

**ELIGIBILITY QUESTIONS
TO BE COMPLETED BY PROPOSED INSURED/EMPLOYEE**

1. Are you actively working with the employer listed on the first page of this application? Yes No

If you answered No to Question 1, a policy will not be issued; therefore, do not submit this application.

2. Do you work fewer than 19 hours per week with the employer listed on the first page of this application? Yes No

3. Do you have disability coverage that you purchased that will remain in force which, combined with this applied-for coverage, will exceed 72 percent of your gross monthly income? Yes No

If you answered Yes to Question 2 or 3, a policy will not be issued; therefore, do not submit this application.

4. I certify that my taxable (gross) annual income from my job with the employer listed on the first page of this application is \$ _____ (If you are self-employed, please use an average of the **net earnings** for the past two years from the business listed on this application.) I understand that this information may require verification, to include tax records, at the time of claim. **Annual income must be \$9,000 or greater for coverage to be issued.**

TO BE COMPLETED BY AFLAC ASSOCIATE/AGENT

Billing Method:

- Payroll Deduction
- Bank Draft (B/D, ACH)
- Credit Card (C/C)

Mode:

- 01 Weekly
- 01 14-Day Biweekly
- 01 Semimonthly
- 01 28-Day Biweekly
- 01 Monthly
- 03 Quarterly
- 06 Semiannual
- 12 Annual

PLEASE NOTE: If B/D, ACH, or C/C billing method is checked, only the following modes of payment are available: Monthly, Quarterly, Semiannual, or Annual.

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

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

CHECK COVERAGE DESIRED: [Class: A B C

Total Disability Benefit Periods:	<input type="checkbox"/> 3 Months <input type="checkbox"/> 6 Months
Partial Disability Benefit Period:	3 Months
Elimination Periods: Injury/Sickness	<input type="checkbox"/> 0/7 Days <input type="checkbox"/> 0/14 Days <input type="checkbox"/> 7/7 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 Total Disability Benefit Period)

	No. of Units	Premium	<input type="checkbox"/> Pre-Tax or <input type="checkbox"/> After-Tax
<input type="checkbox"/> Base Policy Form A57600TX			
<input type="checkbox"/> Base Policy Form A57600LBTX			
<input type="checkbox"/> On-the-Job Injury Rider Form A57650TX			
<input type="checkbox"/> On-the-Job Injury Rider Form A57650LBTX			
Are you currently covered by on-the-job disability income replacement under a collective bargaining agreement, workers' compensation or a similar law in your job with the employer listed on the first page of this application? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Similar laws include but are not limited to the following: Railroad Retirement Act; Jones Act; Maritime Doctrine of Maintenance, Wages, or Cure; Longshore and Harbor Workers' Compensation Act			
NOTE: Each unit is equal to a \$100 monthly benefit.	Total Premium]		

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 (1) Aflac is not bound by any statement made by me, or any associate/agent of Aflac, unless written herein, and (2) the associate/agent cannot change the provisions of the policy or waive any of its provisions, either orally or in writing.
- I understand that (1) the policy, together with this application, and the endorsements, benefit agreements, riders, and attached papers, if any, constitutes the entire contract of insurance; and (2) 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 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.
- I understand that the following conditions apply:
 - Coverage is not provided for an illness, disease, infection, disorder, condition 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, including deliveries for children conceived prior to the Effective Date of coverage, or reinjuries to a Pre-existing Condition will not be covered unless it begins more than 12 months after the Effective Date of coverage (or begins 6 months from the Effective Date for insureds who were issued the policy at age 65 or over);
 - Coverage is not provided for an illness, disease, infection, or any other physical condition, independent of Injury, that is diagnosed or treated by a Physician within the first 30 days after the Effective Date of coverage, unless the resulting Disability begins more than 12 months after the Effective Date of coverage; and
 - Aflac will not pay benefits for a Disability that is caused by or occurs as a result of pregnancy or childbirth if the pregnancy began prior to the Effective Date of coverage. Complications of such pregnancy will be covered to the same extent as a Sickness.

Proposed Insured's Initials _____

- 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.

Proposed Insured's Initials _____

- 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 material misrepresentations herein may result in loss of coverage under this policy.
- I acknowledge receipt of, if applicable:
 - Replacement Notice
 - Outline of Coverage
 - Guide to Health Insurance for People With Medicare*
 - Fair Credit Reporting Notice

SUPPLEMENTAL NOTIFICATION

COMPLETE IF YOU ARE REPLACING OR 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 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, Kansas, Maine, Massachusetts, Minnesota, Montana, Nevada, New Jersey, North Carolina, Ohio, Oregon, Virginia, and Wisconsin.

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

I authorize the following to give information (as defined below) to Aflac or any person or entity acting on its part: any medical professional, medical care institution, pharmacy-related service organizations, 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 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 if coverage is 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 to contest 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.

I would prefer to receive an electronic copy of my policy instead of a paper copy. 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 recorded 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.**