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| CHECK COVERAGE DESIRED: | Class: <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> E |
|--------------------------------|--|

| | |
|---|---|
| Benefit Periods: | <input type="checkbox"/> 3 Months <input type="checkbox"/> 12 Months <input type="checkbox"/> 24 Months (maximum of 30 units) <input type="checkbox"/> 6 Months <input type="checkbox"/> 18 Months (maximum of 30 units) |
| Elimination Periods: Injury/Sickness | <input type="checkbox"/> 0/7 Days <input type="checkbox"/> 0/14 Days <input type="checkbox"/> 7/14 Days <input type="checkbox"/> 14/14 Days <input type="checkbox"/> 0/30 Days* <input type="checkbox"/> 30/30 Days* (*not available with 3-month Benefit Period) <input type="checkbox"/> 60/60 Days** <input type="checkbox"/> 90/90 Days** <input type="checkbox"/> 180/180 Days** (**not available with 3- or 6-month Benefit Period) |

| | No. of Units Purchased for this Application | Premium | |
|---|---|---------|--|
| <input type="checkbox"/> Base Policy Series A57500 | | | <input type="checkbox"/> Pre-Tax or <input type="checkbox"/> After-Tax |
| <input type="checkbox"/> On-the-Job Injury Rider Series A57550 | | | |
| <input type="checkbox"/> Additional Units of Disability Benefit Rider Series A57551 (applies to base policy only) Current Units: _____ (includes any additional units previously purchased) (must match policy elimination and benefit periods) | | | |
| NOTE: Each unit is equal to a \$100 monthly benefit. | Total Premium | | |

TO BE COMPLETED BY PROPOSED INSURED/EMPLOYEE

- Do you work fewer than 19 hours per week in your primary job at which you work for pay or benefits and which is considered full time employment by your employer listed on the first page of this application? Yes No
- Do you have disability coverage that you purchased that will remain in force, which combined with this applied for coverage, will exceed 70 percent of your gross monthly income? Yes No
- 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
- 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 \$15,000 or greater for coverage to be issued.**

If you answered Yes to any Question 1–3, a policy will not be issued; therefore, do not submit this application.

- Do you have any of Aflac's accident policies with disability benefits? Yes No
If yes, please complete the Supplemental Notification section at the end of this application and be aware that you cannot have this policy without canceling those disability benefits with Aflac.

Form A575PAPPAZ

PLEASE COMPLETE THE FOLLOWING QUESTIONS

- Is anyone to be covered currently disabled due to sickness or injury, or has anyone to be covered been out of work or disabled due to sickness or injury more than 5 consecutive days within the last 12 months (excluding routine childbirth)? Yes No
- Has anyone to be covered been hospitalized more than 24 hours within the last 12 months for reasons other than routine childbirth? Yes No
- Does anyone to be covered have any condition for which any medical procedure (including but not limited to surgery, child delivery, organ or bone marrow transplant) has been planned or the possibility of which has been discussed with medical personnel? Yes No
- Has anyone to be covered been to see a member of the medical profession about a medical condition that has yet to be diagnosed? Yes No

5. Has anyone to be covered, within the last five years: been convicted of a felony; been charged two or more times with operating a vehicle while under the influence of alcohol or drugs; been charged three or more times with a moving violation; or is currently on parole or incarcerated in a correctional institution? Yes No
6. Does anyone to be covered currently have or in the last 12 months, has anyone to be covered been diagnosed with or treated for any of the following conditions or had any of the following procedures: Yes No

| | |
|------------------------|---|
| AIDS | ulcerative colitis |
| Systemic lupus | ulcerative proctitis |
| muscular dystrophy | vascular insufficiency (circulatory problems) |
| Parkinson's Disease | diabetes (Type II) diagnosed prior to age 30 |
| cystic fibrosis | any sort of back, neck, or joint disorder |
| pulmonary hypertension | carpal tunnel syndrome |
| renal hypertension | psoriatic arthritis |
| Crohn's disease | rheumatoid arthritis |
| Ileitis | sciatica |
| regional enteritis | |

7. Within the last 5 years, has anyone to be covered been diagnosed with or treated for any of the following conditions or had any of the following procedures: Yes No

| | |
|---|---|
| heart attack | diabetes treated with insulin |
| cardiomyopathy | diabetes with complications to include nephropathy; |
| bypass/stents/angioplasty | neuropathy; or retinopathy |
| atrial fibrillation | kidney disease or disorder (not including stones) |
| implant of pacemaker/defibrillator | liver disease or disorder (excluding Hepatitis A) |
| heart surgery (including valve replacement or correction) | fibromyalgia |
| congestive heart failure | chronic fatigue syndrome |
| stroke/TIA | sarcoidosis |
| chronic obstructive pulmonary disease (COPD) | multiple sclerosis |
| emphysema | alcohol or drug abuse |
| pulmonary fibrosis | internal cancer (to include myelodysplastic blood disorder and myeloproliferative blood disorder) |
| diabetes and used tobacco after diagnosis | melanoma (Clark's Level III or higher, or a Breslow Level greater than 1.5 mm) |

If you answered Yes to any question 1 - 7, you are not eligible for any disability coverage; therefore, do not submit this application.

8. Has anyone to be covered ever tested positive for human immunodeficiency virus (HIV)? Yes No
 If yes, has the result been substantiated by one ELISA test and one Western Blot Blood Test? Please Yes No
 complete Supplemental Questionnaire A-14394-AZ and if applicable, Consent Notice A-14393AZR.

**PLEASE COMPLETE THE FOLLOWING QUESTIONS IF YOU ARE APPLYING FOR MORE THAN 20 UNITS OF COVERAGE OR A BENEFIT PERIOD GREATER THAN 12 MONTHS.
 Additional underwriting may be required.**

9. During the last 6 months, have you received any medical treatment, including injections, or been prescribed or taken medications (other than prescription contraceptives)? Yes No
 If yes, please provide descriptive information below.

| Medical Conditions/Treatments | Onset (mo/yr) | Surgery Performed? (If yes, provide the type of procedure and date) | Date Last Treated | Released by Physician | For Hypertension and Diabetes, List the Average Reading (for the last three months) |
|-------------------------------|---------------|---|-------------------|--|---|
| | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | |

| | | | | | |
|--|--|--|--|--|--|
| | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | |

| Medication Name | Dosage | Date First Prescribed | Medical Condition |
|-----------------|--------|-----------------------|-------------------|
| | | | |
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10. Has anyone to be covered used tobacco products or products containing nicotine of any type in the last 12 months? Yes No
11. a. Do you have any individual disability income coverage in force? Yes No
b. Do you have any group disability income coverage in force? Yes No
- If yes to 11a or 11b, please list your monthly benefit amounts/percentages: _____, your benefit period: _____, and your Elimination Period: _____.

PLEASE COMPLETE THE FOLLOWING QUESTION IF YOU ARE APPLYING FOR THE ON-THE-JOB INJURY RIDER.

12. Are you covered by worker's compensation or a similar law in your full-time job? Yes No
- Similar laws include but are not limited to the following:**
Railroad Retirement Act
Jones Act
Maritime Doctrine of Maintenance
Wages or Cure
Longshoremen's and Harbor Worker's Acts

If you answered Yes, you are not eligible for On-the-Job Injury Rider coverage; and therefore, this rider will not be issued.

Form AuwallAZ

APPLICANT'S STATEMENTS AND AGREEMENTS

- I understand that the Effective Date of the policy will be the date recorded in the Policy Schedule by Aflac Worldwide Headquarters. It is not the date this application was signed by me.
- I understand that coverage is not provided for an illness, disease, infection, disorder, or injury for which, within the 12-month period before the Effective Date of coverage, medical advice, consultation, or treatment was recommended or received, or for which symptoms existed that would ordinarily cause a prudent person to seek diagnosis, care, or treatment. Disability caused by a Pre-existing Condition or reinjuries to a Pre-existing Condition, including deliveries for children conceived prior to the Effective Date of coverage, will not be covered unless it begins more than 12 months after the Effective Date of coverage.
- I acknowledge receipt of, if applicable:
 - Replacement Notice
 - Outline of Coverage
 - Guide to Health Insurance for People With Medicare*
 - Fair Credit Reporting Notice

- 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) the policy, together with this application, endorsements, benefit agreements, riders, and attached papers, if any, constitutes the entire contract of insurance; and (3) no change to the policy will be valid until approved by Aflac's president and secretary, and noted in or attached to the policy.
- I understand that the associate/agent cannot change the provisions of the policy or waive any of its provisions either orally or in writing.
- 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 on an online enrollment system, if applicable.
- If I am applying to replace existing Aflac 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 Aflac policy and its benefits for the benefits provided in this Aflac policy.
- I have reviewed the statements and answers I have provided on this application. I understand that this policy is to be issued based upon these statements and answers, and any other pertinent information Aflac may require for proper underwriting. The answers are complete and true. I understand that all statements made in this application are deemed representations and not warranties but that any fraudulent material misrepresentations herein may result in loss of coverage under this policy. I further understand that I am signing this application one time even though I may have used it to apply for more than one policy.

SUPPLEMENTAL NOTIFICATION

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

I, _____, am applying for Aflac's short-term disability policy. I currently have disability benefits under Aflac accident/disability Policy Number _____. I understand that I must cancel existing Aflac disability coverage to purchase this short-term disability policy.

- Please cancel the disability riders attached to my accident policy, but keep my accident policy in force.
- I wish to retain my spouse disability rider. I may retain the spouse disability rider **ONLY** if the accident policy remains in force.
- Please cancel my entire accident policy (with Disability Benefits) number _____. I understand that I will be terminating benefits provided for in my current accident policy that are not provided for in the new short-term disability 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.

INFORMATION REGARDING THE MEDICAL INFORMATION BUREAU (MIB)

PRENOTICE

Information regarding your insurability will be treated as confidential. Aflac may, however, make a brief report thereon to MIB, Inc., formerly known as the Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file. Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB toll-free at 1-866-692-6901 (TTY 1-866-346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

Aflac may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its web site at www.mib.com.

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), MIB, Inc., formerly known as 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 nonmedical 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 MIB, Inc. I understand that I may request an interview in connection with the preparation of the investigative consumer report and that upon request, receive a copy.

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 redisclosed 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, Attn: 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 and that I or an authorized representative may request a copy of this authorization.

Form A575PAPPAZ

I, the undersigned Proposed Insured/Employee, agree that by signing below I am submitting an application to Aflac for the following insurance policy(ies).

- Lump Sum Critical Illness
- Lump Sum Cancer
- Short Term Disability
- Accident
- Dental
- Hospital Confinement
- Specified Health Event
- Vision
- Specified Disease/Cancer
- Hospital Intensive Care

I would prefer to receive an electronic copy of my policy(ies) instead of paper. Yes No

Signed and Dated at _____ on _____
City and State Date

Proposed Insured's/Employee's Signature _____

I certify that I personally saw the Proposed Insured/Employee when the application was written, and each question was asked of the Proposed Insured/Employee 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.**