VOLUNTARY GROUP TERM LIFE INSURANCE

Application to: American Family Life Assurance Company of Columbus (AFLAC)
Worldwide Headquarters
Columbus, Georgia 31999

Policy Number

Please Print In Black Ink - To Be Completed by Proposed Insured

Proposed Insured's Name ____________________ DOB __________ Sex ______
Last First MI Month/Day/Year

Proposed Insured's Height ______ ft. ______ in. Weight ______ lbs. Age ______ SS# ______ - ___ - ______

Address ______________________________
Street or Post Office Box Apt.#

City ____________________ State __________ ZIP Code __________- ______

Proposed Insured's Occupation ____________________

Full-Time Employer ____________________ Hire Date __________
(Proposed Insured must be employed full-time with this employer.)

Home Telephone (____) ____________________ May we call you at work? ❑ Yes ❑ No

Business Phone (____) ____________________ Best time to call: ____________________

Primary Beneficiary ____________________ Contingent Beneficiary ____________________

Relationship to Proposed Insured ______________ Relationship to Proposed Insured ______________

Amount of Insurance Applied for $ ______________ ❑ New ❑ Increase

Billable Premium: $ ______________ Premium Collected: $ ______________

Billing Modes:

❑ 01 Weekly	❑ 01 Monthly	❑ 06 Semiannual	❑ Pre-Tax
❑ 01 Biweekly	❑ 03 Quarterly	❑ 12 Annual	❑ After-Tax
❑ 01 Semimonthly			

IF ANY OF QUESTIONS 1-6 ARE ANSWERED "YES," DO NOT SUBMIT THE APPLICATION.

1. Are you classified as a part-time employee by your employer? ❑ Yes ❑ No
2. In the past two years, have you been denied life insurance coverage by this or any other insurance company? ❑ Yes ❑ No
3. Do you now participate in any hazardous sports or avocations such as sky diving, motor vehicle racing or cave exploration, or engage in aviation as a private pilot or student pilot? ❑ Yes ❑ No
4. Have you been charged with driving under the influence of alcohol within the last 12 months, or charged with driving under the influence of alcohol two or more times within the last five years? ❑ Yes ❑ No
5. In the past five years, have you been treated for or received counseling for alcohol or drug use, or within this time have you been advised by a member of the medical profession that such treatment or counseling is needed? ❑ Yes ❑ No
6. Has a member of the medical profession diagnosed you with or treated you for acquired immune deficiency syndrome (AIDS) or AIDS-related complex (ARC)? ❑ Yes ❑ No
7. Have you had two or more T-cell suppressor tests that were abnormal in the last 24 months? ❑ Yes ❑ No

IF ANY OF QUESTIONS 8-9 ARE ANSWERED "YES," GIVE DETAILS IN ITEM 10.

8. Has a member of the medical profession ever diagnosed you with or treated you for any of the following (check all that apply and provide details in Item 10):

❑ diabetes	❑ leukemia	❑ pancreatitis
❑ heart disease	❑ liver disease	❑ stroke
❑ high blood pressure	❑ lung disease	❑ systemic lupus
❑ internal cancer	❑ melanoma	❑ tumor
❑ kidney disease		

9. During the past five years, have you been restricted for 10 days or more from your job duties due to illness and upon the advice of a physician or other medical practitioner? Have you been in the hospital or had surgery in the past five years? ❑ Yes ❑ No

10. If Question 8 or 9 is answered "Yes," please furnish us with details.

	Question Number 8	Question Number 9
Diagnosis		
Name and address of physician		
Treatment		
Present condition		

If you are taking any prescription or over-the-counter medication please provide the name and dosage of any and all of the medication(s) and reason(s) for taking it below. If you are **not** taking any medication, check here. ❑

Please provide the name and dosage of the medication(s) you are currently taking and the reason(s) for taking it.

Medication name	Dosage	Frequency	Date first prescribed	Reason

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 acknowledge receipt, if applicable, of the notices explaining my rights under the Fair Credit Reporting Act as it pertains to investigative consumer reports and the Medical Information Bureau.

I have read or had read to me the completed application, and the statements and answers are true and complete to the best of my knowledge and belief. It is agreed that (a) subject to minimum participation limits, this application and any amendments hereto shall be the basis of any insurance granted; (b) no associate/agent or any other person has authority to waive the answer to any question in the application, to pass on insurability, to waive any of AFLAC's rights or requirements or to make or alter any contract; (c) no change in the amount, classification or benefits shall be effective unless agreed to in writing by the proposed insured, and (d) no insurance shall be considered in force unless and until a certificate has been issued by AFLAC, and been received and accepted by the proposed insured, all during the lifetime and before any change in insurability from that stated herein, and (e) insurance shall be effective on the date shown in the certificate.

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

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

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

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

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

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

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

Form A-90072

Dated at ______________________________ this ________ day of ___________________________, 20 _________

Proposed Insured's Signature: **X**____

I certify that I have reviewed the recorded responses to all questions on this application with the proposed insured; I have not knowingly allowed any false or misleading statements on this application; and I have made a full and accurate disclosure to AFLAC of all known factors that might affect the underwriting of the risk.

____ / __________________ / ______________ / ______________

Signature of Associate/Agent Date Writing No. Sit. Code

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RECEIPT

Received from____ an application bearing the date of this

receipt for plan__________________with an Amount of Insurance of $___________

The premium will be $_____________

❑ Weekly ❑ Biweekly ❑ Semimonthly ❑ Monthly
❑ Quarterly ❑ Semiannual ❑ Annual

Date_____________________Associate/Agent____

I understand that coverage under any certificate issued from an application bearing the date of this receipt will take effect on the date shown in the certificate when the following conditions precedent to coverage are met: the person proposed for coverage is in good health and, upon receipt of the application and any further information required, is determined by AFLAC at its headquarters, according to its rules and practices, to be insurable, on such date at standard rates for coverage exactly as applied for. The maximum limit of life insurance on the Proposed Insured, however, including any previously issued or pending with AFLAC, and any accidental-death benefits issued in conjunction therewith, which may take effect as a result of this application, is $100,000.

Coverage under any certificate not issued exactly as applied for, or life insurance in excess of the maximum limit, will take effect upon acceptance by the applicant and payment of the first premium during the lifetime and good health of the person proposed for coverage.

Except as provided above, no coverage will take effect, and the liability of the company is limited to a refund of any amount paid.
Dated at ____________________________ this _______ day of _______________________, 20 ________

Proposed Insured's Signature: **X**____

NOTICE TO APPLICANT

Without further consent from you, information given in your application may be made available to other insurance companies to which you make application for life or health insurance coverage or to which a claim is submitted.

Information you provide will be treated as confidential except that American Family Life Assurance Company of Columbus (AFLAC) or its Reinsurers may, however, make a brief report thereon to the Medical Information Bureau (MIB), a non-profit membership organization of life insurance companies, that operates an information exchange in behalf of its members. Upon request by another member insurance company to which you have applied for life or health insurance coverage or to which a claim is submitted, the MIB will supply such company with the information it may have in its files.

Upon receipt of a request from you, the MIB will arrange disclosure of any information it may have in its file. (Medical information will be disclosed only to your attending physician.) If you question the accuracy of information in the MIB's file, you may contact the MIB and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the MIB's information office is P.O. Box 105, Boston, Massachusetts 02112; telephone number (617) 426-3660.

AFLAC or its Reinsurers may also release information in its file to other life insurance companies to whom you may apply for life or health insurance or to whom a claim for benefits may be submitted.

FAIR CREDIT REPORTING INFORMATION NOTICE

As a part of our normal procedure for processing your application, an investigative consumer report may be obtained whereby information is secured through personal interviews with your friends, neighbors and others with whom you are acquainted. This report, if obtained, typically contains information as to your character, general reputation, personal characteristics and mode of living. You have the right to make a written request within a reasonable period of time for a complete and accurate disclosure of additional information concerning the nature and scope of this report. Please address your request to our Life Underwriting Department.