



VISION INSURANCE POLICY (VSN100 Series)

New

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

Policy Number:  
**QR273**

Please Print in Black Ink – To Be Completed by Applicant

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

Applicant's SSN \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Will dependent children be covered?  Yes  No

(Write spouse's name below if you are applying for Two-Parent Family or Named Insured/Spouse Only coverage; if you have no spouse or your spouse is not to be covered, put N/A in space below.)

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

Address \_\_\_\_\_  
Street or Post Office Box Apt. No.

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Home Telephone ( ) \_\_\_\_\_

Policy Owner's Name \_\_\_\_\_ Relationship to Applicant \_\_\_\_\_  
(If Other Than Applicant)

Address \_\_\_\_\_ Policy Owner's SSN \_\_\_\_\_  
Street or Post Office Box Apt. No.

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Name of Vision Care Provider (optional) \_\_\_\_\_

Name of Spouse's Employer (optional) \_\_\_\_\_

Payroll Account Name \_\_\_\_\_ Payroll Account Number \_\_\_\_\_  
(optional)

Are you covered by Medi-Cal?  Yes  No If "YES", then a policy will not be issued.

Is this insurance intended to replace any other vision insurance other than eye exams and materials now in force?  
 Yes  
 No

If yes, please read and sign the Replacement Notice provided by your associate/agent, if applicable.  
If the applicant is age 65, list all health and disability policies that are still in force (by type and company):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**TO BE COMPLETED BY AFLAC ASSOCIATE/AGENT**

<b>Check Coverage Desired:</b>	<input type="checkbox"/> Individual	<input type="checkbox"/> Named Insured/ Spouse Only	<input type="checkbox"/> One-Parent Family	<input type="checkbox"/> Two-Parent Family
<input type="checkbox"/> Option 1: Policy with Vision Correction Benefit; Materials; No waiting period - \$50 every year				<input checked="" type="checkbox"/> Pre-Tax
<input type="checkbox"/> Option 2: Policy with Vision Correction Benefit; Materials; 12-mo. waiting period - \$120 every 2 years				or
<input type="checkbox"/> Option 3: Policy with Vision Correction Benefit; Materials; 24-mo. waiting period - \$210 every 3 years				<input type="checkbox"/> After-Tax
<b>Billing Method:</b>	<b>Mode:</b>			
<input checked="" type="checkbox"/> Payroll Deduction	<input type="checkbox"/> 01 Weekly	<input type="checkbox"/> 01 Semimonthly	<input type="checkbox"/> 06 Semiannual	
	<input type="checkbox"/> 01 14-Day Biweekly	<input type="checkbox"/> 01 Monthly	<input type="checkbox"/> 12 Annual	
	<input checked="" type="checkbox"/> 01 28-Day Biweekly	<input type="checkbox"/> 03 Quarterly		
Employee No. _____	Dept. No. _____	Assoc./Agent's No. _____		
Billable Premium \$ _____	Premium Collected \$ _____	Sit. Code _____		

**ALL OF THE FOLLOWING MUST BE COMPLETED:**

1. Has anyone to be covered ever been diagnosed with or treated by a member of the medical profession for any of the following?  Yes  No

Glaucoma, preglaucoma, and/or borderline glaucoma	Tumor of the eye or brain
Macular degeneration	Detached retina
Diabetic retinopathy	Multiple sclerosis
Type I diabetes	Retinitis pigmentosa
Cataract	Optic neuritis or optic neuropathy
Legal blindness	Total blindness
Ocular hypertension	Cancer of the eye or brain
  
2. Has anyone to be covered ever been diagnosed by a member of the medical profession with an ongoing visual impairment/condition that cannot be corrected by eyeglasses, contact lenses, or surgery?  Yes  No
  
3. In the last 24 months, has anyone to be covered had or been advised by a member of the medical profession to have eye surgery (other than any type of Refractive Error Correction Surgery) or diagnosed with amblyopia (lazy eye) or treated with any eye patch regimen?  Yes  No

**If any one of Questions 1 through 3 is answered yes, was it the:**

Named Insured  Spouse  Child? If Child, please list the name of the child(ren).

\_\_\_\_\_

**Any person(s) so designated will not be covered under the policy. If this is the Named Insured, the Applicant's Name on the first page of this application must be different.**

**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. a. I understand that if I selected Vision Correction Benefit option 2 there will be a 12-month waiting period for the Vision Correction Benefit and if I selected Vision Correction Benefit option 3, there will be a 24-month waiting period for the Vision Correction Benefit.
- b. **The policy contains a 30-day waiting period.** If a covered person has an eye disease or disorder, other than one caused by an Injury, diagnosed before coverage has been in force 30 days from the Effective Date of coverage shown in the Policy Schedule, benefits for treatment of that eye disease or disorder will apply only to treatment occurring after two years from the Effective Date of the policy, or, at your option, you may elect to void the policy from its beginning and receive a full refund of premium. **The 30-day waiting period for the policy does not apply to the Eye Examination Benefit or the Vision Correction Benefit.**

- 3. I understand that the policy I am applying for will not cover any person who has attained age 66 before the Effective Date of the policy.
- 4. I understand that dependent children, if any, will be covered until age 25.
- 5. I acknowledge receipt of, if applicable:
  - Replacement Notice
  - Outline of Coverage
  - Guide to Health Insurance for People with Medicare
- 6. I understand that: (a) Aflac is not bound by any statement made by me, the applicant, or any associate/agent of Aflac unless written herein. (b) The associate/agent cannot change the provisions of the policy or waive any of its provisions either orally or in writing. (c) The policy, together with this application, endorsements, benefit agreements, riders, and attached papers, if any, is the entire contract of insurance. (d) No change to the policy will be valid until approved by Aflac's president and secretary, 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 also understand that if I or anyone to be covered is receiving any Medicaid benefits, the purchase of this coverage is not necessary.**

**CALIFORNIA LAW PROHIBITS AN HIV TEST FROM BEING REQUIRED OR USED BY HEALTH INSURANCE COMPANIES AS A CONDITION OF OBTAINING HEALTH INSURANCE COVERAGE.**

If I am applying to replace existing coverage with this policy, I acknowledge that the policies may have different benefits and that I should make a comparison to personally determine which is best for me. I understand and agree that I am terminating my current policy and its benefits for the benefits provided in the Aflac policy. I have read, or had read to me, the completed application, and I realize that policy issuance is based upon statements and answers provided herein, and they are complete and true to the best of my knowledge and belief.

Signed and Dated at \_\_\_\_\_ on \_\_\_\_\_  
City and State Date

Applicant's Signature \_\_\_\_\_

Policy Owner's Signature: \_\_\_\_\_  
(If Different From Applicant)

**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's/Agent's Signature \_\_\_\_\_ Date \_\_\_\_\_  
Licensed Resident Associate/Agent

**MAKE CHECK OR MONEY ORDER PAYABLE TO AFLAC.  
FOR INFORMATION, CALL TOLL-FREE 1-800-99-AFLAC (1-800-992-3522).  
VISIT OUR WEB SITE AT [aflac.com](http://aflac.com).**

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

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy. Medicare generally pays for most or all of these expenses.

This insurance provides limited benefits if you meet the conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

**Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:**

- \* hospitalization
- \* physician services
- \* hospice
- \* 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.

Form M-1940TH