AFLAC NEW BUSINESS TRANSMITTAL

❒ Bank Draft ❒ Payroll ❒ Association ❒ Direct
❒ Credit Card ❒ Employee Nonpayroll ❒ Conversion

1. Associate's Transmittal No. (Two Digits Only) [ ][ ]

2. Date: ____________________
3. State Business Written In: __________
4. Multi-State/Multi-Location Account ❒ Yes ❒ No
If yes, has account been registered with Account Relations Department? ❒ Yes ❒ No

5. **ASSOCIATE INFORMATION**

A. % Payable to: ____________ (Writing Associate Name) Writing No.: ______ Sit. Code: ______ Phone No.: ______
Associate's Address: ____________________ Fax No.: ______

B. % Payable to: ____________ (Writing Agent Name) Writing No.: ______ Sit. Code: ______ Phone No.: ______
Associate's Address: ____________________ Fax No.: ______

C. % Payable to: ____________ (Writing Associate Name) Writing No.: ______ Sit. Code: ______ Phone No.: ______
Associate's Address: ____________________ Fax No.: ______

D. % Payable to: ____________ (Writing Associate Name) Writing No.: ______ Sit. Code: ______ Phone No.: ______
Associate's Address: ____________________ Fax No.: ______

Split-Business Requirements: "I, the writing associate A, certify that it is my desire to have all compensation paid as indicated above." The associate who signed the applications must sign this statement. If applications were signed by two different associates, both must sign below.

____
Signature of Writing Associate A

6. **IF EMPLOYEE OR ASSOCIATION BUSINESS, COMPLETE THIS SECTION:**
By completing this section, I certify that this account meets the requirements set forth by Aflac and that each applicant is a valid member/employee of the account.

Name and Address of Employer or Association:
____
____

If PEO/Leasing or Staffing Company, list contracted Company Name: _________
____________________ Approved Aflac ID No.: ____________

7. ❒ New Account
❒ Additions to Existing Account No.
Is this account sponsored by employer?
Yes ❒ No ❒ (PA residents only)

8. ❒ Nonsoliciting Broker ❒ General Agent
____
Broker/General Agent No.: ____________
Level No.: ____________

Has SIC/Industry Code been approved by SIC unit at Aflac? If not, seek approval before submitting applications.

9. **Wingspan℠ Cafeteria Plan or Cafeteria Information (if applicable):**
Plan Year: ____________ Beginning (MM/DD/YY) Ending (MM/DD/YY)
❒ New Wingspan℠ Cafeteria Plan Account
❒ Addition to existing New Wingspan℠ Cafeteria Account No.: ____________
❒ Existing Aflac payroll account to be converted to a new New Wingspan℠ Cafeteria Account
❒ Other cafeteria plan____________________

FOR WWHQ USE ONLY:
Summary Number: ____________
Specialist Name: ____________
Date Processed: ____________
Effective Date: _________ **Specification Code:** _________

10. NAME OF APPLICANT Last First MI	11. New/Existing Employee	12. Line of Business	13. Modal Prem. Sold *After-Tax	14. Dept. No.	15. Premium Remitted
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					

16. **SEND POLICY TO:** **(01) Applicant ❒** **(02) Associate ❒** **(03) Account ❒** **(04) State Office ❒** **Other ❒** **(EXPLAIN BELOW)**

17. **REQUESTED EFFECTIVE DATE:**

18. **SPECIAL INSTRUCTIONS/INFORMATION:**

FOR RPS USE ONLY:

PROCEDURES FOR COMPLETING THE AFLAC TRANSMITTAL

GENERAL INFORMATION

- This form is to be used for all lines of business.
- Please submit Medicare supplement, Long-Term Care, or Life business on separate transmittals from other lines of business. Do not submit new business and conversion applications on the same transmittal.
- If sales are made on more than one account, prepare a separate transmittal form for each account. This applies to Payroll and Nonpayroll account business.
- Attach applications to transmittal form in the same sequence that they are listed on the transmittal.
- To avoid delays in processing, make sure all applications contain complete information (including signatures when applicable) and that the information shown is legible.
- Submit an application requiring skin cancer or other exclusion riders on a separate transmittal.
- Please submit one transmittal copy to worldwide headquarters.

HOW TO COMPLETE THE NEW BUSINESS TRANSMITTAL

1. Number each transmittal with a two-digit identification number (e.g., 01, 02) in the space provided under Associate's Transmittal No. When worldwide headquarters issues you a commission check for a particular transmittal, the number that you furnish will be printed on the stub. This is for your convenience in reconciling checks with transmittal copies. We suggest that you start numbering your transmittals at the first of the month with the number 01, and number them consecutively throughout the month. Start over with 01 at the first of the next month, etc.
2. Write the date the transmittal is being completed.
3. It is imperative that you indicate the state business is written in. Example: Applicant resides in Alabama, but the application is written in Georgia. This means that the business is produced in the state of Georgia; therefore, Item 3 should show Georgia.
4. Indicate whether the payroll account is a multi-state or multi-location account. If Yes, indicate whether the account has been registered with the Account Relations Department.
5. a. Please complete the writing associate's percent of commission, name, address, phone number, fax number, writing number, and proper situation code.

   b. Complete this section if this is a split commission. The associate(s) who signed the applications must provide his or her legal signature under the split-business requirement.
6. Complete this section if this is employee or association business.
7. Check the appropriate box for a new or existing account and give the account number. (If PA residents, the question concerning employer sponsorship must be answered.)
8. If the account is a broker account, this box must be checked and the nonsoliciting broker or general agent's name, writing number, and level number must be provided.
9. To maintain accurate records, it is important that this section be appropriately completed for all WingspanSM Cafeteria Plan cafeteria accounts. All premium listed will be considered pre-tax unless indicated as after-tax on No. 13. If this is an existing account that is converting to a WingspanSM Cafeteria Plan cafeteria plan, please submit, with the initial business, a copy of the previous month's invoice noting whether the premiums are to be pre-tax or after-tax.
10. Print applicant's last name, first name, and middle initial.
11. If the account is a WingspanSM Cafeteria Plan account, indicate whether the employee is new or existing. This is essential in assigning effective dates.
12. Enter the proper abbreviation in the line of business: Accident=**AD**, Cancer=**CA**, Dental=**DE**, Group Medicare Supplement=**GMS**, Group Short-Term Disability=**GS**, Hospital Indemnity=**HP**, Intensive Care=**IC**, Long-Term Care=**LT**, Payroll LifeAssurance=**LC**, Preferred Life and Voluntary Group Term Life=**AL**, Short-Term Disability=**SD**, Specified Event=**SE**, Term to Age 25, Life Needs, and Conversion Whole Life=**LP,** Vision=**VS**
13. Please enter the premium amount for the mode on the applications. Example: Applicant chooses quarterly, family, payroll coverage—the amount should be listed in this column minus any registration fee. Note: For WingspanSM Cafeteria Plan business, indicate (*) for after-tax. <u>If an asterisk (*) is not present or if the modal premium is not listed, the premium will be considered pre-tax.</u>
14. Enter the department number, if applicable.
15. If money is being remitted with the application, enter the dollar amount, including the registration fee (if applicable) in this space. If this is COD payroll business, enter "PR" in this space.
16. Check the appropriate box to indicate where the policy should be mailed. If no box is checked, the policy will be mailed to the applicant.
17. Please indicate the requested effective date required. Otherwise, normal effective date procedures will be followed.
18. This space is provided for the associate's special instructions or comments. When submitting multi-state conversions, use this space to indicate that the statement should receive production credit.

Aflac

Payment Authorization Agreement

Policyholder/Applicant Information

		Policy Numbers	Premium Amount	Policy Numbers	Premium Amount
Name:					
Address:					
City, State, ZIP:					
Phone:		No. of policies:		Total: $	

Deduction Information

For newly issued policies only: For ease of your policy administration, if the policy is issued, we will make the effective date of coverage the same as your selected draft date following the receipt of your application at Aflac Worldwide Headquarters. For Direct Life only, if the policy is issued, we will make the effective date of coverage the same as your selected draft date following the approval by Underwriting of your application.

Applicant's Initials

When would you like your premiums deducted?

How often? ☐ Monthly ☐ Quarterly ☐ Semiannually ☐ Annually

Please choose a month for the first deduction. ______________________________

Please choose any day 1–28 for the first deduction. ______________________________

☐ I choose to pay by electronic draft.

Account Holder's Name: ______________________________

Account Holder's Address: ______________________________

City: ______________________ State: ______________ ZIP: ______________

Routing Transit Number: ☐☐☐☐☐☐☐☐☐

Account Number: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

☐ Checking ☐ Savings

☐ I choose to pay by credit or debit card (only Visa, MasterCard, and American Express are accepted).

Card Holder's Name: ______________________________

Card Holder's Address: ______________________ City: ______________ State: _____ Zip: _____

Card Number: ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐

Expiration Date: ☐☐ / ☐☐

Confirmation

I authorize Aflac to initiate debit entries electronically to my account indicated above, and I authorize the depository institution named above to debit same to such account. This authorization remains effective and in full force until Aflac and the depository/institution receives written notification from me of its termination in such time and in such manner to afford Aflac and the depository/institution a reasonable opportunity to act on it.

Account Holder's/Card Holder's Signature: ______________________________ Date: ________
(If different from Policyholder/Applicant)

Policyholder's/Applicant's Signature: ______________________________ Date: ________

Agent's Signature: ______________________________ Writing Number: ________ Date: ________
(Required for SNG Only)

American Family Life Assurance Company of Columbus
Worldwide Headquarters ● 1932 Wynnton Road ● Columbus, GA 31999
1.800.99.AFLAC. (1.800.992.3522) ● aflac.com

Agent-Only

ACCIDENT-ONLY INSURANCE (A36000 Series)

❑ New
❑ Conversion

Policy Number:

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

Please Print in Black Ink – To Be Completed by Proposed Insured

Proposed Insured's Name ______________________________
Last First MI

DOB ______________ Sex ________ SSN ________ - ________ - ________
Month/Day/Year

Address ______________________________
Street or Post Office Box Apt. No.

City ______________ State ________ ZIP ______________

Telephone ( ) ______________ Best Time to Call ______________
❑ Home ❑ Work ❑ Cell

Email Address ______________________________

Are you applying for Dependent Child(ren) coverage? ❑ Yes ❑ No
If yes, Dependent Children must be under age 26 as of the Effective Date of coverage.

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 the space below.

Spouse's Name ______________________________ DOB ______________ Sex ________
Last First MI Month/Day/Year

Account Name ______________________________ Account No. ______________

Name of Employer ______________________________ Type of Business ______________

Job Duties ______________________________

Job Title ______________________________

Occupation Class ______________ Industry Code ______________
(Completed by agent) (Completed by agent)

PLEASE COMPLETE THE FOLLOWING ELIGIBILITY QUESTION

1. Are you, the Proposed Insured, actively at work with the employer listed above? ❑ Yes ❑ No
   If no, a policy will not be issued; therefore, do not submit this application.

Is this insurance intended to replace any other health insurance now in force? ❑ Yes ❑ No
If yes, please read and sign the Replacement Notice provided by your agent, and provide the policy number, company name, and Effective Date of the policy being replaced here: ______________________________

____

Does anyone to be covered currently have any other Accident coverage with Aflac or have you, the Proposed Insured, had any other Accident coverage with Aflac that terminated within the last six months? ❑ Yes ❑ No
If yes, or we determine that other Accident coverage was in force within the last six months, this application will be processed as a conversion of that coverage. Please give current policy number and see Applicant's Statements and Agreements concerning conversions and replacement of coverage.

Policy Number: ______________________________

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Check Coverage Desired:	❑ Individual	❑ Named Insured/ Spouse Only	❑ One-Parent Family	❑ Two-Parent Family

Class: ☐ E ☒ After-Tax

SELECT ONE TYPE OF COVERAGE: ☒ 24-Hour Accident-Only

SELECT ONE PLAN OPTION (Issue Ages 18-75):	❑ Option 1	❑ Option 2	❑ Option 3	❑ Option 4

Optional Rider (Issue Ages 18-70):	
❑ Additional Accidental-Death Benefit Rider Series A36050	☒After-Tax Only

Billing Method:
❑ Statement Deduction
❑ Bank Draft (B/D, ACH)
❑ Credit Card (C/C)

Mode:
❑ 01 Monthly
❑ 03 Quarterly
❑ 06 Semiannual
❑ 12 Annual

Employee No. ____________________ Dept. No. ____________________ Agent's No. ____________________

Billable Premium $ __________________ Premium Collected $ ____________ Sit. Code ______________________

PLEASE COMPLETE THE FOLLOWING QUESTION IF YOU ARE APPLYING FOR AN ACCIDENT-ONLY POLICY.

1. Within the last five years, has anyone to be covered been convicted of a felony; been convicted two or more times with operating a vehicle while under the influence of alcohol or drugs; been convicted three or more times with a moving violation; or is anyone to be covered currently on parole or incarcerated in a correctional institution? ❑ Yes ❑ No

If you answered Yes to Question 1 above, was it the:

❑ Proposed Insured? ❑ Spouse? ❑ Child? If a child, please list the name(s) of the child(ren):

____
Name of person(s)

Any person(s) indicated above will not be covered under the policy. If the Proposed Insured, a policy will not be issued; therefore, do not submit this application.

If a child, are other children to be covered? ❑Yes ❑ No

BENEFICIARY INFORMATION

PLEASE NOTE: Your beneficiary will be your estate unless otherwise indicated.

If you name a trust as your beneficiary, please include full name of trust.

We do not recommend that you name a minor child as your beneficiary. If you name a minor child as your beneficiary, any benefits due your minor beneficiary will not be payable until a guardian for the financial estate of the minor is appointed by the court or such beneficiary reaches the age of majority as defined by your state. We suggest you obtain legal advice before naming a minor child as your beneficiary.

Primary beneficiary(ies): **NOTE: Total % of Proceeds must equal 100%**

(1) Name ____ % of Proceeds ____________
Last Name First Name MI

Or Trustee(s) of ____
Name of Trust

Trust under trust agreement dated ______________________________

Address ____
Street Address City State Zip

Telephone No. ___________________________ SSN _________ -_________ -____________

Date of Birth ___________________________ Relationship to Insured ____________________

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(2) Name ____ % of Proceeds ___________
Last Name First Name MI

Or Trustee(s) of _______________________________________
Name of Trust

Trust under trust agreement dated __________________________

Address ____
Street Address City State Zip

Telephone No. ________________________ SSN _______ -_______ -__________

Date of Birth _________________________ Relationship to Insured _________________

Contingent beneficiary(ies): **NOTE: Total % of Proceeds must equal 100%**

(1) Name ____ % of Proceeds ___________
Last Name First Name MI

Or Trustee(s) of _______________________________________
Name of Trust

Trust under trust agreement dated __________________________

Address ____
Street Address City State Zip

Telephone No. ________________________ SSN _______ -_______ -__________

Date of Birth ________________________ Relationship to Insured _________________

(2) Name ____ % of Proceeds ___________
Last Name First Name MI

Or Trustee(s) of _______________________________________
Name of Trust

Trust under trust agreement dated __________________________

Address ____
Street Address City State Zip

Telephone No. ________________________ SSN _______ -_______ -__________

Date of Birth _________________________ Relationship to Insured _________________

APPLICANT'S STATEMENTS AND AGREEMENTS:

- I understand that the Effective Date of the policy and/or rider(s) will be the date recorded in the Policy Schedule by Aflac Worldwide Headquarters. It is not the date I signed this application.
- I understand that the policy I am applying for will not cover any person who has reached his or her 76th birthday before the Effective Date of coverage. If I am applying for an optional rider, I understand that the rider I am applying for will not cover any person who has reached his or her 71st birthday before the Effective Date of coverage.
- If applicable, I understand that Dependent Children, if any, must be under age 26 as of the Effective Date of coverage. Once covered, Dependent Children will continue to be covered until their 26th birthday. When coverage on all Dependent Children terminates, you must notify Aflac, in writing, and elect whether to continue the coverage on an Individual or Named Insured/Spouse Only basis. After such notice, Aflac will arrange for the payment of the appropriate premium due, including returning any unearned premium.

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- I acknowledge receipt of, if applicable:
  - ❑ Replacement Notice
  - ❑ Outline of Coverage
  - ❑ *Guide to Health Insurance for People With Medicare*
  - ❑ Electronic Delivery Notice
- I understand that (1) the policy, together with the applications, 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 (1) Aflac is not bound by any statement made by me, or any agent of Aflac, unless written herein and (2) the agent cannot change the provisions of the policy or waive any of its provisions either orally or in writing.
- I understand that the purchase of the policy and/or rider(s) is intended to supplement my existing comprehensive health care coverage. It is not intended to replace or be issued in lieu of that coverage.
- 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 and/or rider(s) may have different benefits and that I should compare them to determine which is best for me. I understand and agree that I am terminating my current Aflac policy and/or rider(s) and its/their benefits for the benefits provided in this Aflac policy.

  Proposed Insured's Initials ________________________
- I acknowledge that I was offered the optional rider(s), and I have personally determined which, if any, are best for me.

  Proposed Insured's Initials ________________________
- I have read, or had read to me, the statements and answers I have provided on this application. I understand that the policy and/or rider(s) are 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 to the best of my knowledge and belief. 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 the policy and/or rider(s).

I prefer to receive an electronic copy of my policy instead of a paper copy. ❑ Yes ❑ No
If yes, please enter your email address on Page 1.

The policy provides limited benefits. Review your policy carefully.

Any person who knowingly and with intent to injure, defraud or deceive any insurer, files a statement of claim or an application containing any false, incomplete or misleading information, is guilty of a felony of the third degree.

Signed and Dated at ____ on ________________________
City and State Date

Proposed Insured's Signature ____

MAKE CHECK OR MONEY ORDER PAYABLE TO AFLAC.
FOR INFORMATION, CALL TOLL-FREE 1.800.99.AFLAC (1.800.992.3522).
VISIT OUR WEBSITE AT AFLAC.COM.

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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 conditions listed in the policy. 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
* hospice
* outpatient prescription drugs if you are enrolled in Medicare Part D
* 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 health insurance assistance program (SHIP).

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