benefit Periods: ☐ 6 Months ☐ 12 Months
Accident Disability Elimination Periods: ☐ 0 Days ☐ 7 Days

Card Name _____ Card No. _____ Expiration Date _____

I authorize American Family Life Assurance Company of Columbus (AFLAC) to charge my VISA/MASTERCARD/AMERICAN EXPRESS account in accordance with the premium rate that I have chosen. Premiums will be advanced by my bank until I cancel authorization in writing to AFLAC. Cancellation will be effective on the first day of the month following AFLAC's receipt of notice to cancel.

Signature _____ Date _____

Assoc./Agent No. _____ Sit. Code _____ Billable Premium \$ _____ Premium Collected \$ _____

CHECK COVERAGE DESIRED: ☐ Individual ☐ Two-Parent Family
☐ One-Parent Family ☐ Named Insured/Spouse Only

Class: E	Total No. of Units	Premium	
<input type="checkbox"/> Level 1 Policy Series A-34100			
<input type="checkbox"/> Level 2 Policy Series A-34200			
The Disability Riders shown below do not apply to your spouse or dependents.			
<input type="checkbox"/> Off-the-Job Accident Disability Rider			Maximum of 15 units
<input type="checkbox"/> On-the-Job Accident Disability Rider			Maximum of 10 units
	Total Premium		

PLEASE COMPLETE QUESTIONS 1 and 2

1. Have you or has anyone to be covered by this policy 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? If yes, please list the name and the relationship of each person on the line below. Any person so named will not be covered under the policy. ☐ Yes ☐ No

If a person so named is the primary insured, a policy will not be issued; therefore, do not submit this application.

2. In the past 12 months, has a member of the medical profession diagnosed you (or anyone to be covered) with or treated you for an Injury, disease, or disorder of the back, the neck, or a joint? ☐ Yes ☐ No

If you answered yes to Question 2, you must complete Item 3 and provide details in Item 4.

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

Medication Name	Dosage	Frequency	Date First Prescribed	Reason

4. Details to Question 2

	Medical Conditions	Onset (mo/yr)	Surgery Performed? (If yes, provide the type of procedure and date.)
Question 2			

PLEASE COMPLETE QUESTIONS 5 THROUGH 11 IF APPLYING FOR ANY DISABILITY RIDER:

5. I certify that my net earnings for my full-time job are \$_____. I further certify that I have been an AFLAC associate/agent for at least [two years]. (Please submit [two years] of income verification, such as copies of self-employment tax returns. Net earnings must be [\$10,000] or greater for coverage to be issued.)
6. Do you currently have disability coverage, that you purchased, that will remain in force, which combined with this applied-for coverage exceeds 70% of your net earnings? ☐ Yes ☐ No
7. 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
8. Are you currently on leave or not working because of Sickness, maternity, or Injury? ☐ Yes ☐ No
9. Are there any material or substantial duties of your job that you are unable to perform because of Sickness, maternity, or Injury? ☐ Yes ☐ No
10. 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
11. Within the last six weeks, have you taken prescribed medication for treatment of Injury, disease, or disorder of the back, neck, or joints? ☐ Yes ☐ No

If you answered yes to any one of Questions 6 through 11, you are not eligible for any disability rider coverage and, therefore no disability rider will be issued.

APPLICANT'S STATEMENTS AND AGREEMENTS

12. I understand that the Effective Date of the policy will be the date recorded in the Policy Schedule by AFLAC Worldwide Headquarters.
13. I acknowledge receipt of, if applicable:

<input type="checkbox"/> Replacement Notice	<input type="checkbox"/> <i>Guide to Health Insurance for People With Medicare</i>
<input type="checkbox"/> Outline of Coverage	<input type="checkbox"/> Fair Credit Reporting Notice

14. 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, endorsements, benefit agreements, riders, and attached papers, if any, constitutes 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.

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.

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.

Signed and Dated at _____ on _____
City and State Date

Applicant's Signature (X) _____

Beneficiary (your estate unless otherwise indicated) _____
Relationship

**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.

Section 7

***Leave With
Applicant***

Replacement Notice

- Some states require that an applicant complete a Replacement Notice (**Form A-8691**) if the applicant intends to replace existing disability insurance with another carrier. **Please refer to your state introduction package.**
- If your state requires the Replacement Notice, forward the original to headquarters with the application and leave the duplicate with the applicant.
- If the replacement question is answered yes, the Replacement Notice must also be completed.

Outline of Coverage

Some states require that an Outline of Coverage [**Form A-34125** (Level 1) or **Form A-34225** (Level 2)] be left with the applicant. **Please refer to your specific state introduction package.**

Section 8

Personal Accident Indemnity Plan Codes

The PAI has six plan codes for the base policy and 11 plan codes for the riders.

Please refer to your specific state introduction packet for complete details.

Base Policy Plan Codes

	Individual/Family	Named Insured/Spouse	One-Parent Family
Level 1	AADP01	AADP11	AADP21
Level 2	AADP02	AADP12	AADP22

Optional Rider Plan Codes

Off-the-Job Disability Rider – Primary Insured

Elimination Period	Benefit Period	Plan Codes
0-day	6-month	ADRFF1
0-day	12-month	ADRFF2
7-day	6-month	ADRFF3
7-day	12-month	ADRFF4

On-the-Job Disability Rider – Primary Insured

Elimination Period	Benefit Period	Plan Codes
0-day	6-month	ADRNN1
0-day	12-month	ADRNN2
7-day	6-month	ADRNN3
7-day	12- month	ADRNN4

Sickness Disability Rider – Primary Insured

Elimination Period	Benefit Period	Plan Codes
14-day	6-month	ASRSR1
14-day	12-month	ASRSR2

Off-the-Job Accident Disability Rider – Spouse Coverage Only

Elimination Period	Benefit Period	Plan Codes
0-day	6-month	ADRSP1

Section 9

Personal Accident Indemnity Premium Rates

PAI is available on Premium Quote. No registration fee is required at the time of sale.

Types of Coverage Available

- **Individual:** Covers only the named insured listed in the Policy Schedule.
- **Named Insured/Spouse Only:** Covers the named insured and spouse.
- **Two-Parent Family:** Covers the named insured, his/her spouse and all dependent children (or those of the spouse). Dependent children are natural children, stepchildren, or legally adopted children who are unmarried, under 19 years of age (age 23 if full-time students) and who qualify as legal dependents for tax exemption purposes under the United States Internal Revenue Service Tax Code. (Dependent age varies by state.)
- **One-Parent Family:** Covers the named insured and all dependent children. Dependent children are natural children, stepchildren, or legally adopted children who are unmarried, under 19 years of age (age 23 if full-time students), and who qualify as legal dependent for tax exemption purposes under the United States Internal Revenue Service Tax Code. (Dependent age varies by state.)

Base Accident Coverage

Monthly Premium Rates

Payroll

Policy Form	Issue Ages	Industry Class	Individual	One-Parent Family	Named Insured/Spouse	Two-Parent Family
A-34100 Accident Plan Level 1	18–64	A	\$15.90	\$26.20	\$22.40	\$33.20
	18–64	B	19.80	28.70	26.50	35.60
	18–64	C	23.90	30.80	30.50	37.50
	18–64	D/E	28.40	34.90	34.50	41.30
A-34200 Accident Plan Level 2	18–64	A	\$19.40	\$32.10	\$27.50	\$40.70
	18–64	B	24.10	35.10	32.30	43.30
	18–64	C	28.70	37.00	36.60	45.00
	18–64	D/E	34.10	41.90	41.40	49.60
Annual, semiannual, and quarterly mode premiums are 12, 6, and 3 times monthly.						

Optional Disability Riders

Monthly Premium Rates per \$100 of Monthly Benefit

Payroll

Form	Issue Ages	Industry Class	Elimination Period in Days	Benefit Period in Months	Individual
A-34050 Off-the-Job Accident	18–64	A	0	6	\$0.50
	18–64	B	0	6	0.80
	18–64	C	0	6	1.10
	18–64	E	0	6	1.50
	18–64	A	0	12	\$0.60
	18–64	B	0	12	1.00
	18–64	C	0	12	1.20
	18–64	E	0	12	1.70
	18–64	A	7	6	\$0.40
	18–64	B	7	6	0.70
	18–64	C	7	6	0.90
	18–64	E	7	6	1.30
	18–64	A	7	12	\$0.50
	18–64	B	7	12	0.90
	18–64	C	7	12	1.00
	18–64	E	7	12	1.50

A-34051 On-the-Job Accident Disability	18–64	A	0	6	\$0.80
	18–64	B	0	6	1.20
	18–64	C/E	0	6	2.00
	18–64	A	0	12	\$1.00
	18–64	B	0	12	1.50
	18–64	C/E	0	12	2.50
	18–64	A	7	6	\$0.70
	18–64	B	7	6	1.00
	18–64	C/E	7	6	1.70
	18–64	A	7	12	\$0.90
	18–64	B	7	12	1.30
	18–64	C/E	7	12	2.20

Optional Disability Riders

Monthly Premium Rates per \$100 of Monthly Benefit

Payroll

Form	Issue Ages	Industry Class	Elimination Period in Days	Benefit Period in Months	Individual
A-34052 Sickness Disability	18–49	A	14	6	\$1.80
	50–64	A	14	6	2.60
	18–49	B	14	6	2.00
	50–64	B	14	6	2.90
	18–49	C	14	6	2.10
	50–64	C	14	6	3.90
	18–49	E	14	6	3.00
	50–64	E	14	6	5.00
	18–49	A	14	12	\$2.10
	50–64	A	14	12	2.90
	18–49	B	14	12	2.40
	50–64	B	14	12	3.70
	18–49	C	14	12	2.50
	50–64	C	14	12	4.90
	18–49	E	14	12	3.50
	50–64	E	14	12	6.30
A-34053 Spouse Off- the-Job Accident Disability	18–64	All	0	6	\$1.20

Optional Disability Riders

Monthly Premium Rates per \$100 of Monthly Benefit

Payroll

Form	Issue Ages	Industry Class	Elimination Period in Days	Benefit Period in Months	Individual
A-34052 Sickness Disability	18–49	A	14	6	\$1.80
	50–64	A	14	6	2.60
	18–49	B	14	6	2.00
	50–64	B	14	6	2.90
	18–49	C	14	6	2.10
	50–64	C	14	6	3.90
	18–49	E	14	6	3.00
	50–64	E	14	6	5.00
	18–49	A	14	12	\$2.10
	50–64	A	14	12	2.90
	18–49	B	14	12	2.40
	50–64	B	14	12	3.70
	18–49	C	14	12	2.50
	50–64	C	14	12	4.90
	18–49	E	14	12	3.50
	50–64	E	14	12	6.30

A-34053 Spouse Off- the-Job Accident Disability	18–64	All	0	6	\$1.20
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Rate Calculation Example

Assume selecting Level 2 base policy with two-parent coverage, occupational code B, age 40, biweekly mode, with additional Off-the-Job Disability Rider with seven-day elimination period, 12-month benefit period, and ten units of coverage:

\$43.30 x 12	\$519.60	AP Base Plan Annual Premium
(\$0.90 x 10 units) x 12	<u>\$ 97.20</u>	AP Off-the-Job Disability Rider
		\$616.80 Total Annualized Premium
Divided by	26	Modal Factor
	<u>\$ 23.73</u>	Total Biweekly Premium

Modal Factors

Weekly = Annual/52	Biweekly = Annual/26	Semimonthly = Annual/24
Monthly = Annual/12	10-Month = Annual/10	9-Month = Annual/9
8-Month = Annual/8	Quarterly = Annual/4	Semiannual = Annual/2

Section 11

Sales Support Materials

Brochure

Aflac's Personal Accident Indemnity will have two brochures to assist with the sale of the Personal Accident Indemnity. Both brochures will reflect the base policy benefits only. The applicable brochure must be left with the applicant.

- Brochure **A-34175** will be used with policy **A-34100** (Level 1).
- Brochure **A-34275** will be used with policy **A-34200** (Level 2).

Rider Insert Page

There is a separate insert page for each disability rider.

- Insert page **A-34076** lists benefits offered for Off-the-Job Disability Benefit Rider **A-34050**.
- Insert page **A-34077** lists benefits offered for On-the-Job Disability Benefit Rider **A-34051**.
- Insert page **A-34078** lists benefits offered for Sickness Disability Benefit Rider **A-34052**.
- Insert page **A-34079** lists benefits offered for Spouse Off-the-Job Disability Benefit Rider **A-34053**.
- Insert page **A-34175-SS** lists benefits offered for the Accident Specific-Sum Injuries Benefit for Policy Level 1 (**Form A-34100**).
- Insert page **A-34275-SS** lists benefits offered for the Accident Specific-Sum Injuries Benefit for Policy Level 2 (**Form A-34200**).

Mailer

Mailer **A-34090** is available with this product and is designed to target the employee.

Note: Sales materials may vary by state.

Section 12

Claims

To ensure prompt and efficient service, please list all policy numbers when filing a claim.

- Claims for accident, sickness, or initial disability will require Form **S-00198**.
- Claims for continuing disability, whether due to accident or sickness, will require Form **S-13270.1**.
- **Continuing disability claims should be submitted every 30 days.**

AMERICAN FAMILY LIFE ASSURANCE COMPANY OF COLUMBUS (AFLAC)

Attention: Claims Department

Worldwide Headquarters: 1932 Wynnton Road Columbus Georgia 31999-7260

For information or help filing your claim, please call toll-free 1-800-99-AFLAC (1-800-992-3522) or visit our Web site at www.aflac.com.
Toll-free fax number 1-877-44-AFLAC (1-877-442-3522)

FOR ASSOCIATE USE ONLY:

Check the appropriate box: <input type="checkbox"/> Send the insured's check to the agent for delivery. <input type="checkbox"/> Contact the associate only if additional information is needed to complete processing of this claim.	Writing No.: _____ Name: _____ Address: _____ _____
---	---

ACCIDENT AND DISABILITY CLAIM FORM

If you are filing an accident claim:

1. Complete **Section A** below; be sure to fully explain how you were injured.
2. Send us a copy of the hospital bill; if you were treated in the emergency room or a doctor's office, send us a copy of these bills also.
3. Ask your doctor to complete and sign **Section C** on the reverse side of this form for all claims and return the form to us at the above address.

If you are filing for disability benefits

1. Complete **Section A** below; be sure to fully explain how you became disabled.
2. Your employer should answer the questions in **Section B** below. *If you are self-employed:*
 - a. Answer all questions on this side, and
 - b. Send us a copy of your current business license (if required to be licensed) and your most recent quarterly tax returns.
3. Ask your doctor to complete and sign **Section C** on the reverse side of this form for all claims and return the form to us at the above address.

SECTION A: PATIENT'S INFORMATION Please answer each question COMPLETELY.

LAST	FIRST	MIDDLE	SEX	BIRTH DATE ____/____/____	MARITAL STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> OTHER	SOCIAL SECURITY # ____-____-____
ADDRESS STREET & NUMBER			CITY		STATE AND ZIP CODE	
<input type="checkbox"/> FULL-TIME STUDENT <input type="checkbox"/> PART-TIME STUDENT			RELATIONSHIP TO POLICYHOLDER <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> STEPCHILD		POLICYHOLDER POLICY NUMBER(S)	

1. Is claim due to an accident or a disability caused by an accident? ☐ Yes ☐ No Date of accident: ____/____/____
Describe how accident occurred: _____
If auto accident, was patient: ☐ driver ☐ passenger ☐ unknown ****If driver, a copy of the police report is required.****
2. Is claim due to disability caused by a sickness? ☐ Yes ☐ No If yes, briefly describe sickness: _____
3. Is claim due to disability related to ☐ pregnancy ☐ complications of pregnancy? Please explain: _____
Are you pregnant now? ☐ Yes ☐ No Date of delivery or expected date of delivery: ____/____/____

SECTION B: EMPLOYER'S INFORMATION Please complete if filing for disability.

Name and address of patient's employer: _____

Number of hours per week: _____ Monthly salary: _____ Date of hire: ____/____/____ Is disability due to an accident that occurred on the job? ☐ Yes ☐ No If yes, name of Workers' Compensation carrier: _____

Dates employee did not work due to accident or sickness: ____/____/____ to ____/____/____ Is he/she still employed? ☐ Yes ☐ No
If no, when did employment terminate? ____/____/____ If yes, please indicate date employee is expected to return to work. ____/____/____

Is employee currently working ☐ Full-time ☐ Part-time ☐ Light duty Number of hours worked per week: _____

If Light Duty, is the employee's current salary at least 80% of his or her previous salary? ☐ Yes ☐ No

Please list job duties employee is unable to perform and the percentage of time this requires daily:

_____%
_____%

Was employer authorization to include disability insurance signed? ☐ Yes ☐ No

Does employer pay a portion of the disability premium for the employee? ☐ Yes ☐ No If yes, what percent? _____%

Indicate if employee is exempt from the following deductions: ☐ Social Security ☐ Medicare Does the employee pay disability premiums with pre-tax dollars? ☐ Yes ☐ No If yes, FICA deductions will be deducted from claim payments.

Please note: the employer is required to report disability benefits paid on pre-tax plans on its Form 941 and the employee's Form W-2.

SIGNATURE OF EMPLOYER _____	TITLE _____	DATE _____
PLEASE PRINT FULL NAME _____	PHONE NUMBER _____	

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.

AMERICAN FAMILY LIFE ASSURANCE COMPANY OF COLUMBUS (AFLAC)

Attention: Claims Department

Worldwide Headquarters: 1932 Wynnton Road Columbus, Georgia 31999-7260

For information or help filing your claim, please call toll-free 1-800-99-AFLAC (1-800-992-3522) or visit our website at www.aflac.com.
Toll-free fax number 1-877-44-AFLAC (1-877-442-3522)

ACCIDENT AND DISABILITY CLAIM FORM**SECTION C: DOCTOR'S INFORMATION Please answer each question COMPLETELY.**

LAST	FIRST	MIDDLE	SEX	BIRTH DATE	MARITAL STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> OTHER	SOCIAL SECURITY #
ADDRESS STREET & NUMBER			CITY	STATE AND ZIP CODE		PHONE NUMBER
<input type="checkbox"/> FULL-TIME STUDENT <input type="checkbox"/> PART-TIME STUDENT	RELATIONSHIP TO POLICYHOLDER <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> STEPCCHILD		<input type="checkbox"/> SELF	POLICYHOLDER		POLICY NUMBER(S)

DIAGNOSIS	LIST ANY CHRONIC SICKNESS OR DISEASE	ONSET DATE

- Is this claim for: ☐ An accident ☐ A disability due to an accident? Give date and place of accident: _____
Give details of the accident: _____
If auto accident, was patient: ☐ driver ☐ passenger ☐ unknown
- Is this claim for ☐ Disability due to sickness? ☐ Disability due to pregnancy? ☐ Disability due to complications of pregnancy?
Date of delivery or expected delivery: ____/____/____ Type of delivery: ☐ Vaginal ☐ Caesarean
If filing for complications, please explain: _____
- Is this accident/sickness covered by Medicaid/state aid? ☐ Yes ☐ No
- Symptoms first occurred on: ____/____/____ Patient first consulted you for this condition on ____/____/____.
- Has patient ever had same or similar condition? ☐ No ☐ Yes If yes, state when and describe: _____
- Referring physician (name/address): _____
- If patient was hospitalized for this condition, list dates and name(s) of hospital(s): _____

DATES OF SERVICE	PLACE OF SERVICE (IP/OP)	PROCEDURE DESCRIPTION	# UNITS	CODE: CPT/HCPCS/RVS	DIAGNOSIS CODE ICD-9	CHARGE
If patient is disabled, please answer Questions 8 through 11:						TOTAL \$

- If patient is disabled, give dates of disability: from ____/____/____ Will return to work on: ____/____/____
- What specific job duties is patient unable to perform? _____
- Is patient ☐ Ambulatory? ☐ Bed-confined? ☐ House-confined? ☐ Hospital-confined? ☐ Other? _____
- If retired or employed less than 30 hours per week, which activities of daily living (ADLs) is patient unable to perform?
Check all that apply: ☐ Continence ☐ Transferring ☐ Dressing ☐ Toileting ☐ Eating ☐ Bathing (PA only)

Date: _____, _____ Signed: _____
(Attending Physician)Name of attending physician (please print): _____
Tax ID or Social Security Number

(Street Address) (City or Town) (State and Zip Code) (Area Code Phone)

I hereby request and authorize any health care provider to furnish to AMERICAN FAMILY LIFE ASSURANCE COMPANY OF COLUMBUS (AFLAC) or its representative any and all medical information concerning any sickness or injury I may have suffered, including HIV testing and the diagnosis and treatment of communicable diseases, ARC, AIDS, chemical dependency or psychiatric sickness.

Persons signing may receive a copy of this authorization. Any copy of this authorization shall have the same authority as the original.

SIGNATURE OF PATIENT; IF MINOR, PARENT MUST SIGN

DATE

If signed on behalf of another, state the relationship. _____ (Only if patient is unable to sign)
(Expires six months from date stated above unless indicated otherwise or revoked earlier.)

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.

AMERICAN FAMILY LIFE ASSURANCE COMPANY OF COLUMBUS (AFLAC)

Attention: Claims Department

Worldwide Headquarters: 1932 Wynnton Road Columbus, GA 31999-7260

For information or help filing your claim, please call toll-free 1-800-99-AFLAC (1-800-992-3522) or visit our Web site at www.aflac.com

Toll-free fax number 1-877-44AFLAC (1-877-442-3522)

CLAIM FORM FOR CONTINUING DISABILITY ONLY
(If filing first claim for disability, use Form S-00198)**PART A: PATIENT'S INFORMATION**

LAST	FIRST	MIDDLE	ADDRESS - STREET & NUMBER	
CITY		STATE/ZIP CODE	BIRTH DATE	AREA CODE & PHONE NO.
POLICY NO.			SOCIAL SECURITY NO.	

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.

PART B: DOCTOR'S INFORMATION FOR CONTINUING DISABILITY ONLY**Please answer each question as completely as possible.**Is this claim for continuation of a previous disability? ☐ Yes ☐ No What is the diagnosis? _____Is disability due to: ☐ An accident? ☐ A sickness? ☐ Pregnancy? ☐ Complications of pregnancy?

If due to an accident, when did the accident occur? ____/____/____ If due to a sickness, symptoms first occurred on: ____/____/____

Patient first consulted you for this condition on ____/____/____ Date of initial disability due to this diagnosis: ____/____/____

Date of last treatment: ____/____/____ Type and frequency of treatment: _____

If pregnant, expected date of delivery: ____/____/____

If filing for pregnancy post-partum, what was delivery date? ____/____/____ Was delivery ☐ Vaginal ☐ Caesarean

Is patient released to return to work?

☐ Yes - May return to work on: ____/____/____ List any work restrictions: _____☐ No - Date expected to return to work: ____/____/____

DATE SIGNATURE (attending physician) TAX ID or SOCIAL SECURITY NUMBER

PRINT NAME OF ATTENDING PHYSICIAN TELEPHONE

STREET ADDRESS CITY OR TOWN STATE ZIP CODE

PART C: EMPLOYER'S INFORMATION FOR CONTINUING DISABILITY ONLY**To be completed by Human Resources/Payroll Department****Please answer each question as completely as possible.**Is this claim for continuation of a previous disability? ☐ Yes ☐ No If yes, date employee was first out for this disability: ____/____/____Is disability due to an accident that occurred on the job? ☐ Yes ☐ NoIs claimant still employed? ☐ Yes ☐ No If no, date of termination: ____/____/____

Has employee returned to work?

☐ No Date expected to return to work: ____/____/____☐ Yes Date returned to work: ____/____/____ ☐ Full-time ☐ Part-time ☐ Light dutyIf yes, is the employee's current salary at least 80% of his or her previous salary? ☐ Yes ☐ No Number of hours worked per week: _____Is employee performing all job duties? ☐ Yes ☐ No If no, what job duties is insured unable to perform, and what percentage of the day

do these duties require? _____ %

Will you continue to remit the employee's premiums during this disability? ☐ Yes ☐ NoAre disability insurance premiums paid with pre-tax dollars? ☐ Yes ☐ NoIf yes, indicate if employee is exempt from the following deductions: ☐ Social Security ☐ MedicareDoes employer pay a portion of the disability premiums? ☐ Yes ☐ No If yes, what percent? _____ %

SIGNATURE of EMPLOYER TITLE DATE

PLEASE PRINT FULL NAME TELEPHONE

STREET ADDRESS CITY OR TOWN STATE ZIP CODE

Section 13

Off-the-Job Personal Accident Indemnity

The Off-the-Job Personal Accident Indemnity benefits are identical to the Personal Accident Indemnity benefits, but are payable only for accidents that occur off the job. This policy is ideal for accounts with concerns that accident coverage may increase their on-the-job accidents or for accounts (such as airlines or taxis) whose primary activities are excluded from coverage.

The **Off-the-Job** Personal Accident Indemnity forms are identical to the Personal Accident Indemnity policies **with the following exceptions:**

- 1. Different policy form number:**
A-34300 is the form number for the Level 1 **Off-the-Job** Personal Accident Indemnity Policy.
A-34400 is the form number for the Level 2 **Off-the-Job** Personal Accident Indemnity Policy.
- 2. Different application form number:**
A-34301 is the form number for the **Off-the-Job** PAI with disability application.
A-34301A is the form number for **Off-the-Job** PAI base application (no disability riders).
- 3. Different outline of coverage form number:**
A-34325 is the form number for the Level 1 **Off-the-Job** Personal Accident Indemnity outline of coverage.
A-34425 is the form number for the Level 2 **Off-the-Job** Personal Accident Indemnity outline of coverage.
- 4. Different brochure form number and insert:**
A-34375 is the form number for the Level 1 **Off-the-Job** Personal Accident Indemnity brochure and A-34375-SS is the corresponding Specific-Sum Injuries insert.
A-34475 is the form number for the Level 2 **Off-the-Job** Personal Accident Indemnity brochure and A-34475-SS is the corresponding Specific-Sum Injuries insert.

The **Off-the-Job** Personal Accident Indemnity administrative guidelines are identical to the Personal Accident Indemnity policies **with the following exceptions:**

1. The On-the-Job Disability Benefit Rider (A-34051) **IS NOT AVAILABLE** with the **Off-the-Job** PAI.
2. The other three riders—Off-the-Job Accident Disability Rider, Sickness Disability Rider, and the Spouse Off-the-Job Accident Disability Rider—**are** available with the **Off-the-Job** PAI.
3. The **Off-the-Job** Personal Accident Indemnity **IS NOT AVAILABLE** for purchase by the field force.
4. The **Off-the-Job** Personal Accident Indemnity **IS NOT AVAILABLE ON A DIRECT BASIS**. It is available for purchase only on a **PAYROLL BASIS**.
5. The plan codes and premiums for the **Off-the-Job** Personal Accident Indemnity plan **are different**.

All other Personal Accident Indemnity administrative procedures, including the Disability Benefits Limits chart (Form M-1019) and the commissions, will also apply to the Off-the-Job Personal Accident Indemnity product.

Off-the-Job
Personal Accident Indemnity Policy
(Series A-34400 Level 2)

Two levels of the **Off-the-Job** Personal Accident Indemnity plan are available: Form **A-34300** (Level 1) and Form **A-34400** (Level 2). We will use Form **A-34400** for illustrative purposes in this manual.

This is a sample base policy to be used for training purposes only. **Benefits and limitations and exclusions may vary by state; please refer to your specific state introduction packet for complete details.**

OFF-THE-JOB ACCIDENT-ONLY POLICY

This is an Off-the-Job accident-only policy;
it does not pay benefits for Injuries occurring On-the-Job or Sickness.

IMPORTANT: This is a limited policy.
Read it carefully with the Outline of Coverage, if applicable.

In this policy, you, the Insured as shown in the Policy Schedule, are referred to as "you," "your," or "yours." **American Family Life Assurance Company of Columbus (AFLAC)**, a stock company, is referred to as "we," "our," "us," or "AFLAC."

CONSIDERATION

We promise to insure you for the benefits described in this policy. We make this promise in consideration of the application for this policy and the payment of all premiums when due.

YOUR RIGHT TO EXAMINE THIS POLICY

It is important to us that you are satisfied with this policy and that it meets your insurance needs. If you are not satisfied, you may return it within 30 days after you receive it. Send it to our associate (duly licensed agent) or to AFLAC Worldwide Headquarters, 1932 Wynnton Road, Columbus, Georgia 31999. You will receive a full refund of all premiums paid, and your policy will be void from its Effective Date. If you return the policy, please note in writing: "This policy is returned for cancellation and refund of premium."

IMPORTANT NOTICE: Please read your application attached to this policy. This policy is issued on the basis that the information shown on the application is correct and complete to the best of your knowledge and belief. Carefully check the application. Write to us within 30 days of the date you receive this policy if any information shown on it is not correct or complete. Incorrect information can result in the denial of a claim or termination of this policy. No associate (duly licensed agent) may change this policy or waive any of its provisions.

THIS POLICY IS GUARANTEED-RENEWABLE FOR YOUR LIFETIME, SUBJECT TO OUR RIGHT TO CHANGE PREMIUMS BY CLASS UPON ANY RENEWAL DATE.

We agree that this policy will never be restricted by the addition of any rider without your consent, nor will renewal be refused because of any change in a covered person's health or physical condition. You are guaranteed the right to renew this policy for your lifetime by the payment of premiums at the rate in effect at the beginning of each term. We may change the established premium rate, but only if the rate is changed for all policies of this class. While this policy is in force, no change will be made in your class because of the age, sex, or physical condition of any covered person(s). "Class" means all policies of this form number and premium classification in your state that are then in force. If the established premium rate changes, we will notify you in writing at your last known address at least 30 days before the change becomes effective.

American Family Life Assurance Company of Columbus (AFLAC)
Worldwide Headquarters: 1932 Wynnton Road, Columbus, Georgia 31999
Call toll-free 1-800-99-AFLAC (1-800-992-3522).

INDEX

Insured.....	Policy Schedule
Definitions.....	Part 1
Limitations and Exclusions.....	Part 2
Right of Conversion	Part 3
Uniform Provisions.....	Part 4
Benefits.....	Part 5

Policy Schedule

INSURED: John A. Doe

POLICY NUMBER: 111-2222

TYPE OF COVERAGE: Individual

COVERAGE: XXXXXX
AAABBB

MODE OF PAYMENT: Monthly

DISABILITY BENEFIT PERIOD:

ELIMINATION PERIOD:

Accident:
Sickness:
Rider:

Accident:
Sickness:
Rider:

PREMIUMS

Policy: \$XX
Rider: \$XX

EFFECTIVE DATES

Policy: XX/XX/XX
Riders: XX/XX/XX

In witness whereof, AFLAC's president and secretary signed this policy in Columbus, Georgia, as of the policy Effective Date shown in the Policy Schedule.

ABCD

Joey M. Loudermilk, Secretary

ABCD

Daniel P. Amos, President

This policy is a contract between you and AFLAC.

READ YOUR POLICY CAREFULLY.

Part 1

DEFINITIONS

- A. ACCIDENTAL-DEATH OR -DISMEMBERMENT:** death or Dismemberment caused by an accident that occurs on or after the Effective Date of coverage and while coverage is in force, independent of disease, bodily infirmity, or any other cause. See the Limitations and Exclusions section for death or Dismemberment not covered by this policy.
- B. AMBULATORY SURGICAL CENTER:** a facility, licensed as such, that provides surgical services on an outpatient basis. This does not include a Physician's or dentist's office, clinic, or other such location.
- C. COMA:** a continuous state of profound unconsciousness, diagnosed or treated after the Effective Date of this policy, lasting for a period of seven or more consecutive days, characterized by the absence of: 1) spontaneous eye movements, 2) response to painful stimuli, and 3) vocalization. The condition must require intubation for respiratory assistance.
- D. CHIP FRACTURE:** a Fracture in which a piece of the bone is broken off near a joint at a place where a ligament is usually attached. It must be diagnosed by a Physician through the use of an X-ray.
- E. 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 a proper authority to transport passengers for a fee. Common-carrier vehicles are limited to airplanes, trains, buses, trolleys, and boats that operate on a regularly scheduled basis between predetermined points or cities. **A taxi is not a common-carrier vehicle.**
- F. DISLOCATION:** a completely separated joint. It must be diagnosed as a Dislocation by a Physician within 72 hours after the date of the accident. The Dislocation must require correction by a Physician. It can be corrected by open or closed Reduction.
- G. DISMEMBERMENT OR LOSS OF (with or without reattachment):** (1) Arm - actual severance above the elbow; (2) Leg - actual severance above the knee; (3) Hand - actual severance above the wrist; (4) Foot - actual severance above the ankle; (5) Finger - actual severance at the joint (proximate to the first interphalangeal joint) where it is attached to the hand; (6) Toe - actual severance at the joint (proximate to the first interphalangeal joint) where it is attached to the foot; and (7) Eye - loss of the eye or permanent loss of vision such that central visual acuity cannot be corrected to better than 20/200. **Loss of use does not constitute Dismemberment, except as stated above in (7) Eye.**
- H. EFFECTIVE DATE:** the date shown in the Policy Schedule. The Effective Date of the policy **is not** the date you signed the application for coverage.
- I. FRACTURE:** a break in a bone that can be seen by X-ray. It must be diagnosed as a Fracture by a Physician within 14 days after the date of the accident. The Fracture must require correction by a Physician. It can be corrected by open or closed Reduction.
- J. HOSPITAL:** a legally operated institution licensed by the state in which it is located that maintains and uses a laboratory, X-ray equipment and an operating room on its premises or

in facilities available to it on a prearranged, written, contractual basis. The institution must also have permanent and full-time facilities for the care of overnight-resident bed patients under the supervision of one or more licensed Physicians, provide 24-hour-a-day nursing service by or under the supervision of a registered professional nurse, and maintain the patients' written histories and medical records on the premises. The term "Hospital" also includes Ambulatory Surgical Centers and satellite emergency centers. The term "Hospital" does not include any institution or part thereof used as a Rehabilitation Unit; 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.

- K. HOSPITAL CONFINEMENT:** a stay of a covered person confined to a bed in a Hospital for which a room 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.
- L. IMMEDIATE FAMILY:** anyone related to you in the following manner: your spouse; brothers or sisters (includes stepbrothers and stepsisters); children (includes stepchildren); parents (includes stepparents); grandchildren; father-in-law or mother-in-law; and spouses, as applicable, of any of these.
- M. 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 this policy.
- N. INTENSIVE CARE UNIT (ICU):** a specifically designated facility of the Hospital that provides the highest level of medical care and that is restricted to those patients who are critically ill or injured. Such facilities must be separate and apart from the surgical recovery room and from rooms, beds, and wards customarily used for patient confinement. The ICU must be permanently equipped with special lifesaving equipment for the care of the critically ill or injured, and the patients must be under constant and continual observation by nursing staffs assigned exclusively to the ICU on a full-time basis. These units must be listed as Intensive Care Units in the current edition of the American Hospital Association Guide or be eligible to be listed therein. This guide lists three types of facilities that meet this definition: (1) Intensive Care Units, (2) Cardiac Intensive Care Units, and (3) Infant (Neonatal) Intensive Care Units.
- O. OFF-THE-JOB ACCIDENT:** an accident that occurs while you are not working at any job for pay or benefits.
- P. ON-THE-JOB ACCIDENT:** an accident that occurs while you are working at any job for pay or benefits.
- Q. OTHER ACCIDENTS:** accidents that occur on or after the Effective Date of coverage and while coverage is in force that are not classified as Common-Carrier Accidents and that are not specifically excluded in the Limitations and Exclusions section.
- R. PARALYSIS:** 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 30 days. Your Paralysis must be confirmed by your attending Physician.

- S. PERIOD OF HOSPITAL CONFINEMENT:** a time period of Hospital Confinement that starts while this policy is in force. If the confinement follows a previously covered confinement, it will be deemed a continuation of the first confinement unless the later confinement is the result of an entirely unrelated Injury or the confinements are separated by 30 days or more.
- T. PHYSICAL THERAPIST (also known as "Physiotherapist"):** a licensed specialist in physical therapy.
- U. PHYSICIAN:** a legally qualified person, other than a member of your Immediate Family, who is licensed as a Physician by the state to treat the type of condition for which a claim is made.
- V. PROSTHETIC DEVICE/PROSTHESIS:** an artificial device designed to replace a missing part of the body.
- W. REHABILITATION UNIT:** a unit of a Hospital providing coordinated multidisciplinary physical restorative services to inpatients under the direction of a Physician who is knowledgeable and experienced in rehabilitative medicine. Beds must be set up and staffed in a unit specifically designated for this service.
- X. REDUCTION:** open (surgical) or closed (manipulative) repair of a Fracture or Dislocation.
- Y. SICKNESS:** a disease, disorder, infection, or any other abnormal physical condition that is not caused by an Injury that is first manifested or treated more than 30 days after your Effective Date of coverage and while coverage is in force. "Sickness" includes diseases or conditions resulting from insect bites or infestations by microorganisms. If you purchase the Optional Sickness Disability Rider Series A-34052, and the disease or disorder is first manifested or treated within the first 30 days after your Effective Date of coverage, any resulting disability will not be covered unless it begins more than 12 months after the Effective Date of coverage.
- Z. TYPE OF COVERAGE:** see your Policy Schedule to determine the Type of Coverage issued: Individual, Named Insured/Spouse Only, One-Parent Family, or Two-Parent Family.
- (1) **Individual:** coverage for only you (the Insured listed in the Policy Schedule).
- (2) **Named Insured/Spouse Only:** coverage for only you (the Insured) and your spouse.
- (3) **One-Parent Family:** coverage for you (the Insured) and all of your dependent children (or those of your spouse) who are unmarried and under age 19. "Dependent children" are your natural children, stepchildren, or legally adopted children who are unmarried, who are under age 19, and who qualify as legal dependents for tax exemption purposes under the United States Internal Revenue Service Tax Code. Coverage of a dependent child will be extended to age 23 if he/she is enrolled as a full-time student in a post secondary institution of higher learning for five calendar months in that calendar year; or, if not enrolled, would have been eligible to enroll and was prevented from enrolling due to Sickness or Injury. Children born to dependent children of the Named Insured or spouse are not covered under this policy.
- (4) **Two-Parent Family:** coverage for you (the Insured), your spouse, and all of your dependent children (or those of your spouse) who are unmarried and under age 19. Dependent children are your natural children, stepchildren, or legally adopted children who are unmarried, who are under age 19, and who qualify as legal dependents for tax exemption purposes under the United States Internal Revenue Service Tax Code. Coverage of a

dependent child will be extended to age 23 if he/she is enrolled as a full-time student in a post secondary institution of higher learning for five calendar months in that calendar year; or, if not enrolled, would have been eligible to enroll and was prevented from enrolling due to Sickness or Injury. Children born to dependent children of the Insured or the Insured's spouse are not covered under this policy.

Persons covered under Individual, Named Insured/Spouse, One-Parent Family, or Two-Parent Family coverage are referred to as "covered persons." Newborn children are automatically covered under the terms of the policy from the moment of birth, and adopted children are covered from the date of petition. If Individual or Named Insured/Spouse coverage is issued and you desire uninterrupted coverage for a newborn or adopted child, you must notify AFLAC within 31 days of the child's birth or the date of petition for adoption. Upon notification, AFLAC will convert this policy to One-Parent Family or Two-Parent Family coverage and advise you of the additional premium due. If One-Parent Family or Two-Parent Family coverage is in force, it is not necessary for you to notify AFLAC of the birth of your child or the date of petition for adoption, and an additional premium payment is not required. If you wish any other person to be covered after the Effective Date of the policy, you must apply for such coverage, and that person must be added by endorsement. Insurance for persons added by endorsement becomes effective on the date specified on the endorsement.

The insurance on any dependent child will terminate on the policy anniversary date following the child's 19th birthday (23rd if a full-time student), the child's marriage, or at the time the child no longer qualifies as a legal dependent for tax exemption purposes under the United States Internal Revenue Service Tax Code, whichever occurs first. Termination will be without prejudice to any prior claim. AFLAC's acceptance of premium after such date will be considered as premium for only the remaining persons who qualify as covered persons under the policy. Coverage provided under any One-Parent Family or Two-Parent Family contract will include any other unmarried 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 before age 19. Proof of such incapacity and dependency must be furnished to AFLAC by you within 31 days of the dependent child's 19th birthday. Proof of continued incapacity and dependency must be furnished at AFLAC's request, but not more often than annually, after the two-year period following the child's 19th birthday.

Part 2

LIMITATIONS AND EXCLUSIONS

- A. We will not pay benefits for an accident that is caused by or occurs as a result of a covered person being injured On-the-Job.**
- B. We will not pay benefits for services rendered by a member of the Immediate Family of a covered person.**
- C. We will not pay benefits for an accident or Sickness that is caused by or occurs as a result of a covered person's:**
 - 1. 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);**

2. Driving any taxi for wage, compensation, or profit;
3. Mountaineering using ropes and/or other equipment; parachuting; or hang gliding;
4. Participating in, or attempting to participate in, an illegal activity that is defined as a felony, whether charged or not ("felony" is as defined by the law of the jurisdiction in which the activity takes place); or being incarcerated in any type penal institution;
5. Intentionally self-inflicting bodily Injury or attempting suicide, while sane or insane;
6. Having cosmetic surgery or other elective procedures that are not medically necessary, or having dental treatment except as a result of Injury;
7. Being exposed to war or any act of war, declared or undeclared;
8. Actively serving in any of the armed forces, or units auxiliary thereto, including the National Guard or Army Reserve;
9. Participating in any form of flight aviation other than as a fare-paying passenger in a fully licensed, passenger-carrying aircraft;
10. Participating in any sport or sporting activity for wage, compensation, or profit, including officiating or coaching; or racing any type vehicle in an organized event.

Part 3 **RIGHT OF CONVERSION**

A. Dissolution of Marriage:

If you and your spouse dissolve your marriage by a valid decree of dissolution of marriage and your spouse was covered under Named Insured/Spouse Only or Two-Parent Family coverage, coverage for your spouse will terminate. Your ex-spouse can apply for and receive, without evidence of insurability, a policy in his/her occupation class providing coverage not greater than the terminated coverage. To obtain the policy, your ex-spouse must apply to AFLAC within 60 days following the entry of the decree of dissolution of marriage and pay the appropriate premium. Conversion rights do not apply to Off-the-Job Accident Disability Rider Series A-34050 and Sickness Disability Rider Series A-34052. If your ex-spouse is covered under the Spouse Off-the-Job Rider Series A-34053, this rider will terminate. However, the spouse rider will convert to the Off-the-Job Rider Series A-34050 for the same amount of coverage as provided in the Spouse Off-the-Job Rider Series A-34053. If additional coverage is desired, additional underwriting will be required.

If such dissolution of marriage occurs, the Named Insured under this policy at the time of the dissolution will retain that status. Any covered dependents may be insured under either policy, but not both.

B. Death:

In the event of your death, your spouse (if covered hereunder) will become the Named Insured and coverage will continue in the same occupation class. Conversion rights do not apply to Off-the-Job Accident Disability Rider Series A-34050 and Sickness Disability Rider Series A-34052. If your spouse is covered under the Spouse Off-the-Job Rider Series A-34053, this rider will terminate. However, the spouse rider will convert to the Off-the-Job Rider Series A-34050 for the same amount of coverage as provided in the Spouse Off-the-Job Rider Series A-34053. If

additional coverage is desired, additional underwriting will be required.

C. Termination of Dependency:

A dependent child covered under this policy who has reached his or her 19th birthday or who has married and desires to continue coverage as the Insured under a separate policy may do so by notifying AFLAC of the request in writing. The child will have the right to continue coverage as an Insured on a separate equivalent policy in his/her occupation class without a requirement for evidence of insurability and without interruption in coverage, provided AFLAC receives written notification of the request before 30 days after the policy anniversary date following the dependent's 19th birthday or marriage. Conversion rights do not apply to Off-the-Job Accident Disability Rider Series A-34050 and Sickness Disability Rider Series A-34052.

Part 4
UNIFORM PROVISIONS

- A. ENTIRE CONTRACT; CHANGES:** This policy, together with the application, endorsements, benefit agreements, riders, and attached papers, if any, constitutes the entire contract of insurance. No change in this policy is valid until approved in writing by the secretary and president of AFLAC at our worldwide headquarters. Any such change must be noted on or attached hereto. No associate (duly licensed agent) has the authority to change this policy or to waive any of its provisions.
- B. TIME LIMIT ON CERTAIN DEFENSES:** After two years from the Effective Date of this policy, any misstatements, except fraudulent misstatements, made by you in the application shall not be used to void the policy or to deny a claim for care commencing after the expiration of such two-year period.
- C. TERM:** The term of this policy begins at midnight, standard time, at the place where you reside on the Effective Date shown in the Policy Schedule. It ends at midnight, at the same standard time, on the first renewal date. Each renewal term ends at midnight, at the same standard time, on the next following renewal date. Renewal dates are determined by the mode of payment. The mode of payment for the original term of this policy is shown in the Policy Schedule. An annual premium will maintain this policy in force for 12 months, semiannual for six months, quarterly for three months, and monthly for one month. Premium for a term is due on the first day of that term. If you fail to pay your premium by the end of the grace period, coverage under this policy will terminate.
- D. MISSTATEMENT OF AGE:** If an age has been misstated on the application, the benefits will be those the premium paid would have purchased at the correct age. We will refund all unearned premiums paid, less any benefits paid, if the misstated age at the time of application was outside the age limits for this policy.
- E. REINSTATEMENT:** You may request reinstatement of your policy from our associate (duly licensed agent) or from AFLAC. If your policy has lapsed for nonpayment of premium and we accept a later payment without requiring an application, your policy shall be reinstated. If we require a written application and provide you with a conditional receipt, your policy will be reinstated upon our approval of the application. If we do not notify you of our disapproval in writing within 45 days of the date of your application, your policy shall be deemed reinstated. The reinstated policy shall cover only loss resulting from accidental Injury that takes place after the date of reinstatement and loss resulting from Sickness (if you purchased Rider Form Series A-34052) that begins more than 10 days after the date of reinstatement. In all other

respects, the Insured and AFLAC shall have the same rights as provided under the policy immediately before the due date of the defaulted premium, subject to any provisions added in connection with the reinstatement. Any premium accepted in connection with a reinstatement will not be applied to any period prior to the date of reinstatement.

- F. 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.
- G. MISSTATEMENT OF OCCUPATION OR INCOME:** If your occupation has been misstated, the benefits will be those that the premiums paid would have purchased for your correct occupation. If your income has been misstated, the benefit payable will be that which would have been allowed for your true income level, and any overpayment of premium will be refunded.
- H. NOTICE OF CLAIM:** Written notice of claim must be given within 60 days after a covered loss starts or as soon as reasonably possible. The notice can be given to AFLAC at our worldwide headquarters or to your associate (duly licensed agent). The notice should include the name of the covered person and the policy number.
- I. CLAIM FORMS:** When we receive a notice of claim, we will send you forms for filing proof of loss. If the forms are not given to you within ten working days, you will meet the proof-of-loss requirements by giving us a written statement of the nature and extent of the loss within the time limit stated in the Proof of Loss provision.
- J. PROOF OF LOSS:** Written proof of loss must be furnished to AFLAC at our worldwide headquarters within 90 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate or reduce any claim if it was not reasonably possible to give proof within such time. However, such proof must be furnished as soon as reasonably possible and in no event (except in the absence of legal capacity) later than 15 months from the time proof is otherwise required.
- K. TIME OF PAYMENT OF CLAIMS:** All benefits payable under this policy will be paid immediately upon receipt of written proof of loss.
- L. PAYMENT OF CLAIMS:** All benefits will be payable to you unless assigned by you or by operation of law. Any accrued benefits unpaid at your death will be paid to your estate.
- M. LEGAL ACTIONS:** Any legal action may not be brought to recover on this policy within 60 days after written proof of loss has been furnished in accordance with the requirements of this policy. Any such action may not be brought after six years from the time written proof of loss is required to be furnished.
- N. CONFORMITY WITH STATE AND FEDERAL STATUTES:** Any provision of this policy that, on its Effective Date, is in conflict with the statutes of the state in which it was issued or with any federal statute is hereby amended to conform to the minimum requirements of such statutes.
- O. PHYSICAL EXAMINATIONS AND AUTOPSY:** AFLAC, at its own expense, shall have the right and opportunity to have a covered person examined by a Physician of our choice as often as it may be reasonably required during the pendency of a claim hereunder, and to have an autopsy performed in the case of death, where autopsy is not forbidden by law.

P. CHANGE OF BENEFICIARY: Unless you made the beneficiary designation in the attached Form A-34400

application irrevocable, you have the right to make a change. The consent of the beneficiary is not required to surrender the policy, assign benefits, or make any other changes to this policy.

- Q. ASSIGNMENT:** We will not assume responsibility for determining the validity of an assignment of your benefits to a provider of services. No such assignment of benefits will be recognized until we receive notice that you have specifically assigned the benefits of your AFLAC policy at our worldwide headquarters.
- R. OTHER INSURANCE WITH AFLAC:** If a person is covered under more than one accident only policy, only one AFLAC policy chosen by you, your beneficiary, or your estate, as the case may be, will be effective. We will pay benefits under the policies for claims that may have been incurred since their respective Effective Dates. We will also return all premiums paid for the canceled policies from the date of duplication, less any benefits paid under these policies from such date.

Part 5

BENEFITS

Benefit A is a preventive benefit; the death, Dismemberment, or Injury of a covered person is not required for this benefit to be payable.

- A. WELLNESS BENEFIT:** After this policy has been in force for 12 months, we will pay \$60 (sixty dollars) if you or any one family member undergoes routine examinations or other preventive testing during the following policy year. Services covered are: annual physical examinations, dental exams, mammograms, Pap smears, eye examinations, immunizations, flexible sigmoidoscopies, prostate-specific antigen tests (PSAs), ultrasounds, and blood screenings. This benefit will become available following each anniversary of the policy's Effective Date for service received during the following policy year and is payable only once per policy each 12-month period following your policy anniversary date. Eligible family members are your spouse and the dependent children of either you or your spouse. Service must be under the supervision of or recommended by a Physician, received while your policy is in force, and a charge must be incurred.

We will pay the following benefits as applicable if a covered person's death, Dismemberment, or Injury is caused by a covered Off-the-Job Accident. Death, Dismemberment, or Injury must be independent of disease or bodily infirmity, or of any cause other than a covered Off-the-Job Accident. A covered accident must also occur while coverage is in force and is subject to the limitations and exclusions.

- B. ACCIDENT EMERGENCY TREATMENT BENEFIT:** If a covered person receives treatment for Injuries sustained in a covered Off-the-Job Accident, we will pay the following benefit for treatment received. This benefit is payable for treatment by a Physician, X-rays, or 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 Off-the-Job Accident, per covered person.

<u>Insured</u>	<u>Spouse</u>	<u>Child</u>
\$120	\$120	\$70

- C. ACCIDENT FOLLOW-UP TREATMENT BENEFIT:** If a covered person receives emergency

treatment for Injuries sustained in a covered Off-the-Job Accident and later requires additional treatment over and above emergency treatment administered in the first 72 hours following the accident, we will pay \$35 (thirty-five dollars) per treatment for such follow-up treatment. We will pay for one treatment per day for up to a maximum of six treatments per covered Off-the-Job Accident, per covered person. The treatment must begin within 30 days of the covered Off-the-Job 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. **This benefit is not payable for the same visit that the Physical Therapy Benefit is paid.**

D. INITIAL ACCIDENT HOSPITALIZATION BENEFIT: When a covered person is confined to a Hospital for at least 24 hours for Injuries sustained in a covered Off-the-Job Accident, we will pay an Initial Accident Hospitalization Benefit of \$1,000 (one thousand dollars), or we will pay \$2,000 (two thousand dollars) if the covered person is admitted directly to an Intensive Care Unit. This benefit is payable only once per Hospital or Intensive Care Unit Confinement and only once per calendar year, per covered person. Confinements must start within 30 days of the accident.

E. ACCIDENT HOSPITAL CONFINEMENT BENEFIT: When a covered person is confined to a Hospital for at least 18 hours for treatment of Injuries sustained in a covered Off-the-Job Accident, we will pay \$250 (two hundred fifty dollars) for each day of Hospital Confinement for which a covered person is charged for a room. We will pay this benefit up to 365 days per covered Off-the-Job Accident, per covered person. Confinements must start within 30 days of the accident.

The Accident Hospital Confinement Benefit and the Rehabilitation Unit Benefit will not be paid on the same day. The highest eligible benefit will be paid.

F. INTENSIVE CARE UNIT CONFINEMENT BENEFIT: While a covered person is receiving the Accident Hospital Confinement Benefit, we will pay an additional \$400 (four hundred dollars) for each day the covered person is confined and charged for a room in an Intensive Care Unit. This Intensive Care Unit Confinement Benefit is payable for up to 15 days per covered Off-the-Job Accident, per covered person. Confinements must start within 30 days of the accident.

G. ACCIDENT SPECIFIC-SUM INJURIES BENEFITS: If a covered person receives treatment for Injuries sustained in a covered Off-the-Job Accident, we will pay the following benefit for the treatment listed.

1. Dislocation (reduced under general anesthesia):

We will pay for no more than two Dislocations per covered Off-the-Job Accident, per covered person.

Benefits are payable for only the first Dislocation of a joint.

	Benefit:	
	Open Reduction	Closed Reduction
a. Hip	\$2,500	\$625
b. Knee or shoulder	\$625	\$250
c. Collar bone	\$1000	\$200
d. Ankle or foot (excluding toes)	\$625	\$200
e. Lower jaw	\$625	\$325
f. Wrist or elbow	\$500	\$250

g. Toe or finger

\$125

\$65

If a Dislocation is reduced with local anesthesia or no anesthesia by a Physician, we will pay **25%** of the amount shown for the closed Reduction Dislocation.

2. Burns (treated by a Physician within 72 hours after a covered Off-the-Job Accident):

Benefit:

	2nd Degree	3rd Degree
Less than 20 square centimeters of the body surface	\$125	\$250
More than 20 but less than 40 square centimeters of the body surface	\$250	\$625
More than 40 but less than 65 square centimeters of the body surface	\$500	\$1,250
More than 65 but less than 160 square centimeters of the body surface	\$750	\$3,750
More than 160 but less than 225 square centimeters of the body surface	\$1,000	\$8,750
More than 225 square centimeters of the body surface	\$1,250	\$12,500

3. Skin Grafts:

If a covered person receives one or more skin grafts for a covered burn, we will pay a total of 50% of the Burn benefit amount we paid for the burn involved.

4. Eye Injury:

Benefit:

Surgical repair	\$300
Removal of foreign body by a Physician	\$65

5. Lacerations, due to a covered Off-the-Job Accident, requiring sutures (must be repaired within 72 hours after the accident and repaired under the attendance of a Physician):

Benefit:

Laceration(s) not requiring sutures and treated by a Physician	\$35
Single laceration less than 5 centimeters	\$65
Lacerations at least 5 centimeters but not more than 15 centimeters (total of all lacerations)	\$250
Lacerations over 15 centimeters (total of all lacerations)	\$500

6. Fractures:

We will pay 25% of the benefit amount shown for the closed Reduction for Chip Fractures and other Fractures not reduced by open or closed Reduction.

We will pay for no more than two Fractures per covered Off-the-Job Accident, per covered person.

Benefit:

	Open Reduction	Closed Reduction
a. Hip	\$2,500	\$1,250
b. Leg	\$1,250	\$625
c. Hand (excluding fingers)	\$625	\$325
d. Foot (excluding toes/heel)	\$625	\$325
e. Wrist, elbow, ankle, kneecap	\$625	\$325
f. Shoulder blade or forearm	\$625	\$325
g. Lower jaw	\$625	\$325
h. Vertebrae (body of), pelvis (excluding coccyx) or sternum	\$1,250	\$625

i. Upper jaw, upper arm or face (excluding nose)	\$750	\$375
j. Rib	\$1,250	\$125
k. Nose, heel or finger	\$625	\$125
l. Coccyx	\$250	\$125
m. Toe	\$250	\$125
n. Vertebral processes	\$1,250	\$200
o. Skull		
depressed	\$1,875	
simple	\$625	

7. Concussion (brain):

Benefit:
\$50

8. Emergency dental work:

Benefit:
Broken teeth repaired with crowns \$200
Broken teeth resulting in extractions \$65

We will pay for no more than one dental benefit per covered accident, per covered person.

9. Coma duration of at least 7 days:

Benefit:
\$12,500

10. Paralysis:

If a covered person suffers Paralysis as a result of a covered Off-the-Job Accident, we will pay the applicable benefit indicated below. The duration of the Paralysis must be a minimum of 30 days.

Benefit:
Quadriplegia (Paralysis of four limbs) \$12,500
Paraplegia (Paralysis of lower limbs) \$6,250

This benefit will be payable once per covered person.

11. Surgical Procedures:

Treatment must be performed within one year of a covered Off-the-Job Accident. Two or more surgical procedures performed through the same incision will be considered one operation and benefits will be paid based upon the most expensive procedure.

Benefit:
Repair of:
Tendons and/or ligaments \$625
Torn Rotator Cuffs \$625
Ruptured discs \$625
Torn knee cartilages \$625
Arthroscopy without surgical repair \$300
Open abdominal (including exploratory laparotomy), cranial, hernia, or thoracic surgery \$1,250

Miscellaneous surgery requiring general anesthesia that is not covered by any other specific-

sum Injury benefit (Only one miscellaneous surgery benefit is payable per 24-hour period even though more than one surgical procedure may be performed.):

Benefit:
\$300

- H. MAJOR DIAGNOSTIC EXAMS:** If a covered person requires one of the following exams for Injuries sustained in a covered Off-the-Job Accident and a charge is incurred, we will pay \$200 (two hundred dollars): CT (computerized tomography) scan, MRI (magnetic resonance imaging), or EEG (electroencephalogram). These exams must be performed in a Hospital, a Physician's office, or an Ambulatory Surgical Center. This benefit is limited to one payment per calendar year, per covered person. No lifetime maximum.
- I. PHYSICAL THERAPY BENEFIT:** If a covered person receives emergency treatment for Injuries sustained in a covered Off-the-Job Accident and later a Physician advises the covered person to seek treatment from a Physical Therapist, we will pay \$35 (thirty-five dollars) per treatment. Physical therapy must be for Injuries sustained in a covered Off-the-Job Accident and must start within 30 days of the covered Off-the-Job Accident or discharge from the Hospital. We will pay for one treatment per day for up to a maximum of 10 treatments per covered Off-the-Job Accident, per covered person. The treatment must take place within six months after the accident. **This benefit is not payable for the same visit that the Accident Follow-Up Treatment Benefit is paid.**
- J. REHABILITATION UNIT BENEFIT:** When a covered person is confined in a Hospital and is transferred to a bed in a Rehabilitation Unit of a Hospital for a covered Off-the-Job Accident, we will pay \$150 (one hundred fifty dollars) per day for each day you are charged for a room. This benefit is limited to 30 days for each covered person per Period of Hospital Confinement and is limited to a calendar year maximum of 60 days. No lifetime maximum.
- The Accident Hospital Confinement Benefit and the Rehabilitation Unit Benefit will not be paid on the same day. The highest eligible benefit will be paid.**
- K. APPLIANCES BENEFIT:** If, as a result of Injuries sustained in a covered Off-the-Job Accident, a covered person requires, as advised by a Physician, the use of a medical appliance as an aid in personal locomotion, we will pay \$125 (one hundred twenty-five dollars). Benefits include and are payable for crutches, wheelchairs, leg braces, back braces, and walkers. This benefit is payable once per covered Off-the-Job Accident, per covered person.
- L. PROSTHESIS BENEFIT:** If a covered person requires use of a Prosthetic Device as a result of Injuries sustained in a covered Off-the-Job Accident, we will pay \$750 (seven hundred fifty dollars). This benefit is not payable for hearing aids, wigs, or any dental aids to include false teeth. This benefit is payable once per covered Off-the-Job Accident, per covered person.
- M. BLOOD/PLASMA/PLATELETS BENEFIT:** If a covered person requires blood/plasma and/or platelets for the treatment of Injuries sustained in a covered Off-the-Job Accident, we will pay \$200 (two hundred dollars). This benefit does not pay for immunoglobulins and is payable only one time per covered Off-the-Job Accident, per covered person.
- N. AMBULANCE BENEFIT:** If a covered person requires ambulance transportation to a Hospital or emergency center for Injuries sustained in a covered Off-the-Job Accident, we will

pay \$200 (two hundred dollars). Ambulance transportation must be within 72 hours of the covered Off-the-Job Accident. We will pay \$1,500 (fifteen hundred dollars) for transportation provided by an air ambulance. A licensed professional ambulance company must provide the ambulance service.

O. TRANSPORTATION BENEFIT: If a covered person requires special treatment and confinement in a Hospital for Injuries sustained in a covered Off-the-Job Accident, we will pay \$600 (six hundred dollars) per round trip. This benefit is not payable for transportation by ambulance or air ambulance to the Hospital. 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 such dependent child). The local attending Physician must prescribe the treatment, and the treatment must not be available locally. This benefit is not payable for transportation to any Hospital located within a 100-mile radius of the site of the accident or residence of the covered person. This benefit is payable for up to three round trips per calendar year, per covered person.

P. FAMILY LODGING BENEFIT: If a covered person requires Hospital Confinement for the treatment of Injuries sustained in a covered Off-the-Job Accident, we will pay \$125 (one hundred twenty-five dollars) per night for one motel/hotel room for a member(s) of the Immediate Family to accompany the covered person. 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. This benefit is payable up to 30 days per covered Off-the-Job Accident.

Q. ACCIDENTAL-DEATH BENEFIT: We will pay the applicable lump-sum benefit indicated below for Accidental Death. Death must occur as a result of Injuries sustained in a covered Off-the-Job Accident and must occur within 90 days of such accident.

	<u>Insured</u>	<u>Spouse</u>	<u>Child</u>
Common-Carrier Accidents	\$150,000	\$150,000	\$25,000
Other Accidents	\$40,000	\$40,000	\$12,500

R. ACCIDENTAL-DISEMBLEMENT BENEFIT: We will pay the applicable lump-sum benefit indicated below for Dismemberment. Dismemberment must occur as a result of Injuries sustained in a covered Off-the-Job Accident and must occur within 90 days of the accident.

Dismemberment or complete loss of, with or without reattachment:

	<u>Insured</u>	<u>Spouse</u>	<u>Child</u>
Both arms and both legs	\$40,000	\$40,000	\$12,500
Two eyes, feet, hands, arms, or legs	\$40,000	\$40,000	\$12,500
One eye, foot, hand, arm, or leg	\$10,000	\$10,000	\$3,750
One or more fingers and/or one or more toes	\$2,000	\$2,000	\$625

Only the highest single benefit per covered person will be paid for Accidental Dismemberment. Benefits will be paid only once for any covered Off-the-Job Accident. If death and Dismemberment result from the same accident, only the Accidental-Death Benefit will be paid.

S. CONTINUATION OF COVERAGE BENEFIT: 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. Your 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 through:
 - (a) your new employer's payroll deduction process or
 - (b) direct payment to AFLAC.

You will again become eligible to receive this benefit after:

1. You re-establish your premium payments through payroll deduction for a period of at least six months, and
2. 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.

Section 14

Off-the-Job Personal Accident Indemnity Plan Codes

The **Off-the-Job** PAI policy has six base plan codes. Refer to Section 8 for the rider plan codes.

Please refer to your specific state introduction packet for complete details.

Base Off-the-Job PAI Plan Codes

	Individual/ Family	Named Insured/Spouse	One-Parent Family
Level 1	AADPA1	AADPB1	AADPC1
Level 2	AADPA2	AADPB2	AADPC2

Rider Plan Codes – refer to Section 8

Section 15

***Off-the-Job
Personal
Accident Indemnity
Premium Rates***

The **Off-the-Job PAI** is available on Premium Quote. No registration fee is required at the time of sale.

Types of Coverage (same as types of coverage for PAI)

- **Individual:** Covers only the named insured listed in the Policy Schedule.
- **Named Insured/Spouse:** Covers only the named insured and spouse.
- **Two-Parent Family:** Covers the named insured, his/her spouse and all dependent children (or those of the spouse). Dependent children are natural children, stepchildren or legally adopted children who are unmarried, under 19 years of age (age 23 if full-time students) and who qualify as legal dependents for tax exemption purposes under the United States Internal Revenue Service Tax Code. (Dependent age varies by state.)
- **One-Parent Family:** Covers the named insured and all dependent children. Dependent children are natural children, stepchildren, or legally adopted children who are unmarried, under 19 years of age (age 23 if full-time students), and who qualify as legal dependents for tax exemption purposes under the United States Internal Revenue Service Tax Code. (Dependent age varies by state.)

Base Off-the Job Accident Coverage

Monthly Premium Rates

PAYROLL

Policy Form	Issue Ages	Industry Class	Individual	One-Parent Family	Named Insured/Spouse	Two-Parent Family
A-34300 Accident Plan Level 1	18–64	A	\$ 14.30	\$ 23.60	\$ 20.20	\$ 29.90
	18–64	B	17.00	24.70	22.80	30.60
	18–64	C	19.60	25.30	25.00	30.80
	18–64	D/E	22.70	27.90	33.00	
A-34400 Accident Plan Level 2	18–64	A	\$ 17.50	\$ 28.90	\$ 24.80	\$33.60
	18–64	B	20.70	30.20	27.80	36.90
	18–64	C	23.50	30.30	30.00	37.20
	18–64	D/E	27.30	33.50	33.10	39.70
Annual, semiannual, and quarterly mode premiums are 12, 6, and 3 times yearly.						

Section 16

Review of the Consultative Sales Process

Principles of Buyer's Decisions

In selling, certain principles are always present. These are known as ***The Five Buying Decisions***. There is a specific order in which these decisions are made by your prospect. Our sales presentation must match this sequence for making purchase decisions.

THE FIVE BUYING DECISIONS ARE:

- 1. The salesperson**
- 2. The company (Aflac)**
- 3. The product**
- 4. The cost (in time and money)**
- 5. The time to buy**

If buyers are allowed to make decisions out of order, we usually lose.

The Nine Acts or Steps of a Sale

There are nine acts or steps in the sales process that correspond to the five buying decisions.

Act 1 Commitment objective (Set a goal to gain an authorization, schedule an appointment, or get a signed application during this call.)

FIRST BUYING DECISION – Sell yourself by following Acts 2, 3, and 4.

Act 2 People skills (Sell yourself during the interview by asking open-ended questions. Build rapport.)

Act 3 Ask the right questions (Uncover existing needs and offer solutions. Don't pitch.)

Act 4 Agree on needs (Confirm that your prospects understand their needs, and that you understand their needs as well.)

SECOND BUYING DECISION – Sell Aflac!

Act 5 Sell the company (Sell Aflac and our products and services as the solution to their problem.)

THIRD BUYING DECISION – Sell the Product

Act 6 Sell the product (Sell them on the benefits and features of your product. The product must meet the prospect's needs.)

FOURTH BUYING DECISION – The Cost (in time and money)

Act 7 Ask for commitment (Summarize what it will do for them and quote costs in terms of time and/or money.)

FIFTH BUYING DECISION – The time to buy

During your presentation, it is important to confirm with the employer whether he/she prefers that you make individual presentations or an employee group presentation. The employer may leave the decision to you. Also determine if the plan is Flex or non-Flex and the current plan's renewal date. Close the sale!

Act 8 Confirm the Sale (The purpose of this step is to avoid buyer's remorse – also known as FUD – fear, uncertainty, and doubt.) Assure the buyer that he/she has made a wise decision, and that you will provide the best service possible; then schedule the enrollment.)

Act 9 Replay the call (Review the call in your own mind so you can duplicate your successes and eliminate your failures.)

Section 17

Marketing PAI and Off-the-Job PAI

New Accounts

When approaching a new company, try to contact the employer, owner, or president of the company first. You can never go wrong by starting at the top with decision-makers. They are busy, but they will see you if you offer something valuable and they know that you will not waste their time. Their power and authority can overcome any obstacles that arise in their business.

The employer, owner, or president of the company usually understands the importance of offering benefit plans and can facilitate the enrollment process. But if this person will not see you, no harm has been done. You simply refocus your energy toward the benefits specialist or human resource person.

The benefits specialist or HR person is certainly involved in this type of decision-making process. They often have extensive knowledge of payroll-deducted insurance and may be the person responsible for implementing our Personal Accident Indemnity plan.

First Buying Decision

Sell yourself. Ask the right questions. Agree on need. Restate need.

Develop rapport. Begin by asking open-ended questions about the business's operations. While asking questions, listen carefully and take notes. Do not give an employer an employee presentation. Forget the pitch.

- What does the business do?
- How is business?
- How many employees do you have?
- What types of employee benefits do you offer your employees now?
- What's the employee participation level in your plan?
- Do your employees share in the costs of their benefits package; if so, what portion do they pay?
- Do you deduct your employees' portion of the premiums before or after tax?
- What would you like to improve about your current benefits package?
- Who are your current providers, and are you satisfied with their service?

If the employer is not familiar with the current benefit structure, ask if the benefits manager or other responsible party is available. If not, reschedule the appointment to include all parties involved in the benefit decision-making process.

Employers respect logic. Adding new benefits or increasing current benefit levels builds employee morale and enhances employer-employee relations.

- If the employer owns a small business and competition for good employees is high, explain that employee benefits are a great recruiting tool.
- Explain that with today's rising **deductibles** and **copayments** and high **managed care** expenses, it is important for employees to have coverage that can help offset unexpected expenses.
- Say, "As I understand it, you have a concern about ... Is that correct?"

Second Buying Decision **Sell the Company**

- Make sure the employer understands how Aflac's voluntary benefits work and that the company doesn't pay a portion of the premium (our policies are 100 percent employee paid). In other words, there is no direct cost to the employer.
- Point out that Aflac's voluntary benefits enhance the employee benefit plan, thereby improving employee retention.
- Provide facts about Aflac. For example: A Fortune 500 company with assets exceeding \$59 billion. Aflac is rated A+ (Superior) by A.M. Best (June 2005). Aflac is the number one provider of guaranteed-renewable insurance (*National Underwriter*, July 2004).
- Refer to similar payroll accounts in the area to which the employer may relate.

Third Buying Decision **Sell the Product**

- We have a plan specifically designed for companies like yours.
- That's why Aflac designed our personal accident plans—to meet the needs of companies just like yours.

Fourth Buying Decision **The Cost (in Time and Money)**

- Summarize the benefits and quote the cost in time and dollars.
- **Group presentation or individual presentation?** During your presentation to the employer, it is important to confirm with the employer whether he/she prefers that you make a group presentation or individual presentations. The employer may leave the decision to you.

Fifth Buying Decision **The Time to Buy – Close the Sale!**

- (Mr./Mrs. Employer), if three or more of your employees want to enroll in our Personal Accident Indemnity plan and wish to have their premiums payroll deducted, you will payroll deduct the premiums for them, won't you?
- (Mr./Mrs. Employer), Aflac's Personal Accident Indemnity plans will significantly improve your employees' perception of your company's current benefits program. How do you see that helping you out? Would you like to go ahead?

Note: Aflac's Business Survey sheet may be downloaded from your Associate Services Web site.



Business Survey

I. (Commitment Objective)

Date: _____ Commitment Objective: _____
Existing AFLAC Account: ☐ Yes ☐ No Group # _____
Company: _____
Address: _____
Address: _____
City: _____ State: _____ ZIP: _____
Phone (____) _____ - _____ Fax (____) _____ - _____
Industry Code: _____
Contact Person: _____ Title: _____
E-mail Address: _____

II. (Company)

- ☐ What does your company do? _____
- ☐ How long have you been in business? _____
- ☐ How many locations does your company have? _____
- ☐ Are there any related companies? _____
- ☐ How many employees? _____ ☐ Full-time _____ ☐ Part-time _____
- ☐ How has your business changed in the past five years? _____
- ☐ What's challenging in regard to offering benefits? _____

(Personal)

- ☐ How long have you worked for this company? _____
 - ☐ Did you start the company yourself? _____
- ☐ What are your personal objectives for the company? _____
- ☐ What obstacles do you see in reaching those objectives? _____

III. (Current Benefits)

- ☐ Tell me about your current benefits plan.
☐ Section 125 (Flex) Renewal date: _____ Administrative cost? _____
- ☐ What type of plan? Eligibility _____
☐ POP ☐ DDC ☐ URM ☐ Credit ☐ Core
- ☐ What benefits do you offer?
☐ Major Medical Employee costs? _____
Copays _____ Deductible _____
How many employees participate in family coverage? _____
Average employee wage? _____ / _____ per hour/week
☐ HMO ☐ PPO ☐ POS
☐ Group Life (Max. \$ _____) ☐ AD&D (Max. \$ _____)
- ☐ What Supplemental/Voluntary Benefits?
☐ Cancer ☐ Accident ☐ Individual STD ☐ Intensive Care
☐ Dental ☐ Vision ☐ Legal ☐ HIP
☐ Voluntary Life ☐ Long-Term Care ☐ Critical illness
☐ Group Term Life? ____ Yes ____ No Coverage amount \$ _____
- ☐ Group Med. Supp.
☐ Group STD Elimination Period _____ Benefit Period _____ Dollar Max. _____
☐ Group LTD Elimination Period _____ Benefit Period _____ Dollar Max. _____
☐ Other _____
- ☐ Workers' Compensation? ____ Yes ____ No Claims? ____ Yes ____ No
Rate Increases? ____ Yes ____ No Employee absenteeism ____ Yes ____ No
- ☐ What retirement (pension) plans do you offer?
☐ 401(k) ☐ Defined Benefit ☐ IRAs ☐ Defined Contribution
☐ Annuities ☐ Other _____

EMPLOYER ISSUES

- ☐ How good is your company in attracting/retaining employees? _____
- ☐ How are health care trends impacting your business? _____

EMPLOYEE ISSUES

- ☐ How do employees perceive their benefits? _____
- ☐ How do you communicate the value of your company's benefits package with your employees? _____

YOUR POSITION

- ☐ Who are your current benefits providers? _____
- ☐ How satisfied are you with their service? _____
- ☐ What services could be improved? _____

TIME FRAME

- ☐ What is your health insurance plan year? _____
- ☐ (If non-Flex) If you could begin saving your company tax dollars on a monthly basis, when would you like to start? _____

BUYING INFLUENCE

- ☐ Who, besides you, decides on health care? _____
- ☐ How do you go about making decisions? _____

IV. (Needs Uncovered)

1. _____ 2. _____
3. _____ 4. _____

Section 18

Aflac's TFBRs

TFBR

Use the TFBR method to sell your product or service. Never present a feature of a product and/or service without explaining how it benefits your prospects and their employees.

T – Tie Back:	Remind your prospect of his/her needs.
F – Feature:	What is it?
B – Benefit:	What will the feature do for the prospect?
R – Reaction:	Confirm its importance.

The Tie Back

Preface your feature/benefit statement by first using a tieback. A tieback reminds the prospect of a need or concern he/she expressed earlier during your open-ended questions.

Sample Tie-Back Starters

You mentioned that ...
 You indicated you were concerned about ...
 I know you place a great importance upon ...
 You shared a concern about ...
 You said your company was striving to ...
 You told me you wanted ...

The Reaction Question

End each TFBR with an open-ended reaction question. This involves the prospect in your product presentation and keeps you from doing all the talking. Remember to ask the best questions.

Examples of Reaction Questions

How do you see that working in your situation?
 How do you see this helping your employees out?
 In what way would this be helpful to you?
 Who might benefit the most from this?
 When would this be the most helpful?
 What's your opinion about what we've discussed?

*TFBR for
Employer
Issues*

*** Feature: Initial Accident Hospitalization Benefit**

Tie Back:

You mentioned that you were concerned about your employees' ability to pay their bills and copayments when suffering an accident, and that you have had to make loans to employees on occasion ...

Features:

Aflac's Personal Accident Indemnity plan pays an **Initial Accident Hospitalization Benefit** of **\$1,000** for initial confinement in a hospital or **\$1,500** for initial confinement in an intensive care unit, depending on the plan selected, the first time a covered person is hospitalized for a covered accident.

Benefits:

This helps ensure that your employees have the money to help cover the high costs of deductibles and copayments or to help replace lost income. This keeps you from having to make loans to employees who aren't able to pay their bills.

Reaction Question:

How do you see this helping you out?

*** Feature: Wellness Benefit**

Tie Back:

You stated that your company is striving to increase the employees' perception of their benefits package ...

Features:

After the policy has been in force for 12 months, Aflac's Personal Accident Indemnity plan pays a benefit of **\$60** for the employee or any one family member to have one of the following routine examinations: annual physical examinations, dental exams, mammograms, Pap smears, eye examinations, immunizations, flexible sigmoidoscopies, prostate-specific antigen tests (PSAs), ultrasounds, and blood screenings.

Benefits:

This enables your employees to receive cash benefits even without having an accident, thus increasing their perception of their benefits. It also helps reduce out-of-pocket expenses.

Reaction Question:

In what way would this be helpful to you?

TFBR for
Employer
Issues

*** Feature: Accident Hospital Confinement Benefit**

Tie Back:

You indicated that you were concerned about your employees' ability to pay copayments, deductibles, and other out-of-pocket expenses ...

Features:

Aflac's Personal Accident Indemnity plan pays up to **\$200** per day of hospital confinement, depending on the plan selected.

Benefits:

These benefits are paid directly to your employee, unless assigned. This means that your employee can use the money where it's needed most: to pay the rent, buy groceries, replace lost income, or to pay the high cost of deductibles and copayments.

Reaction Question:

What impact do you think that will have on your employees' ability to pay their copayments and deductibles?

*** Feature: Continuation of Coverage Benefit**

Tie Back:

I know you place great importance on your employees' ability to keep their health care if they ever change careers or retire.

Features:

If an employee terminates employment for any reason, we will waive all monthly premiums due for that policy for up to two months. Aflac must have received six continuous months of premium, and either you or the employee must notify us in writing within 30 days of the date the premium payments cease because of the employee's departure. The employee must start paying premiums at the new place of employment or pay Aflac directly.

Benefits:

This will take the burden of the continuation of coverage from you and place it back on the employee.

Reaction Question:

In what way would this be helpful to you?

*TFBR for
Employee
Issues*

*** Feature: Initial Accident Hospitalization Benefit**

Tie Back:

You mentioned that you were concerned about your ability to pay the hospital deductible if you or a family member were hospitalized for an accident ...

Features:

Aflac's Personal Accident Indemnity plan pays an **Initial Accident Hospitalization Benefit** of **\$1,000** for initial confinement in a hospital or **\$1,500** for initial confinement in an intensive care unit, depending on the plan selected, the first time a covered person is hospitalized for a covered accident.

Benefits:

This helps ensure that you will have the money necessary to help cover the high costs of deductibles and copayments you may have as a result of an accident.

Reaction Question:

How do you see that working in your situation?

*** Feature: Wellness Benefit**

Tie Back:

I know you place great importance on offsetting the cost of physician visits in the office and in the emergency room ...

Features:

After the policy has been in force for 12 months, Aflac's Personal Accident Indemnity plan pays a benefit of **\$60** for the employee or any one family member to have one of the following routine examinations: annual physical examinations, dental exams, mammograms, Pap smears, eye examinations, immunizations, flexible sigmoidoscopies, prostate-specific antigen tests (PSAs), ultrasounds, and blood screenings.

Benefits:

This enables you to receive cash benefits, even without having an accident.

Reaction Question:

In what way would this be helpful to you and your family?

TFBR for
Employee
Issues

*** Feature: Accident Hospital Confinement Benefit**

Tie Back:

You indicated that you were concerned about your ability to pay the high deductibles and copayments associated with your major medical insurance ...

Features:

Aflac's Personal Accident Indemnity plan pays up to **\$200** per day of hospital confinement, depending on the plan selected.

Benefits:

This benefit is paid directly to you, unless assigned. This means that you can use the money where it's needed most: to pay the rent, buy groceries, help replace lost income, or to pay the high cost of deductibles and copayments.

Reaction Question:

How do you see that helping you out?

*** Feature: Major Diagnostic Exams Benefits**

Tie Back:

You shared a concern about your ability to afford necessary diagnostic exams.

Features:

Aflac's Personal Accident Indemnity plan pays \$150 when you or any covered family member has any of the major diagnostic exams listed in the brochure.

Benefits:

I know that you want your family to be able to afford the exams necessary to treat accidents as soon as possible. As you know, many conditions that are caught early can be treated easily and successfully. This feature provides money to help pay the high costs of deductibles and copayments associated with these exams.

Reaction Question:

How do you see this working in your situation?

TFBR for
Employee
Issues

*** Feature: Transportation Benefit**

Tie Back:

You shared a concern about the out-of-pocket cost of travel to obtain medical care.

Features: As you know, the highest level of care isn't always available in your local community. Aflac's Personal Accident Indemnity plan pays a **Transportation Benefit** of \$400 per round trip to a hospital outside of a 100-mile radius of the accident scene or resident of the covered person. This will enable you or a covered family member to travel to another city or state to receive the highest level of care.

Benefits:

This feature will help cover the high cost of transportation and provide you the assurance that you or a covered family member can get the best care available.

Reaction Question:

How do you see that working in your situation?

*** Feature: Continuation of Coverage**

Tie Back:

I know you place great importance on your ability to keep your family's health care if you retire or change careers ...

Features:

If you terminate your employment for any reason, we will waive all monthly premiums due for your policy for up to two months. You must have paid premiums for six continuous months and you must notify us in writing within 30 days of the date the premium payments cease because of your departure. You will begin paying premiums at your new place of employment or directly to Aflac.

Benefits:

This will ensure that your coverage will not be lost and that you will continue to receive the same low rate that you pay through payroll deduction.

Reaction Question:

In what way would this be helpful to you?

Section 19

Underwriting Process

The Underwriting Process

Underwriting disability insurance is an art, not a science. Use the following information to guide you through the probable underwriting actions for specific impairments. No two applications are the same. Don't misrepresent acceptability for coverage to your client, and **do not cancel existing policies until you have approval.**

Telephone interviews may be conducted based on certain criteria, including:

- At the discretion of the underwriter.
- 30 or more units applied for.
- 24-month benefit period and 15 or more units.
- Information from the Medical Information Bureau.
- Information from the Disability Insurance Record System.

Please advise applicants that a Nations CareLink representative may contact them; therefore, it is critical that you provide a best time to call and a valid phone number on the application. If Aflac is unsuccessful in completing the interview due to missing information, we will not be able to complete the underwriting process and the application will be deemed incomplete.

(Note: Medical records may be requested at the underwriter's discretion.)

Not all applicants qualify for disability insurance, and you should disclose this to your clients when they apply for insurance. Take your time during the application process and get as much detailed information as possible about the applicant's medical history. Aflac depends on the field force to provide as much information as possible to approve your client for disability coverage.

Aflac offers you an opportunity to have adverse underwriting decisions reviewed. Please follow the appeals process outlined in Associate Services on the Aflac Web site. It is imperative to submit medical records with your request to receive consideration from Aflac's Underwriting committee.

You may contact Underwriting through it's e-mail address, underwriting@aflac.com, or by fax at (706) 596-5085. Please contact them to avoid submitting an application that would not qualify; they may be able to suggest sending an application for modified coverage to save the sale. Specialists at the Customer Call Center or in Marketing, Product Development may be able to answer specific questions about the disability product.

Disability Underwriting Guidelines for Associates

MEDICAL CONDITION	ACTION
Acquired immune deficiency syndrome (AIDS)/ Human Immunodeficiency virus (HIV)	DEC
Addison's disease	DEC
Alcohol/Drug treatment/abuse	
DUI question answered "yes" on application	DEC
Treatment/Counseling less than 2 years ago	DEC
Alzheimer's disease	DEC
Amyotrophic Lateral Sclerosis (ALS or Lou Gehrig's Disease)	DEC
Angina	
By-pass or angioplasty recommended, activities restricted	DEC
Any indication of OOW, hospitalization or treatment in the in the past 2 years	DEC
Asymptomatic for at least 2 years, no planned treatment, non-smoker	STD
Appendectomy	STD
Arthritis/Gout	
Activites restricted, mobility concerns	DEC
No restrictions, no missed work, no medications	STD
Out of work or hospitalized in the last 12 months	PP
If rheumatoid or psoriaic is indicated	DEC
Current use of pain medication (steriod, gold, methotrexate) or anti-inflammatory medications	DEC
Gout-Use of medication as maintence, under control	STD
Asthma	
Any history of asthmaticus	DEC
Any oral steroid use in the past 12 months	PP
Any treatment in ER or hosp, or missed ten total days of work in the last 12 months.	PP
Artial Fibrillation	
Any indication of OOW, hospitalization or treatment in the in the past 2 years	DEC
Autoimmune disorder, NOC (including but not limited to scleroderma, myasthenia gravis, Sjogren's syndrome, Reiter's syndrome)	DEC
Back, neck or joint(s) injuries/disorder	
Current use of pain medication, muscle relaxer or anti-inflammatory is indicated even if used on PRN basis	PP
Still receiving treatment, still under doctor's care	PP
No medications, complete recovery for 6 months	STD

These guidelines are by no means all inclusive. **We may decline for a combination of impairments, neither of which by itself would be cause for denial.** An example, hypertension, peripheral vascular disease and non-insulin diabetes, combined together would not be an insurable risk.

MEDICAL CONDITION	ACTION
Blood disorder (including but not limited to anemia, hemophilia, Leukemia, sickle cell, platelet disorder)	
Any treatment in ER or hosp, or missed ten total days of work in the last 12 months.	PP
Bone/Joint Replacements (hip, knee)	
Due to rheumatoid arthritis	DEC
Any treatment in ER or hosp, or missed ten total days of work in the last 12 months.	PP
Other, surgically corrected, complete recovery > 1 year, no medications	STD
Bronchitis	
No indication of chronic and no meds (even if hospitalization or OOW)	STD
Seasonal, non-smoker	STD
Cancer	
Use of Tamoxifen for preventive use (not for hormonal use), cancer question answered no	STD
No treatment in 5 years, complete recovery	STD
Treatment within 5 years	DEC
Breast cancer for Florida only, last treatment over 2 years, with Internal Malignancy Form	STD
Cardiomyopathy- any history	DEC
Carpal Tunnel Syndrome	
Currently under treatment, use of medication	DEC
Any indication of OOW, hospitalization or treatment in the in the past 2 years	DEC
Cerebral Palsy	DEC
Chronic Bronchitis	
Any treatment in ER or hosp, or missed ten total days of work in the last 12 months.	PP
Chronic Fatigue Syndrome	DEC
Cold, Influenza, Flu	STD
Congestive Heart Failure	
Any indication of OOW, hospitalization or treatment in the in the past 2 years	DEC
Chronic obstructive pulmonary disease (COPD)	DEC
Crohn's disease	DEC

These guidelines are by no means all inclusive. **We may decline for a combination of impairments, neither of which by itself would be cause for denial.** An example, hypertension, peripheral vascular disease and non-insulin diabetes, combined together would not be an insurable risk.

MEDICAL CONDITION	ACTION
Diabetes	
Diagnosed prior to age 30	DEC
Complications to include retinopathy, neuropathy or nephropathy	DEC
Continued tobacco use	DEC
Controlled orally or with diet, < 2 meds	STD
Uncontrolled Blood Sugar (200+) with complications of heart or vascular disease	DEC
Insulin use in last 5 years (including gestational)	DEC
Any treatment in ER or hosp, or missed ten total days of work in the last 12 months.	PP
Diverticulitis	
Any treatment in ER or hosp, or missed ten total days of work in the last 12 months.	PP
No missed work, hospitalization or treatment in the last 12 months	STD
Emphysema	DEC
Endometriosis	
Out of work or hospitalized in the past 12 months, no hysterectomy surgery	PP
Lupron Treatment in the past 12 months	DEC
Hysterectomy surgery performed, full recovery	STD
Surgery indicated in the last 6 months (unless hysterectomy)	PP
Epilepsy/Seizures	
Any treatment in ER or hosp, or missed ten total days of work in the last 12 months.	PP
Fibromyalgia- any history	DEC
Gastric Bypass	
Any treatment in ER or hosp, or missed ten total days of work in the last 12 months.	PP
Future Surgery	DEC
Heart Attack	
More than two years, no missed time in last year, full recovery, no complications, non-smoker	STD
Any use of blood thinner or nitroglycerin	DEC
less than two years passed	DEC
Heart Condition	
Out of work or hospitalization due to condition or chest pains in the last 12 months (not including stress related)	PP

These guidelines are by no means all inclusive. **We may decline for a combination of impairments, neither of which by itself would be cause for denial.** An example, hypertension, peripheral vascular disease and non-insulin diabetes, combined together would not be an insurable risk.

MEDICAL CONDITION	ACTION
Heart Surgery	
Angioplasty, stents or by-pass less than 2 years ago, continued tobacco use	DEC
Angioplasty, stents or by-pass more than 2 years ago, no work missed in the two years, complete recovery, non-smoker	STD
Heart valve replacement or repair	DEC
Any use of blood thinner or nitroglycerin	DEC
Pacemaker	DEC
Hernia- Surgically corrected, released from doctor's care	STD
High blood pressure	
Any treatment in ER or hosp, or missed ten total days of work in the last 12 months.	PP
Readings of 165/95 or higher, diagnosed as uncontrolled	DEC
Hysterectomy	
Answered no to cancer question	STD
Answered yes to cancer question and less than 5 years	DEC
Answered yes to cancer question and more than 5 years ago	STD
Irritable Bowel Syndrome	
Spastic colon, colitis, any restricted activities or occupational duties, any recommended surgeries, any recent change in weight or any on-going medical treatment	DEC
No missed work, no hospitalization, only OTC medications	STD
Ulcerative colitis	DEC
Regional enteritis/ileitis	DEC
Kidney Disease (not including kidney stones)	
Any indication of OOW, hospitalization or treatment in the in the past 2 years	DEC
Glomerulonephritis	DEC
Chronic Nephritis/Nephritis syndrome	DEC
Liver Disease	
Chronic	DEC
Hepatitis A, over 6 months, complete recovery	STD
Hepatitis all other types, any history	DEC
Lupus	
Systemic	DEC
Discoid	STD
Discoid, any use of methotrexate, plaquenil or prednisone	DEC
Lyme Disease	
Out of work, hospitalization or treatment with medication in the past 6 months	PP
Major Organ Transplant (heart, kidney, liver, lung)	DEC
Melanoma	
Level I or II - 6-12 month, no re-occurrence	STD
Level III or higher within 5 years	DEC

These guidelines are by no means all inclusive. **We may decline for a combination of impairments, neither of which by itself would be cause for denial.** An example, hypertension, peripheral vascular disease and non-insulin diabetes, combined together would not be an insurable risk.

MEDICAL CONDITION	ACTION
Mitral valve prolapse	
Out of work or hospitalization in last 12 months	PP
Mononucleosis	
Full recovery, no medications, doctor released, back to work	STD
Multiple Sclerosis	DEC
Muscular Dystrophy- RSD (reflex sympathetic dystrophy) any Hx	DEC
Oxygen use- current, prescribed	DEC
Osteoporosis	
Compression/stress fractures occurring	DEC
Mobility and/or activities restricted	DEC
Pancreatitis	
Any treatment in ER or hosp, or missed ten total days of work in the last 12 months.	PP
Chronic	DEC
Parkinson's Disease	DEC
Phlebitis/ thrombophlebitis	
Intermittent claudication (spasms, cramping)	DEC
Currently on medications	PP
Superficial phlebitis, complete recovery	STD
Chronic	DEC
Any use of blood thinner	DEC
Pneumonia, fully recovered	STD
Tonsilectomy	STD
Ulcers	
No out of work or hospitalization, use of OTC medication	STD
Vascular insufficiency (circulatory problems)	DEC
DEC- Decline	STD- Standard
PP- Postponed	

The guidelines stated above are the typical responses to a list of common conditions. The actual underwriting may differ based on the particulars of each individual case. If your state does not allow field underwriting, these guidelines still apply.

These guidelines are by no means all inclusive. **We may decline for a combination of impairments, neither of which by itself would be cause for denial.** An example, hypertension, peripheral vascular disease and non-insulin diabetes, combined together would not be an insurable risk.

Section 20

Industry Classification Guide

This *Industry Classification Guide* is intended to provide a general listing of Standard Industry Classifications (SICs) only. Classifications are based upon factors that include industry workers' compensation experience, economic trends, AFLAC morbidity experience, AFLAC lapse experience, and industry lapse trends. Because of these factors, rate classes may have changed over the years. An account that was previously a B may now be a C. **You must verify the industry classification before you approach an account and discuss rates.**

VERIFYING INDUSTRY CLASSIFICATION

Before writing business, even on existing accounts, submit all SIC requests in writing to the SIC team via one of the following methods:

Internet: Complete and submit the Payroll Industry Classification Request (Form M-0988) on the AFLAC Web site (www.aflac.com), Associate Services section.

E-mail SIC@aflac.com: Include the associate's name and writing number and the account's name, address, and telephone number. Also include any additional information (such as a company profile, Web site, etc.) that may be helpful in describing the nature of the business.

Via fax: Fax the completed Payroll Industry Classification Request to (706) 317-0783.

Via mail: Mail the completed Payroll Industry Classification Request to AFLAC Worldwide Headquarters, ATTN: SIC Team, 1932 Wynnnton Road, Columbus, GA 31999.

Upon receipt of your request, an SIC approval will be provided within 24 hours. If a profile or additional information is needed, you will be notified immediately.

SPECIAL GROUPS

Multi-Location Accounts (MLAs)

Until the Personal Accident Indemnity and Personal Disability Income Protector products are introduced in all states, accounts in different locations may be subject to different industry classifications.

When submitting SIC requests for multi-state locations, please indicate that the account is a multi-state account, what states are involved, which is the domicile state, and the tentative enrollment dates.

Nonprofit, Social Services, and Member Organizations

When assigning SICs for not-for-profit, social services, and member organizations, employee persistency and length of time in business are considered. Employee turnover in not-for-profit organizations tends to be higher than that found in similar for-profit businesses, and we therefore evaluate each group individually. Please submit the following when requesting a nonprofit or member organization SIC request:

- How long has the organization been in business?
- Are the employees W-2 employees?
- What is the total number of employees? How many are full-time and eligible for benefits?
- Describe the nature of the organization.
- Does the organization offer job training and/or placement assistance? If yes, will the trainees be offered AFLAC products?
- Please attach a list from the organization showing the hire dates of all employees.

Professional Employer Organizations (PEOs), Staffing, and Leasing Companies

A classification will be assigned for actual employees of the PEO/Staffing/Leasing Company and separate classifications will be assigned to each of the companies contracting with them. Each contracted company's classification is based on the business type. Please submit the following information for evaluation:

- A fully completed SIC request form on the PEO/Staffing/Leasing Company.
- A list of businesses with which the company contracts, to include the business names, phone numbers, addresses, and, if used for billing purposes, department numbers.
- Information on plans being offered and whether any benefits are paid for by the PEO/Staffing/Leasing Company as part of their contract.
- Details on how the account will be set up and billed.
- Are there temporary employees?

Class A

Accounting Firms
Architectural Firms
Banks (**not credit unions**)
Engineering Firms
Management/Consulting Services
Schools (kindergarten through college) – if all employees are offered coverage and not just a select group; **does not include technical or vocational schools**

Class A rate is also available to:

- Attorneys/paralegals employed **outside** the legal industry
- Clerical workers (**except in health services and D or E industries**)
- Inbound-only telephone sales
- Owners of "B" or "C" industries with five or more employees who spend 80% or more of time performing administrative duties in an office environment
- State-certified educators in settings other than schools
- Supervisors/managers who spend 80% or more of time performing administrative duties in an office environment

Class A rate IS NOT available to:

- *Anyone* in a "D" or "E" industry
- *Anyone* in a health services industry
- Attorneys/paralegals in law firms
- Day-care teachers, unless certified in education and performing teaching duties
- Pastors/ministers
- Salespeople, sales supervisors, and sales managers who make sales offers (including those in car sales, telemarketing, showroom/retail sales, and door-to-door sales)
- Supervisors/managers in automotive repair shops, car dealerships, restaurants, and retail stores
- Telemarketers

Class B

(everyone receives B rate, unless qualified for A rate)

Advertising Agencies
Air Conditioning and Heating Companies
Airports
Appliance Sales and Service
Automobile/Motorcycle Dealerships
Automobile Rental
Bail Bond Services
Barber Shops/Beauty Parlors •
Book Publishers/Printers
Candy and Confectionery Products Manufacturers
Carpet and Upholstery Cleaners
Churches (**employees only**)
Collection Agencies
Courts
Credit Unions (**employees only**)
Day-care Centers (**only state-certified teachers are eligible for an A rate**)
Dry Cleaners
Electronic Equipment Manufacturers
Equipment Rental Companies
Governments
Grocery Stores (**not convenience stores**)
Financial Consultants
Funeral Homes
Insurance Company Headquarters (**not sales office**)
Jewelry Repair Services
Legal Services and Firms
Libraries
Medical and Dental Instrument Manufacturers
Mortgage Companies
Movie Theaters
Museums
Photography Studios
Radio/Television Broadcasting Stations
Real Estate Appraisers
Real Estate Management Offices

Class B, continued

(everyone receives B rate, unless qualified for A rate)

Retail (no specialty food or convenience stores)

Book Stores
Clothing Stores
Department Stores
Fabric Stores
Florists
Furniture Stores
Gift Shops
Music Stores
Shoe Stores
Toy Stores
Trophy Stores
Securities Brokers and Dealers
Soft Drink Bottlers/Distributors
Textile Mills
Utility Companies (electric, gas, water)
Veterinarians
Vocational/Technical Schools
Zoos

•1099 Workers/Independent Contractors

Please note that 1099 workers/independent contractors are not eligible for payroll rates. Some examples of industries using 1099 workers are trucking companies, real estate agencies, hair salons, and insurance agencies. Payroll rates are intended only for W-2 employees in a true employer/employee relationship.

Class C

(everyone receives C rate, unless qualified for A rate)

Auto Repair Shops
Building Maintenance Services (includes janitorial)

Bowling Centers

Fire Departments (no volunteer units)

Fruit and Vegetable Markets/Stands

Health Services (no A rates allowed)

Dental Offices/Clinics

Doctors' Offices/Clinics

Health Clinics

Home Health Care Agencies

Hospitals

Medical Labs

Nursing Homes

Heavy Construction Companies

Septic System Contractors

Sprinkler System Installers

Telephone, Power, and Water Line Construction Workers

Hotels/Motels

Insurance Agents/Brokers and Services •

Note: Agents/brokers are eligible for the base accident policy and an off-the-job rider maximum of \$1,500 only; no sickness or on-the-job coverage is allowed.

Lawn and Garden Services

Meat and Fish Retail Markets

Milk and Dairy Products Retail Stores

Painting and Wallpaper Hanging Services

Physical Fitness Facilities/Spas

Police Departments

Public Golf Courses

Railroads

Restaurants (no drive-ins, fast food, pizza parlors, truck stops)

Trucking Companies •

Class D (everyone receives D rate, regardless of job duties)	Class E (everyone receives E rate, regardless of job duties)
<p>Agricultural Services Crop Dusting Harvesting Planting Tree Surgeons Amusement Parks Athletic/Sports Teams Bars/Lounges/Taverns Casinos ♦ Convenience Stores (with or without gas station) Farms and Ranches Dock and Wharf Workers Ferries Fire Departments (volunteer units) Forestry Services Gas Stations (full- or self-service) Horse Farms Hunting, Fishing, and Trapping Limousine Services Logging Marinas and Fishing Piers Meat Slaughtering/Processing Mining (below ground) Oil and Gas Extraction Parking Lots and Garages Racing Companies and Racetracks Restaurants (drive-ins, fast food, pizza parlors, truck stops) Roofing and Siding Contractors Shipbuilding Taxis Telemarketing Firms</p>	<p>Class E represents D industries that are eligible for disability coverage. Applicants in E industries must have been employed for at least one year to be eligible for disability. On-the-job coverage is not available.</p> <p>Garbage/Sewer Services Lumber, Sawmills, Millwork (no logging) Recycling Security Guard Services Surface Mining (not below ground)</p> <p>♦ Exceptions may be made for casinos under limited circumstances by submitting the Request to Offer Disability in a Casino form. Approval must be received <u>before</u> writing business.</p>

Section 21

***Glossary
of
Medical Terms***

Listed below are definitions of diseases and medical terms used on the application. These should be helpful when reviewing an applicant's medical history.

Angina (heart-related chest pain): Band-like chest pain, usually due to a lack of oxygen in the cardiac muscle.

Asthma: Respiratory disorder characterized by narrowing of the airways because of spasms that cause recurring episodes of difficult breathing.

Atrial fibrillation: Top part of heart beating very fast and usually irregular.

Blood disorders: Abnormal condition of blood or blood components.

Cancer (other than non-melanoma skin cancers): Presence of a malignant tumor characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue. Includes leukemia and Hodgkin's disease.

Cardiopathy: Enlarged heart.

Carpal tunnel syndrome (CTS): Painful disorder of the wrist and hand.

Chronic bronchitis: Constant inflammation of the bronchi.

Chronic fatigue syndrome (CFS): Onset of disabling fatigue after viral-like illness.

Chronic hepatitis (excluding hepatitis A): Chronic inflammation of liver caused by hepatitis virus.

Chronic liver disease: Progressive disease process involving the liver, such as cirrhosis.

Chronic obstructive pulmonary disease (COPD): Chronic airway obstruction that encompasses chronic pulmonary disease, bronchitis, and emphysema.

Congestive heart failure (CHF): Inability of the heart to adequately pump blood that is secondary to weakness/disease.

Coronary angioplasty: Procedure of identifying and eliminating blockage in cardiac arteries.

Coronary bypass surgery (CABG): Surgical bypass of a coronary artery.

Crohn's disease: Chronic inflammatory bowel disease that has a high tendency to recur and eventually requires surgery to contain.

Diverticulitis: Herniations (closed pouches or sac-like protrusions) of the muscular layer of the colon.

Drug or alcohol abuse: Misuse or excessive use of drugs (legal or illegal) and alcohol.

Emphysema: Decrease in the elasticity of the lung tissue, resulting in the impaired ability to breathe in, as well as to exhale; loss of lung capacity, thinning of lungs, shortness of breath.

Fibromyalgia: Nonarticular rheumatism, musculoskeletal aching and stiffness, fatigue.

Gastric bypass: To cut and divide the stomach and rejoin the stomach at the jejunum (small intestine).

Heart attack: Damage to cardiac muscle caused by a lack of blood flow that is secondary to an obstruction in a coronary artery.

Heart disease: Conditions affecting the structure or function of the heart.

Heart valve replacement: Surgery to replace a valve due to disease or congenital abnormality.

Hypertension (high blood pressure): Persistently high arterial blood pressure. May have no known cause (essential) or may be associated with other primary diseases (secondary).

Joint replacement: The bone surfaces within the joint are surgically removed and replaced with synthetic materials.

Kidney disease (not including kidney stones): Infection, inflammation, or obstruction of one or both kidneys.

Multiple sclerosis: Hardening of nerve fibers within the nervous system causing the inability of the body to transmit electrical impulses normally.

Muscular Dystrophy: Hereditary disease resulting in progressive wasting of muscles.

Pancreatitis: Inflammation or swelling of the pancreas.

Psoriatic arthritis: A severe form of arthritis accompanied by psoriasis, a chronic skin disease.

Pulmonary fibrosis: Accumulation of fibrous tissue in the lungs caused by chronic inflammation of the lungs.

Regional enteritis/ileitis: Chronic inflammatory disorder involving all layers of the bowel wall and colon.

Rheumatoid arthritis (RA): Chronic destructive collagen disease, characterized by swelling of joints.

Sciatica: Inflammation of the sciatic nerve that causes pain and tenderness through the thighs and legs.

Seizures: Response of an abnormal electrical discharge in the brain. Anything that irritates the brain can produce a seizure. Types of seizures depend on what part of the brain is affected by the abnormal electrical discharge.

Stroke: Also called **CVA** (cerebral vascular accident). Damage to the brain tissue caused by an obstruction of blood flow in an artery of the brain.

Systemic lupus (SLE): Chronic inflammatory disease affecting many systems of the body.

Transient ischemic attack (TIA): Also called a mini-stroke. Partial obstruction of the flow of blood to the brain that resolves without permanent impairment.

Type 1 diabetes (insulin-dependent diabetes): Lack of insulin production by the pancreas that results in the body's inability to maintain a proper blood sugar level.

Type 2 diabetes (adult onset): Occurs as a result of the pancreas producing an insufficient amount of insulin or the body's inability to properly use the insulin. Generally occurs in middle age and results in excess sugar in blood.

Ulcerative colitis: Chronic inflammatory disease of the colon.

Vascular insufficiency (circulatory problems): Numbness in extremities (arms, legs) that is secondary to a decrease in blood circulation.

Section 22

List of Forms for Selling PAI

Listed below are all forms necessary for the sale of the **Personal Accident Indemnity** product. You may view, print, or order most of the forms from Inventory Services by accessing the Web Ordering section on the Associate Services page at **aflac.com** or order through Inventory Services directly. **Submitting your request through Web Ordering can save one to three days in fulfillment time.** You will be able to order forms only for the state(s) in which you are licensed.

The monthly quantity limits differ by level. For your monthly/quarterly limits, refer to the **Forms Management List** in the Web Ordering section of the Web site.

Form numbers may vary by state; please refer to your specific state introduction packet for complete details.

Items to be left with the applicant:

- ✓ Brochure **A-34175** (Level 1) or **A-34275** (Level 2)
- ✓ Off-the-Job Accident Disability Rider insert **A-34076**
- ✓ On-the-Job Accident Disability Rider insert **A-34077**
- ✓ Sickness Disability Rider insert **A-34078**
- ✓ Spouse Off-the-Job Accident Disability Rider insert **A-34079**
- ✓ Specific-Sum Injuries insert page **A-34175-SS** (Level 1) or **A-34275-SS** (Level 2)
- ✓ Outline of Coverage (not required for all states) **A-34125** (Level 1) or **A-34225** (Level 2)
- ✓ Any other state-specific form or forms required

Items needed from applicant:

- ✓ Signed application (if not taken on SmartApp®)
 - **Payroll** application with disability riders **A-34001**
 - **Base payroll** application (no disability riders) **A-34001A**
 - **Non-payroll** application (no disability riders) **A-34002A**
 - **Associates Nonpayroll** application with disability riders **A-34004**
- ✓ Signed original Replacement Notice, if applicable **A-8691**
- ✓ Statement of Understanding (if effective date is advanced more than 60 days) **A-13072**

Personal Accident Indemnity

Items mailed with policy packet:

- ✓ Welcome Letter
- ✓ Policy: **A-34100** (Level 1) or **A-34200** (Level 2)
- ✓ Privacy Practices Form **A-19591**
- ✓ Off-the-Job Accident Disability Rider insert **A-34050**
- ✓ On-the-Job Accident Disability Rider insert **A-34051**
- ✓ Sickness Disability Rider insert **A-34052**
- ✓ Spouse Off-the-Job Accident Disability Rider insert **A-34053**
- ✓ Copy of application
- ✓ Replacement Notice, if applicable
- ✓ Any other state-specific form or forms required

Additional forms:

- ✓ Mailer **A-34090**
- ✓ Field Sales Guide **M-1044**
- ✓ Associates Guide to Disability **M-0816**
- ✓ Disability Benefit Limits Chart **M-1019**
- ✓ Industry Classification Manual **M-1042**
- ✓ Guide **A-10571-2002**
- ✓ Premium Rate Booklet **M-RS065** (also available on Premium Quote)
- ✓ Premium work sheet **M-1018**
- ✓ Reinstatement application **A-34003**
- ✓ Transmittal **M-0018R**
- ✓ Insurance Acknowledgment Form **M-0138**
(Insurance Acknowledgment Form **M-0135R** on SmartApp®)
- ✓ Request for Change Form **H-L0046**
- ✓ Instruction Sheet Form **S-00197**
- ✓ Claim Form **S-00198**
- ✓ Continuing Disability Claims Form **S-13270.1**
- ✓ Existing Account Authorization **M-0486**
- ✓ Wellness form
- ✓ Payroll Industry Classification Request Form **M-0988**

Section 23

List of Forms for Selling Off-the-Job PAI

Listed below are all forms necessary for the sale of the **Off-the-Job** Personal Accident Indemnity product. You may now view, print, or order most of the forms from Inventory Services by accessing the Web Ordering section on the Associate Services page at **aflac.com** or order through Inventory Services directly. **Submitting your request through Web Ordering can save one to three days in fulfillment time.** You will be able to order forms only for the state(s) in which you are licensed.

The monthly quantity limits differ by level. For your monthly/quarterly limits, refer to the **Forms Management List** in the Web Ordering section.

Form numbers may vary by state; please refer to your specific state introduction packet for complete details.

***INDICATES THIS IS SPECIFIC TO OFF-THE-JOB PAI. All other forms can be used for both PAI and Off-the-Job PAI.**

Items to be left with the applicant:

- * Brochure **A-34375** (Level 1) or **A-34475** (Level 2)
Off-the-Job Accident Disability Rider insert **A-34076**
Sickness Disability Rider insert **A-34078**
Spouse Off-the-Job Accident Disability Rider insert **A-34079**
- * Specific-Sum Injuries insert page **A-34375-SS** (Level 1) or **A-34475-SS** (Level 2)
- * Outline of Coverage (not required for all states) **A-34325** (Level 1) or **A-34425** (Level 2)
Any other state-specific form or forms required

Items needed from applicant:

- * Signed application (if not taken on SmartApp®)
 - Payroll** Application with Disability Riders **A-34301**
 - Base Payroll** Application (No Disability Riders) **A-34301A**
- Signed original Replacement Notice, if applicable **A-8691**
- Statement of Understanding (if effective date is advanced more than 60 days) **A-13072**

Off-the-Job
Personal Accident Indemnity

Items mailed with policy packet:

- Welcome letter
- * Policy: **A-34300** (Level 1) or **A-34400** (Level 2)
- Privacy Practices Form **A-19591**
- Off-the-Job Accident Disability Rider insert **A-34050**
- Sickness Disability Rider insert **A-34052**
- Spouse Off-the-Job Accident Disability Rider insert **A-34053**
- Copy of application
- Replacement Notice, if applicable
- Any other state-specific form or forms required

Additional forms:

- Field Sales Guide **M-1044**
- Associates Guide to Disability **M-0816**
- Disability Benefit Limits Chart **M-1019**
- Industry Classification Manual **M-1042**
- Guide **A-10571-2002**
- * Premium Rate Booklet **M-RS066** (also available on Premium Quote)
- * Reinstatement application **A-34303**
- Transmittal **M-0018R**
- Insurance Acknowledgment Form **M-0138**
(Insurance Acknowledgment Form **M-0135R** on SmartApp®)
- Request for Change Form **H-L0046**
- Instruction Sheet Form **S-00197**
- Claim Form **S-00198**
- Continuing Disability Claims Form **S-13270.1**
- Existing Account Authorization **M-0486**
- Wellness form
- Payroll Industry Classification Request Form **M-0988**

Section 24

State Disability

Six states (California, Hawaii, New Jersey, New York, Puerto Rico, and Rhode Island) require most employers to offer government-mandated disability benefits to their employees. To avoid over-insuring the employees already covered by such plans when adding the Personal Accident Indemnity Disability Riders, we use reduced income replacement scales in these states. Because each state's plan is different, this guide provides general information only. Please refer to the administrative guidelines for the state in which you are writing business for complete details.

The PAI and Off-the-Job PAI applications have been modified in these states to include a question about state disability. For example, Hawaii's application asks:

If applying for any disability rider, are you covered under Hawaii's Temporary Disability Insurance (TDI) or an equivalent state-mandated disability insurance plan? ☐ Yes ☐ No

This application question allows for individual exemptions, whereas the PAI allowed only exemptions at the group level. The group exemption form, M-1014, is not required with the PAI product. In most states, employees of government, religious, and nonprofit organizations are excluded from the state plan. However, there may also be groups of employees within an organization who are not part of the state plan due to a union agreement. Therefore, it is important to determine whether or not each individual applicant participates in the state disability plan.

If the applicant answers no to this question, the standard income replacement scale (M-1019) will be allowed. Because the applicant is not eligible for state benefits, he or she is eligible for full Aflac benefits.

If the applicant answers yes to the new application question, a state-specific reduced income replacement scale will be used. This ensures that the applicant is not over-insured during the time that both Aflac and the state plan will pay.

However, for applicants covered by state disability who choose 12 months of coverage, the reduced income replacement scale will not provide sufficient benefits when the state payments cease after six months. You may instead wish to offer these applicants the Personal Disability Income Protector policy, which provides an option to increase benefits after six months. (In California, the state plan pays for 12 months, so the reduced Aflac scales are sufficient for the entire benefit period.)

Note: The revised income scales apply only to disability riders purchased for the primary insured. Regardless of state coverage, the spouse is eligible for up to seven units of the Spouse Off-the-Job Accident Disability Rider.