REQUEST FOR CHANGE/APPLICATION FOR REINSTATEMENT AND/OR ADDITIONS
HOSPITAL CONFINEMENT INDEMNITY SERIES A46000
ATTENTION: POLICYHOLDER SERVICES (PHS)

American Family Life Assurance Company of Columbus (Aflac), Worldwide Headquarters: Columbus, GA 31999
For information, call toll-free 1-800-99-AFLAC (1-800-992-3522).
Fax number – 1-800-448-8922

❑ **Pre-tax** ❑ **After-tax**

Name of Policyholder ____________________ SS No. ____________
Last Name First Name MI

Policy Number ____________ Policy Type ____________ Date of Birth ____________

Associate's/Agent's Signature ____________________ Writing Number ____________
Licensed Resident Associate/Agent

PLEASE MAKE THE FOLLOWING CHANGES TO MY POLICY

❑ **ADDRESS CHANGE ONLY**

New Address of Policyholder ________________________________
Street Apt.No.

City ____________ State ________ ZIP ________ Telephone No. ____________

Former Address of Policyholder ________________________________
Street Apt.No.

City ____________ State ________ ZIP ________

❑ **TRANSFERS TO PAYROLL BILLING ONLY**

Transfer From ________________________________

Transfer To ____________________ Transfer To ____________
Employer Name Account Number

Department No. ____________ Employee No. ____________

Amount Remitted $ ____________ Months ____________

Billing Name ________________________________
Last Name First Name MI

Effective Date of Transfer ________________________________

© 2005 Aflac All Rights Reserved

☐ **TRANSFERS TO DIRECT BILLING ONLY**

☐ Bill at Home ☐ Bankdraft ☐ Credit Card

Transfer From: ____________________

Direct Billing Mode (select one) ☐ Monthly **(Bankdraft / Credit Card Only)** ☐ Quarterly ☐ Semiannual ☐ Annual

Amount Remitted $____________________ Months ____________________

Effective Date of Transfer ____________________

☐ **NAME CHANGE ONLY**

Name Shown on Policy ____________________
Last Name First Name MI Title

Change Name To ____________________
Last Name First Name MI Title

Reason ☐ Marriage ☐ Divorce ☐ Death ☐ Request

Payroll Billing Name ____________________(if policy is on payroll)

Draftee Name ____________________(if policy is on bankdraft)

Effective Date of Change ____________________

☐ **DELETIONS ONLY**

Person to be Deleted ____________________
Last Name First Name MI Title

Sex ☐Male ☐Female Relationship ☐ Insured ☐ Spouse ☐ Child

Reason for Deletion ☐ Divorce ☐ Death ☐ Request

Date of Divorce/Death/Request ____________________

New Policy/Contract Holder's Full Name____________________
Last Name First Name MI

Sex ☐Male ☐Female Birth Date of New Policy/Contract Holder ____________________

Billing Name (only applicable if policy on payroll)____________________
Last Name First Name MI

New Coverage Desired ☐ Individual ☐ One-Parent Family ☐ Two-Parent Family ☐ Named Insured/Spouse Only

© 2005 Aflac All Rights Reserved

❑ **ADDITIONS ONLY – Complete applicable questions listed below.**

Person(s) to be Added ____________________
Last Name First Name MI Title

Sex ❑Male ❑Female Relationship ❑ Insured ❑ Spouse ❑ Child

Reason for Addition ❑ Marriage ❑ Birth ❑ Request

Date of Marriage/Birth/Request ____________________

New Policy/Contract Holder's Full Name____________________
Last Name First Name MI

Sex ❑Male ❑Female Birth Date of New Policy/Contract Holder ____________________

Billing Name (only applicable if policy on payroll)____________________
Last Name First Name MI

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

❑ **REINSTATEMENT OF OR ADDITIONS TO POLICY ONLY – Complete applicable questions listed below.**

ANSWER QUESTIONS 1 THROUGH 8 FOR REINSTATEMENTS OR ADDITIONS ON PAYROLL SALES ONLY.

ALL OF THE FOLLOWING MUST BE COMPLETED:

1. Is anyone to be covered currently confined in a Hospital or nursing home, or has a member of the medical profession recommended hospitalization or nursing home confinement? ❑ Yes ❑ No

2. Has anyone to be covered ever been medically treated or diagnosed by a member of the medical profession as having any of the following? ❑ Yes ❑ No

   * Alzheimer's disease
   * senile dementia
   * uncorrected congenital heart defect (excluding mitral valve prolapse)
   * kidney disease (not including kidney stones)
   * systemic lupus
   * insulin-dependent diabetes
   * end-stage renal disease

3. Has anyone to be covered ever been medically treated or diagnosed by a member of the medical profession for acquired immune deficiency syndrome (AIDS) or has anyone to be covered tested positive for human immunodeficiency virus (HIV)? ❑ Yes ❑ No

4. Has anyone to be covered been medically treated or diagnosed by a member of the medical profession for an internal cancer (which includes melanoma of Clark's Level III or higher, or a Breslow level greater than 1.5 mm) within the last five years? ❑ Yes ❑ No

5. Has anyone to be covered been hospitalized or missed five consecutive days of work within the last 36 months for any of the following? ❑ Yes ❑ No

   * angina (heart-related chest pain)
   * heart surgery
   * congestive heart failure
   * heart attack
   * Parkinson's disease
   * transient ischemic attack (TIA) (ministroke)
   * stroke
   * cerebral vascular insufficiency
   * peripheral vascular disease (circulatory problems)
   * Crohn's disease

© 2005 Aflac All Rights Reserved

6. Has anyone to be covered been confined in a Hospital or received medical treatment by a member of the medical profession in an emergency room within the last 12 months for any of the following? ❑ Yes ❑ No

* emphysema
* sickle cell anemia
* Type II diabetes
* hypertension
* ulcerative colitis
* liver disease or disorder (excluding Hepatitis A)
* chronic obstructive pulmonary disease

7. Has anyone to be covered been confined in a Hospital within the last 12 months for treatment of asthma? ❑ Yes ❑ No

8. **If any one of Questions 1 through 7 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.

COMPLETE NUMBERS 1 THROUGH 13 FOR ADDITIONS AND REINSTATEMENTS ON NONPAYROLL SALES ONLY.

ALL OF THE FOLLOWING MUST BE COMPLETED:

1. Is anyone to be covered currently confined in a Hospital or nursing home, or has a member of the medical profession recommended hospitalization or nursing home confinement? ❑ Yes ❑ No

2. Has anyone to be covered ever been medically treated or diagnosed by a member of the medical profession as having any of the following? ❑ Yes ❑ No

* Alzheimer's disease
* senile dementia
* emphysema
* cerebral vascular insufficiency
* transient ischemic attack (TIA)
* heart bypass surgery (involving four or more vessels)
* uncorrected congenital heart defect (excluding mitral valve prolapse)
* stroke
* cardiomyopathy
* Type I diabetes
* psoriatic arthritis
* systemic lupus
* end-stage renal disease
* kidney failure
* kidney disease or disorder (excluding stones)
* liver disease or disorder
* cirrhosis
* hepatitis (excluding Type A)
* muscular dystrophy
* Crohn's disease
* sickle cell anemia
* cystic fibrosis

3. Has anyone to be covered ever been medically treated or diagnosed by a member of the medical profession as having Type II diabetes diagnosed prior to age 30; Type II diabetes with complications to include retinopathy, neuropathy, or nephropathy; Type II diabetes that required insulin use within the last 12 months; or Type II diabetes with continued tobacco use? ❑ Yes ❑ No

4. Has anyone to be covered ever been medically treated or diagnosed by a member of the medical profession for acquired immune deficiency syndrome (AIDS) or has anyone to be covered tested positive for human immunodeficiency virus (HIV)? ❑ Yes ❑ No

© 2005 Aflac All Rights Reserved

5. Has anyone to be covered ever had or been advised to have an organ transplant, or consulted with or been evaluated by a member of the medical profession of the need to have an organ transplant? ❑ Yes ❑ No

6. Has anyone to be covered been medically treated or diagnosed by a member of the medical profession for an internal cancer (which includes melanoma of Clark's Level III or higher, or a Breslow level greater than 1.5 mm) within the last five years? ❑ Yes ❑ No

7. During the past 36 months has anyone to be covered been medically treated or diagnosed by a member of the medical profession for any of the following? ❑ Yes ❑ No

* angina (chest pains)	* peripheral vascular disease (circulatory problems)
* congestive heart failure	* arrhythmia (with pacemaker or defibrillator)
* heart attack	* pancreatitis
* heart bypass surgery (involving 3 or less vessels)	* ulcerative colitis
* angioplasty or stent placement	* alcohol or drug abuse
* chronic obstructive pulmonary disease (COPD)	* parkinson's disease
	* multiple sclerosis

8. During the past 12 months, has anyone to be covered missed more than seven consecutive days of work due to Injury or Sickness (excluding a normal pregnancy)? ❑ Yes ❑ No

9. During the past 12 months has anyone to be covered been treated in a Hospital or Hospital emergency room for any respiratory disorders or psoriasis? ❑ Yes ❑ No

10. During the past six months, has anyone to be covered been advised by a member of the medical profession to have tests, treatment, or surgery that has not yet been done or are they undergoing evaluation following an abnormal test result? ❑ Yes ❑ No

11. **If any one of Questions 1 through 10 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.

12. Has anyone to be covered been treated or had surgery at a Hospital as an outpatient or inpatient (not including treatment or surgery for elective procedures, childbirth, tonsils, appendix or gallbladder) in the last five years? ❑ Yes ❑ No

If you answered "yes", please provide details about the nature of the illness, Injury or need for medical attention below.

Name of individual(s):	Details:

© 2005 Aflac All Rights Reserved

13. Has anyone to be covered taken any medication recommended or prescribed by a member of the medical profession within the last six weeks (not including prescription contraceptives)? ❑ Yes ❑ No

If yes, please provide complete information below:

Name of Individual(s)	Name of Medication	Frequency	Date first Prescribed	Reason/medical condition

I understand that the reinstated policy will cover loss resulting only from hospitalization that begins more than 10 days after the date of reinstatement. I understand that the information on this form applies **ONLY** to my Aflac Hospital Confinement Indemnity 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. All statements made in this application are deemed representations and not warranties. I realize that any material misrepresentation therein may result in loss of coverage under the policy. I understand that Aflac and I will have the same rights as provided under the policy(s) immediately before the due date of the defaulted premium, subject to any provisions endorsed on or attached to the policy(s) in connection with the reinstatement. I further understand that coverage under the reinstated policy is subject to the terms set forth in my policy(s) Reinstatement Provision.

Signature ______________________________

Signed and Dated at ______________________ on ______________
City and State Date

MAKE CHECKS PAYABLE TO AFLAC.
FOR INFORMATION, CALL TOLL-FREE 1-800-99-AFLAC (1-800-992-3522).
VISIT OUR WEB SITE AT AFLAC.COM.

FOR WORLDWIDE HEADQUARTERS USE ONLY

PTD ______________ No. Months Dropped ______
Lapsed ______________ $ Applied ______________
Reinstated ______________ No. Months ______________
Premiums Applied From ______ New PTD ______________
Initials ______________

© 2005 Aflac All Rights Reserved