Nonpayroll

DENTAL INSURANCE POLICY (A81000 Series)

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

❑ New
❑ Conversion

Policy Number:

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 One-Parent Family, Two-Parent Family or Named Insured/ Spouse Only coverage; if no spouse or spouse is not to be covered, put N/A in space below.)

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

Spouse's SSN _____ - _____ - _____

Address _____
Street or Post Office Box Apt. No.

City _____ State _____ ZIP _____

Home Telephone ( ) _____

Name of Dental Provider (optional): _____

Name of Employer/Association: _____

Do you have any other dental insurance coverage in force with another company? ❑ Yes ❑ No
Are you covered under any other AFLAC dental insurance? ❑ Yes ❑ No
If yes, this must be a conversion of that coverage. Please provide your current policy number. _____
Please read the **"NOTE – IF THIS IS AN APPLICATION FOR CONVERSION"** section on page 2.

Is this insurance intended to replace any other dental insurance now in force? ❑ Yes ❑ No
If yes, please read and sign the Replacement Notice provided by your associate/agent, if applicable.

TO BE COMPLETED BY AFLAC ASSOCIATE/AGENT

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

❑ Basic Policy (Series A81100) $25 Dental Wellness
❑ Standard Policy (Series A81200) $50 Dental Wellness
❑ Premier Policy (Series A81300) $50 Dental Wellness

TO BE COMPLETED BY AFLAC ASSOCIATE/AGENT

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

Modes:
❑ 01 Monthly (B/D & C/C Only)
❑ 03 Quarterly
❑ 06 Semiannual
❑ 12 Annual

Card Name _____ Card No. _____

Expiration Date _____

I authorize American Family Life Assurance Company of Columbus (AFLAC) to charge my VISA/MASTERCARD/AMERICAN EXPRESS account in accordance with the premium rate that I have chosen. Premiums will be advanced by my bank until I cancel authorization in writing to AFLAC. Cancellation will be effective on the first day of the month following AFLAC's receipt of notice to cancel.

Signature _____ Date _____

Associate/Agent No. _____ Sit. Code _____ Billable Premium $ _____ Premium Collected $ _____

The following information must be completed on each dependent child to be covered. If additional space is needed please complete Supplemental Application Form Series A-80005.

Name – Last, First, MI	Date of Birth	Sex	SSN	Check if:
		❑ M ❑ F		❑ Handicapped child
		❑ M ❑ F		❑ Handicapped child
		❑ M ❑ F		❑ Handicapped child
		❑ M ❑ F		❑ Handicapped child
		❑ M ❑ F		❑ Handicapped child
		❑ M ❑ F		❑ Handicapped child
		❑ M ❑ F		❑ Handicapped child
		❑ M ❑ F		❑ Handicapped child

1. Have you or has anyone to be covered been diagnosed with or treated for any gum disease such as gingivitis within the last 24 months? ❑ Yes ❑ No

2. **If Question 1 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.

NOTE – IF THIS IS AN APPLICATION FOR CONVERSION: Any increased benefit amounts resulting from the replacement of the original AFLAC coverage with this new coverage will be subject to new Waiting Periods, if any, beginning with the effective date of this new coverage. The new Waiting Periods, if any, apply only to the amount of coverage being increased. If the Waiting Period is not met on the new policy, then any benefits due will be paid under the original plan.

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. I understand that the policy I am applying for will not cover any person who has attained age 65 before the effective date of the policy.
3. I understand that the policy I am applying for contains different Waiting Periods for benefits listed in the Schedule of Dental Procedures in the policy. This means that no benefits are payable during the listed Waiting Period. The Waiting Period begins on the effective date of the policy.
4. I understand that dependent children, if any, will be covered until age 19 (23 if full-time students).
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) The associate/agent cannot change the provisions of the policy or waive any of its provisions either orally or in writing. (b) The policy, together with this application, endorsements, benefit agreements, riders and attached papers, if any, is the entire contract of insurance. (c) 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.

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 and am applying 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.

I also understand that if I am receiving any Medicaid benefits, the purchase of this coverage is not necessary.

Signed and Dated at _____ on _____
City and State Date

Applicant's Signature _____

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.

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 www.aflac.com.