Payroll

Application for Dental Insurance (A82000 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 Proposed Insured/Employee

Proposed Insured's/Employee's Name _____
Last First MI

DOB _____ Sex _____ SSN _____ - _____ - _____
Month/Day/Year (Optional)

Address _____
Street or Post Office Box Apt. No.

City _____ State _____ ZIP _____

Home Telephone ( ) _____ Business Telephone ( ) _____

E-Mail Address (optional) _____

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

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

Name of Dental Provider (optional): _____

Payroll Account Name _____ Payroll Account No. _____

Name of Employer _____

Does anyone to be covered have any other dental insurance coverage in force with another company? ❑ Yes ❑ No

Does anyone to be covered have any other Aflac dental insurance? ❑ Yes ❑ No
If yes, this must be a conversion of that coverage.
Please provide your current policy number. _____

Does the policy listed above include the orthodontic and/or cosmetic rider? ❑ Yes ❑ No

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	❑ Named Insured/ Spouse Only	❑ One-Parent Family	❑ Two-Parent Family

❑ Essentials Policy (Series A82100) $25 Dental Wellness
❑ Level 1 Policy (Series A82200) $50 Dental Wellness
❑ Level 2 Policy (Series A82300) $50 Dental Wellness
❑ Level 3 Policy (Series A82400) $75 Dental Wellness

❑ Pre-Tax
or
❑ After-Tax

❑ Orthodontic Benefit Rider (Series A82050)

❑ Cosmetic Benefit Rider (Series A82051) ❑ After-Tax Only

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

Mode:
❑ 01 Weekly
❑ 01 14-Day Biweekly
❑ 01 28-Day Biweekly
❑ 01 Semimonthly
❑ 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's No. _____

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

NOTE – IF THIS IS AN APPLICATION FOR CONVERSION: Any increased benefit amounts resulting from the replacement of 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 previous plan.

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, including any attached rider(s) and its benefits, for the benefits provided in this Aflac policy.

Proposed Insured's Initials _____

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 the policy I am applying for will not cover any person who has attained age 71 before the Effective Date of the policy.
- 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.
- I understand that Dependent Children, if any, must be under age 26 at the time of application. Once covered, Dependent Children will continue to be covered until their 26th birthday.
- I acknowledge receipt of, if applicable:
  ❑ Replacement Notice ❑ Outline of Coverage ❑ *Guide To Health Insurance for People with Medicare*
- 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, if applicable. 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 by my associate/agent.
- 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.

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, Kansas, Maine, Massachusetts, Minnesota, Montana, Nevada, New Jersey, North Carolina, Ohio, Oregon, Virginia, and Wisconsin.

Form A82PAPPRNE

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

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.

Form Asignc