

<p><b>PIMA COUNTY DEPARTMENT OF HUMAN RESOURCES</b></p> <p><b>PROJECT: Voluntary Employee Benefits</b></p> <p><b>CONTRACTOR: American Family Life Insurance Company dba AFLAC</b></p> <p><b>AMOUNT: No Cost</b></p> <p><b>FUNDING: Pima County Employees (No cost to County as all costs are borne by the employee that enrolls in these voluntary employee benefits.)</b></p>	<table border="1"> <tr> <td align="center"><b>CONTRACT</b></td> </tr> <tr> <td>NO. <u>11.43.A. 144057-0711</u></td> </tr> <tr> <td><b>AMENDMENT NO.</b> _____</td> </tr> <tr> <td>This number must appear on all invoices, correspondence and documents pertaining to this contract.</td> </tr> <tr> <td align="center">(STAMP HERE)</td> </tr> </table>	<b>CONTRACT</b>	NO. <u>11.43.A. 144057-0711</u>	<b>AMENDMENT NO.</b> _____	This number must appear on all invoices, correspondence and documents pertaining to this contract.	(STAMP HERE)
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(STAMP HERE)						

THIS CONTRACT entered between Pima County, a body politic and corporate of the State of Arizona, hereinafter called COUNTY; and American Family Life Insurance Company dba AFLAC, hereinafter called CONTRACTOR.

**WITNESSETH**

WHEREAS, COUNTY requires the services of a CONTRACTOR to provide voluntary employee benefits and

WHEREAS, CONTRACTOR submitted the most advantageous response to County for Solicitation No. 1101639 for said services;

NOW, THEREFORE, the parties hereto agree as follows:

**ARTICLE I - TERM AND EXTENSION/RENEWAL/CHANGES**

This Contract, as awarded by the Board of Supervisors or the Procurement Director, shall commence on July 1<sup>st</sup>, 2011 and shall terminate on June 30<sup>th</sup>, 2012 unless sooner terminated or further extended pursuant to the provisions of this Contract. The parties may renew this Contract for up to four (4) additional one-year periods or any portion thereof.

Any modification, or extension of the contract termination date, shall be by formal written amendment executed by the parties hereto.

Amendments to the Contract must be approved by the Board of Supervisors or the Procurement Director, as required by the Pima County Procurement code, before any work or deliveries under the Amendment commences.

**ARTICLE II – SCOPE OF SERVICES**

This Contract establishes the agreement under which the CONTRACTOR will provide COUNTY with products and services in accordance with the attached

Exhibit A: Scope of Services (three pages).

Exhibit B: Plans incorporating the following:

Plan A: Short Term Disability

Plan B: Accident Indemnity

Plan C: Cancer Care

Plan D: Hospitalization

CONTRACTOR shall provide COUNTY the goods and services as defined in this Contract. All goods and services shall comply with the requirements and specifications as called for in this Contract and solicitation documents contained or referenced in Pima County Solicitation No 1101639. These documents are incorporated into the Contract the same as set forth in full herein.

CONTRACTOR shall employ suitably trained and skilled professional personnel to perform all consultant services under this Contract. Prior to changing any key personnel, especially those key personnel COUNTY relied upon in making this Contract, CONTRACTOR shall obtain the approval of COUNTY.

### **ARTICLE III – COMPENSATION AND PAYMENT**

In consideration for the goods and services specified in this Contract, the COUNTY agrees to provide payroll deduction services for the Pima County Employees that enroll for the services specified in this contract, including Exhibit C: Voluntary Employee Benefits Premium Schedule (3 Pages).

CONTRACTOR guarantees that premium rates shall not increase for the first twelve months of this contract, effective upon execution.

CONTRACTOR shall not increase premiums without providing the required prior notice. Goods and Services provided without the required prior notice to COUNTY and policyholders shall be at CONTRACTOR'S own risk.

For the period of record retention required under Article XXI, COUNTY reserves the right to question any payment made under this Article and to require reimbursement therefore by setoff or otherwise for payments determined to be improper or contrary to the contract or law.

It is the intention of both parties that pricing shall remain firm during the term of the contract. Price increases shall only be considered in conjunction with a renewal of the Contract. In the event that economic conditions are such that unit price increases are desired by the CONTRACTOR upon renewal of the Contract, CONTRACTOR shall submit a written request to COUNTY with supporting documents justifying such increases at least 90 days prior to the termination date of the Contract. It is agreed that the Unit Prices shall include compensation for the CONTRACTOR to implement and actively conduct cost and price control activities. COUNTY will review the proposed pricing and determine if it is in the best interest of COUNTY to renew or extend the Contract as provided for in Article I of this Contract.

### **ARTICLE IV - INSURANCE**

CONTRACTOR shall obtain and maintain at its own expense, during the entire term of this Contract the following type(s) and amounts of insurance:

- a) Commercial General Liability in the amount of \$1,000,000.00 combined single limit Bodily Injury and Property Damage. Pima County is to be named as an additional insured for all operations performed within the scope of the Contract between Pima County and CONTRACTOR;
- b) Commercial or Business automobile liability coverage for owned, non-owned and hired vehicles used in the performance of this Contract with limits in the amount of \$1,000,000.00 combined single limit or \$1,000,000.00 Bodily Injury, \$1,000,000.00 Property Damage;
- c) If this Contract involves professional services, professional liability insurance in the amount of \$1,000,000.00; and,
- d) If required by law, workers' compensation coverage including employees' liability coverage.

CONTRACTOR shall provide COUNTY with current certificates of insurance. All certificates of insurance must provide for guaranteed thirty (30) days written notice to the COUNTY of cancellation, non-renewal or material change.

### **ARTICLE V - INDEMNIFICATION**

CONTRACTOR shall indemnify, defend, and hold harmless COUNTY, its officers, employees and agents from and against any and all suits, actions, legal administrative proceedings, claims or demands and costs attendant thereto, arising out of any act, omission, fault or negligence by the CONTRACTOR, its agents, employees or anyone under its direction or control or on its behalf in connection with performance of this Contract.

CONTRACTOR warrants that all products and services provided under this contract are non-infringing. CONTRACTOR will indemnify, defend and hold COUNTY harmless from any claim of infringement arising from services provided under this contract or from the provision, license, transfer or use for their intended purpose of any products provided under this Contract.

#### **ARTICLE VI - COMPLIANCE WITH LAWS**

CONTRACTOR shall comply with all federal, state, and local laws, rules, regulations, standards and Executive Orders, without limitation to those designated within this Contract. The laws and regulations of the State of Arizona shall govern the rights of the parties, the performance of this Contract, and any disputes hereunder. Any action relating to this Contract shall be brought in a court of the State of Arizona in Pima County. Any changes in the governing laws, rules, and regulations during the terms of this Contract shall apply, but do not require an amendment.

#### **ARTICLE VII - INDEPENDENT CONTRACTOR**

The status of the CONTRACTOR shall be that of an independent contractor. Neither CONTRACTOR, nor CONTRACTOR'S officers, agents or employees shall be considered an employee of Pima County or be entitled to receive any employment-related fringe benefits under the Pima County Merit System. CONTRACTOR shall be responsible for payment of all federal, state and local taxes associated with the compensation received pursuant to this Contract and shall indemnify and hold COUNTY harmless from any and all liability which COUNTY may incur because of CONTRACTOR'S failure to pay such taxes. CONTRACTOR shall be solely responsible for program development and operation.

#### **ARTICLE VIII - SUBCONTRACTOR**

CONTRACTOR will be fully responsible for all acts and omissions of any subcontractor and of persons directly or indirectly employed by any subcontractor and of persons for whose acts any of them may be liable to the same extent that the CONTRACTOR is responsible for the acts and omissions of persons directly employed by it. Nothing in this contract shall create any obligation on the part of COUNTY to pay or see to the payment of any money due any subcontractor, except as may be required by law.

#### **ARTICLE IX - ASSIGNMENT**

CONTRACTOR shall not assign its rights to this Contract, in whole or in part, without prior written approval of the COUNTY. Approval may be withheld at the sole discretion of COUNTY, provided that such approval shall not be unreasonably withheld.

#### **ARTICLE X - NON-DISCRIMINATION**

CONTRACTOR shall not discriminate against any COUNTY employee, client or any other individual in any way because of that person's age, race, creed, color, religion, sex, disability or national origin in the course of carrying out CONTRACTOR'S duties pursuant to this Contract. CONTRACTOR shall comply with the provisions of Executive Orders 75-5, as amended by Executive Order 99-4, which are incorporated into this Contract by reference as if set forth in full herein.

#### **ARTICLE XI - AMERICANS WITH DISABILITIES ACT**

CONTRACTOR shall comply with all applicable provisions of the Americans with Disabilities Act (Public Law 101-336, 42 U.S.C. 12101-12213) and all applicable federal regulations under the Act, including 28 CFR Parts 35 and 36.

#### **ARTICLE XII - AUTHORITY TO CONTRACT**

CONTRACTOR warrants its right and power to enter into this Contract. If any court or administrative agency determines that COUNTY does not have authority to enter into this Contract, COUNTY shall not be liable to CONTRACTOR or any third party by reason of such determination or by reason of this Contract.

#### **ARTICLE XIII - FULL AND COMPLETE PERFORMANCE**

The failure of either party to insist on one or more instances upon the full and complete performance with any of the terms or conditions of this Contract to be performed on the part of the other, or to take any action permitted as a result thereof, shall not be construed as a waiver or relinquishment of the right to insist upon full and complete performance of the same, or any other covenant or condition, either in the past or in the future. The acceptance by either party of sums less than may be due and owing it at any time shall not be construed as an accord and satisfaction.

**ARTICLE XIV - CANCELLATION FOR CONFLICT OF INTEREST**

This Contract is subject to cancellation for conflict of interest pursuant to ARS ' 38-511, the pertinent provisions of which are incorporated into this Contract by reference.

**ARTICLE XV - TERMINATION**

COUNTY reserves the right to terminate this Contract at any time and without cause by serving upon CONTRACTOR 30 days advance written notice of such intent to terminate. In the event of such termination, the COUNTY'S only obligation to CONTRACTOR shall be payment for services rendered prior to the date of termination.

This Contract may be terminated at any time without advance notice and without further obligation to the COUNTY when the CONTRACTOR is found by COUNTY to be in default of any provision of this Contract.

Notwithstanding any other provision in this Contract, this Contract may be terminated if for any reason, there are not sufficient appropriated and available monies for the purpose of maintaining COUNTY or other public entity obligations under this Contract. In the event of such termination, COUNTY shall have no further obligation to CONTRACTOR, other than to pay for services rendered prior to termination.

**ARTICLE XVI - NOTICE**

Any notice required or permitted to be given under this Contract shall be in writing and shall be served by personal delivery or by certified mail upon the other party as follows:

COUNTY:  
Gwyn Hatcher, Director  
Human Resources Department  
150 W. Congress  
Tucson, AZ 85701

CONTRACTOR:  
American Family Life Assurance Company of Columbus dba AFLAC  
Thomas O. Morey, Vice President, Product Development  
1932 WYNNTON RD  
Columbus, GA 31999

**ARTICLE XVII - NON-EXCLUSIVE CONTRACT**

CONTRACTOR understands that this Contract is nonexclusive and is for the sole convenience of COUNTY. COUNTY reserves the right to obtain like services from other sources for any reason.

**ARTICLE XVIII - OTHER DOCUMENTS**

CONTRACTOR and COUNTY in entering into this Contract have relied upon information provided in the Pima County Solicitation No. 1101639 including the Request For Proposals, Instructions to Bidders, Standard Terms and Conditions, Specific Terms and Conditions, Solicitation Addenda, CONTRACTOR'S proposal and on other information and documents submitted by the CONTRACTOR in its response to Solicitation No. 1101639. These documents are hereby incorporated into and made a part of this Contract as if set forth in full herein, to the extent not inconsistent with the provisions of this contract.

**ARTICLE XIX - REMEDIES**

Either party may pursue any remedies provided by law for the breach of this Contract. No right or remedy is intended to be exclusive of any other right or remedy and each shall be cumulative and in addition to any other right or remedy existing at law or at equity or by virtue of this Contract.

**ARTICLE XX - SEVERABILITY**

Each provision of this Contract stands alone, and any provision of this Contract found to be prohibited by law shall be ineffective to the extent of such prohibition without invalidating the remainder of this Contract.

**ARTICLE XXI - BOOKS AND RECORDS**

CONTRACTOR shall keep and maintain proper and complete books, records and accounts, which shall be open at all reasonable times for inspection and audit by duly authorized representatives of COUNTY.

In addition, CONTRACTOR shall retain all records relating to this contract at least 5 years after its termination or cancellation or, if later, until any related pending proceeding or litigation has been closed.

**ARTICLE XXII - ENTIRE AGREEMENT**

This document constitutes the entire agreement between the parties pertaining to the subject matter hereof, and all prior or contemporaneous agreements and understandings, oral or written, are hereby superseded and merged herein. This Contract may be modified, amended, altered or extended only by a written amendment signed by the parties.

IN WITNESS THEREOF, the parties have affixed their signatures to this Contract on the date written below.

**PIMA COUNTY**

L. H. Williams  
Procurement Director

Date: 6/9/11

APPROVED AS TO CONTENT

[Signature]  
Department Director

APPROVED AS TO FORM

[Signature]  
Deputy County

**MARC NATELSKY**

**CONTRACTOR**

[Signature]  
Authorized Officer Signature

THOMAS O. MOREY VICE PRESIDENT, PRODUCT DIVISION  
Printed Name and Title

## EXHIBIT A: SCOPE OF SERVICES –(TWO PAGES)

CONTRACTOR shall administer the following voluntary benefits to eligible Pima County employees and dependents as well as the employees and dependents of covered outside agencies.

- Plan A: Short Term Disability
- Plan B: Accident Protection
- Plan C: Cancer Care
- Plan D: Hospital Protection

Eligible employees include those that work a minimum of 20 hours per work or 40 hours per pay period. All costs will be borne by the employees and the County makes no guarantee regarding the actual number of employees that will choose to participate. **There can be NO set-up or administrative fees.**

This program allows employees to buy any plan A-D above either separately or collectively.

CONTRACTOR shall perform the following duties:

1. Provide COUNTY with advance written notice of any change in premium structure. COUNTY shall receive such notification within the specified time frame as agreed to by CONTRACTOR and COUNTY, but not less than 180 days before contract expiration date. Notification to employees shall be in the form approved by the County.
2. Provide all communication materials such as: brochures, applications, enrollment and change forms at the expense of CONTRACTOR. COUNTY shall bear no financial responsibility for the cost of printing such brochures, applications, enrollment and/or change forms.
3. Notify COUNTY of any problem with an employee and/or dependent or payroll center that CONTRACTOR is unable to resolve.
4. Notify COUNTY of any appeal and/or claims made by an employee/individual directed to the Arizona Department of Insurance. Such notice shall be provided within fourteen (14) calendar days following the date of CONTRACTOR'S response and shall include the specific nature of the problem and the resolution to the Arizona Department of Insurance.
5. Provide monthly and annual reports broken down by product type, at no additional cost to the COUNTY. CONTRACTOR will provide reports containing, but not limited to, plan participation and claims usage, enrollment reports that detail benefits deductions, eligibility data, etc. All reports provided by CONTRACTOR to the COUNTY will comply with federal privacy and medical information laws.
6. Provide annual notices before open enrollment to employees detailing current coverage in effect, available coverage and option to cancel coverage.
7. Attend annual Open Enrollment meetings, approximately 10-15 and generally held in May.
8. CONTRACTOR shall maintain a formal grievance procedure.
9. CONTRACTOR shall maintain a toll free line for customer service and claims inquiries and shall be manned for answering such inquiries a minimum from 8:00 am to 5:00 pm (MST).
10. Enrollment or changes may be made within 30 days of initial employment, within 31 days of a family status event, or during the annual open enrollment period.
11. CONTRACTOR shall submit operating documents and certificates of coverage to the Procurement department within four (4) weeks of receiving notification of contract award.
12. CONTRACTOR shall provide coverage for eligible employees on an approved leave of absence; provided the employee continues to pay premiums.
13. CONTRACTOR shall review and finalize with Human Resources, prior to changes in claim payment process and related procedures.
14. All plans must be fully-insured. All COSTs (rates) that include payments to any independent contractors, sales distribution partners and enrollers, must disclose in detail what payments will be made relative to the above personnel, independent contractors, brokers, consultants or any third parties that you will pay from the prices and thus premiums received.
15. CONTRACTOR shall retain records in compliance with Arizona's Department of Insurance and federal regulations. CONTRACTOR agrees to give COUNTY access to information pertaining to the maintenance of their account to the extent that it does not violate privacy laws. Access to claim information cannot be granted, as this information is protected under the Medical Privacy Act.

**EXHIBIT A: SCOPE OF SERVICES –(TWO PAGES)**

COUNTY shall perform the following duties:

1. Approve all products offered and reserves the right to restrict product offerings.
2. Promote the Plan to all eligible employees during new employee orientation briefings and coordinate an annual promotion for the Plan.
3. Assist CONTRACTOR with problems relative to eligibility for the Plan.
4. Make the designated employee payroll deductions provided on the payroll transmittal for each payroll of the month.
5. Process any refund credit as requested by the CONTRACTOR and verified by COUNTY
6. Forward the premium payment for active employees to CONTRACTOR.
7. Promptly research and resolve problems brought to the COUNTY'S attention by CONTRACTOR. Types of problems include payroll deduction errors, untimely premium payment, and inability to obtain eligibility lists, etc.
8. Pima County self-bills." Self-bills means that the County will send ONLY those dollars deducted from an employee's paycheck. In the event that a deduction is NOT taken, the County will not make up the difference. This could occur if an employee is on a Leave of Absence Without Pay or otherwise receives a check which is not sufficient to meet the obligation. Along with the transfer of dollars from Pima County (done every two pay periods and includes administrative fees and deferrals), the County will submit data showing the total dollars the amounts applicable to each enrollee. Pima County Human Resources department authorized agent will advise of new hires, terminations and Leaves of Absence or otherwise does not have a deduction taken from his or her paycheck. When the employee returns to work or the employee's check is of a sufficient amount to meet the obligation, the employee will be given the opportunity to make catch up payments or to amend the annual election.

CONTRACTOR, upon receipt of notification from the COUNTY that an employee is on a leave of absence, the employee will be sent correspondence offering him or her the option of paying for his or her coverage on a direct-bill basis until he or she returns to work. Once the employee returns to work, CONTRACTOR will remove him or her from direct billing and add his or her policy(ies) back to COUNTY'S invoice.

**END OF EXHIBIT A**

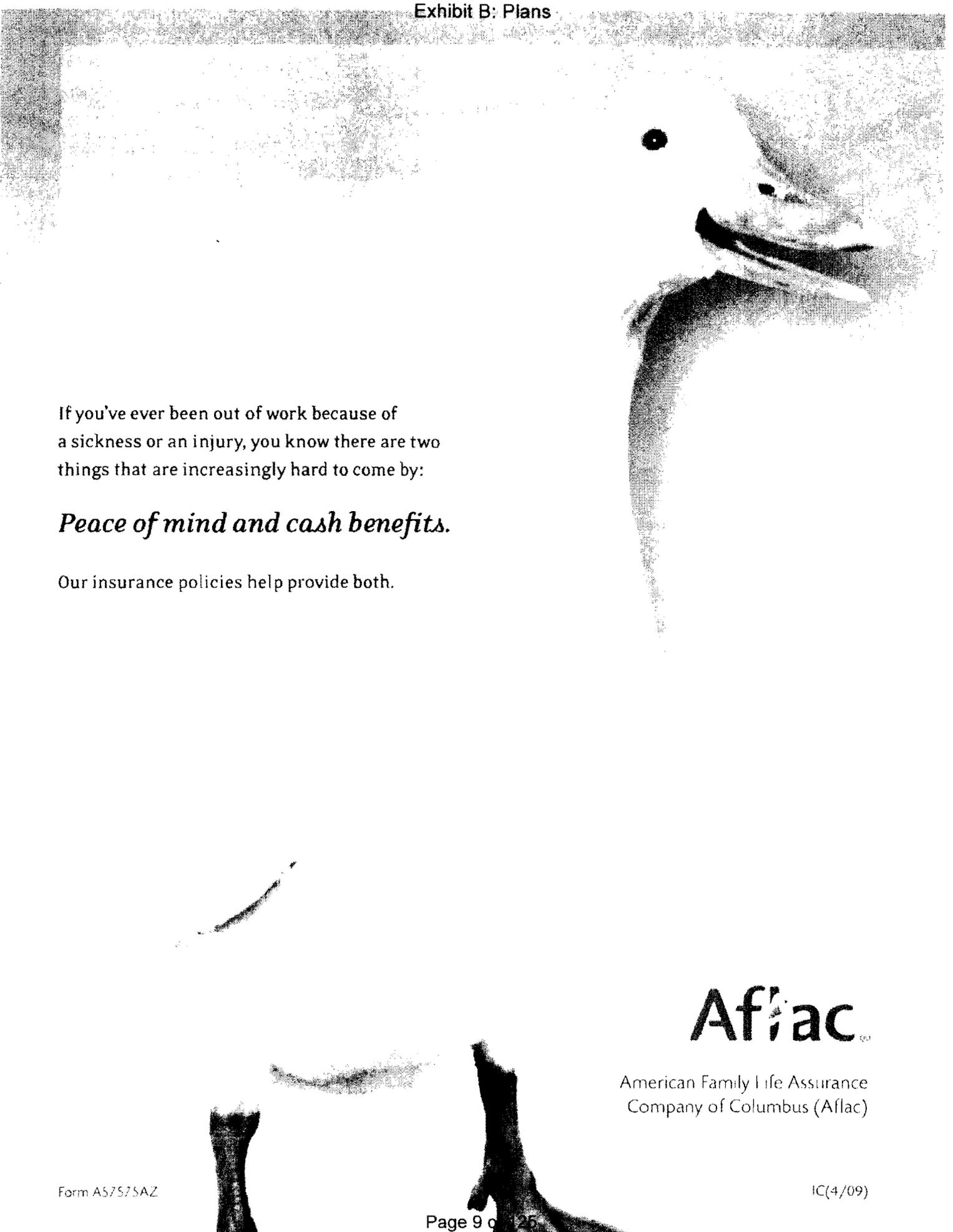
PLAN A - SHORT TERM DISABILITY PLAN

1. Aflac is offering our individual short-term disability plan guarantee-issue during the County's next open enrollment. The following guidelines apply:
  - Guarantee-issue is valid for the current enrollment/plan year only, July 1, 2011, through June 30, 2012. Guarantee-issue simply means that medical underwriting has been waived. We will not ask about a person's health history to determine eligibility for coverage. However, the applicant must fall within the required age limits for a policy. Additionally, all policy provisions and definitions—such as waiting periods, pre-existing conditions language, and limitations and exclusions—still apply.
  - Existing employees will be eligible, for the guarantee-issue offer, during their initial open enrollment period only.
  - New employees will be eligible, for the guarantee-issue offer, during their new employee benefit enrollment period only.
  - Following are the guarantee-issue specifications for the short-term disability plan:
    - The maximum benefit amount for guarantee-issue is limited to \$2,000 (applicants must qualify by income)
    - The elimination period is 14/14 and the benefit period is limited to six months
2. The short-term disability rates are guaranteed for five years. While the rates are guaranteed, we cannot guarantee the availability of this plan.
3. The County's industry code has changed from a "B" to an "A, which decreased the short-term disability premiums.
4. We have expanded coverage for dependent children on new and existing policies to age 26 regardless of marital, IRS, or education status.

If you've ever been out of work because of a sickness or an injury, you know there are two things that are increasingly hard to come by:

*Peace of mind and cash benefits.*

Our insurance policies help provide both.



**Aflac**<sup>SM</sup>  
American Family Life Assurance  
Company of Columbus (Aflac)

*Disability Income Protection Advantage™*

# Short-Term Disability

*Policy Series A57500*

## The Need

*Becoming disabled is often an unexpected and burdensome experience, and it can happen to anyone. What if a disability interrupted your job, your income, and your financial security? How would you make your house or rent payment, or cover day-to-day expenses? It's important to consider these questions because a disability could adversely affect your well-being and your finances at a time when you should be concentrating on recovery.*

### Consider These Facts:

When disabled, you may not only lose the ability to earn a living, but you may also lose savings, retirement funds, or even your home. The financial obligations can be overwhelming. Disability insurance plays an integral and important role in your financial planning.

## How Aflac Can Help

Aflac's Disability Income Protection Advantage benefits provide a source of income while you concentrate on getting better. Knowing that your disability coverage is backed by a market leader with more than 50 years in the insurance industry may help provide you with peace of mind.

Aflac's Short-Term Disability insurance policy provides you with options to help meet your income and financial needs.

- Your Aflac plan stays with you even when you change or leave your job.
- We pay you a cash benefit for each day you are disabled.
- Aflac does not coordinate benefits. Regardless of any other disability insurance benefits you may have, including Social Security, we will pay you directly (unless you assign the benefits).

***Peace of mind. Cash benefits. Knowing that you'll have help in the event of disability. All are good reasons to strongly consider the benefits of Aflac.***

## Exhibit B: Plans

Disability due to pregnancy and childbirth is payable to the same extent as a covered Sickness. Disability benefits for childbirth will only be payable after the policy has been in force ten months. The maximum benefit period allowed for childbirth is six weeks for noncesarean delivery and eight weeks for cesarean delivery, less the elimination period, unless you furnish proof that your disability continues beyond these time frames.

Disability caused by a Pre-Existing Condition or reinjury to a Pre-Existing Condition will not be covered unless it begins more than 12 months after the Effective Date of coverage.

Aflac will not pay benefits for a disability that is being treated outside the territorial limits of the United States.

Aflac will not pay benefits whenever coverage provided by the policy is in violation of any U.S. economic or trade sanctions. If the coverage violates U.S. economic or trade sanctions, such coverage will be null and void.

Aflac will not pay benefits for a disability that is caused by or occurs as a result of any bacterial, viral, or micro-organism infection or infestation, or any condition resulting from insect, arachnid, or other arthropod bites or stings as a "disability due to an Injury"; such disability will be covered to the same extent as a "disability due to Sickness."

**Aflac will not pay benefits for a disability that is caused by or occurs as a result of your:**

- Pregnancy or childbirth within the first ten months of the Effective Date of coverage (complications of pregnancy will be covered to the same extent as a Sickness);
- Using any drug, narcotic, hallucinogen, or chemical substance (unless administered by a physician and taken according to the physician's instructions), or voluntarily taking any kind of poison or inhaling any kind of gas or fumes;
- Participating in any activity or event, including the operation of a vehicle, while under the influence of a controlled substance (unless administered by a physician and taken according to the physician's instructions) or while intoxicated (*intoxicated* means that condition as defined by the law of the jurisdiction in which the accident occurred);
- Participating in, or attempting to participate in, an illegal activity that is defined as a felony (*felony* is defined by the law of the jurisdiction in which the activity takes place); or being incarcerated in any type of penal institution;
- Intentionally self-inflicting a bodily injury, or committing or attempting suicide, while sane or insane;
- Having cosmetic surgery or other elective procedures that are not medically necessary;
- Having dental treatment except as a result of Injury;
- Being exposed to war or any act of war, declared or undeclared;
- Actively serving in any of the armed forces, or units auxiliary thereto, including the National Guard or Reserve;
- Donating an organ within the first 12 months of the Effective Date of the policy;

## Exhibit B: Plans



- Mental or emotional disorders, including but not limited to the following: bipolar affective disorder (manic-depressive syndrome), delusional (paranoid) disorders, psychotic disorders, somatoform disorders (psychosomatic illness), eating disorders, schizophrenia, anxiety disorders, depression, stress, or post-partum depression. The policy will pay, however, for covered disabilities resulting from Alzheimer's disease, or similar forms of senility or senile dementia, first manifested while coverage is in force.

A physician does not include you or a member of your immediate family.

Benefits will be paid for only one disability at a time even if the disability is caused by more than one Sickness, more than one Injury, or a Sickness and an Injury.

The term *complications of pregnancy* does not include premature delivery without incidence, multiple gestation pregnancy, false labor, occasional spotting, prescribed rest during pregnancy, morning sickness, and similar conditions associated with the management of a difficult pregnancy but not constituting a classifiably distinct pregnancy complication. Elective cesarean deliveries are not considered complications of pregnancy.

**Pre-Existing Condition Limitations:** A *Pre-Existing Condition* is 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 or reinjuries to a Pre-Existing Condition, including deliveries for children conceived prior to the Effective Date of coverage, will not be covered unless it begins more than 12 months after the Effective Date of coverage.

**Fully Portable:** When you own Aflac's Disability Income Protection Advantage, you may choose to keep your policy regardless of job changes by continuing to pay premiums.

The payroll rate may be retained after one month's premium payment on payroll deduction.

**Guaranteed-Renewable to Age 70:** You are guaranteed the right to continue the policy in force until the policy anniversary date following your 70th birthday by the timely payment of premiums at the rate in effect at the beginning of each term. You can never be singled out for a rate increase. Rates can be changed only if the rate is changed for all policies of this class. While the policy is in force, no change will be made in your class because of your age, sex, or physical condition.

**Provisions of Coverage:** Aflac reserves the right to meet with you during the pendency of a claim or to use an independent consultant and a physician's statement to determine whether you are qualified to receive disability benefits. You must be under the care and attendance of a physician for benefits to be payable. Benefits will cease on the date of your death.

If you have any other disability benefit in force with Aflac, only one disability benefit is payable.

The policy to which this sales material pertains is written only in English; the policy prevails if interpretation of this material varies.

## Exhibit B: Plans

- **Monthly Benefit: \$500–\$5,000 (subject to income requirements)**
- **Benefit Periods: 3, 6, 12, 18, or 24 months**
- **Elimination Periods (Injury/Sickness): 0/7, 0/14, 7/14, 14/14, 0/30, 30/30, 60/60, 90/90, 180/180**

**Total Disability Benefit:** If you have a Full-Time Job and your coverage is in force at the time of your Sickness or Off-the-Job Injury, we will insure you as follows: If your covered Sickness or covered Off-the-Job Injury causes your Total Disability within 90 days of your last treatment for your covered Sickness or covered Off-the-Job Injury, we will pay you the daily disability benefit for each day of your disability or your Successive Periods of Disability.

You will no longer be qualified to receive this benefit upon the earlier of your: (1) being released by your physician to perform the material and substantial duties of your Full-Time Job or (2) working at any job.

**Partial Disability Benefit:** If you have a Full-Time Job and your coverage is in force at the time of your Sickness or Off-the-Job Injury, we will insure you as follows: If your covered Sickness or covered Off-the-Job Injury causes your Partial Disability within 90 days of your last treatment for your covered Sickness or covered Off-the-Job Injury, we will pay you the daily disability benefit for each day of your disability or your Successive Periods of Disability.

You will no longer be qualified to receive this benefit upon the earlier of your: (1) being released by your physician to perform the material and substantial duties of your Full-Time Job or (2) working at any job earning 80 percent or more of your predisability Base Pay Earnings.

**Transitional Disability Benefit:** If you do not have a Full-Time Job and your coverage is in force at the time of your Sickness or Off-the-Job Injury, we will insure you as follows: If your covered Sickness or covered Off-the-Job Injury causes your Transitional Disability within 15 days of your last treatment for your covered Sickness or covered Off-the-Job Injury, we will pay you one-half of the daily disability benefit for each day you remain unable to work at any job. This benefit is payable for a maximum period of three months of disability or Successive Periods of Disability and is subject to the elimination period shown in the Policy Schedule.

You will no longer be qualified to receive this benefit upon the earlier of your: (1) being released by your physician to perform the material and substantial duties of any job or (2) working at any job. This benefit is limited to a lifetime maximum period of a total of three months, regardless of the number of disabilities or the duration of any disability.

The daily disability benefit is one-thirtieth of the applicable monthly disability benefit shown in the Policy Schedule.

The Total and Partial Disability benefits are payable up to the benefit period selected and are subject to the elimination period shown in the Policy Schedule.

**The policy has limitations and exclusions that may affect benefits payable. This brochure is for illustrative purposes only. See the policy for complete details, definitions, limitations, and exclusions.**

## Exhibit B: Plans

**Base Pay Earnings:** your gross salary or wages for your Full-Time Job, not including variable pay such as overtime (unless contractual), bonuses, or other incentives. If you are self-employed, *Base Pay Earnings* means your business's gross income minus the allowable business deductions from that business. (For tax purposes, *Base Pay Earnings* is referred to as *net earnings*.)

**Effective Date:** the date coverage begins as shown in the Policy Schedule. The Effective Date is not the date you signed the application for coverage.

**Full-Time Job:** your primary job at which you work 19 or more hours per week for pay or benefits.

**Injury:** a bodily injury caused directly by an accident, independent of Sickness, disease, bodily infirmity, or any other cause, occurring on or after the Effective Date of coverage and while coverage is in force.

**Off-the-Job Injury:** an Injury that occurs while you are not working at any job for pay or benefits.

**Partial Disability:** being under the care and attendance of a physician due to a condition that causes you to be unable to perform the material and substantial duties of your Full-Time Job, but able to work at any job earning less than 80 percent of your Full-Time Job's Base Pay Earnings at the time you became disabled.

**Sickness:** an illness, disease, infection, or any other abnormal physical condition, independent of Injury, occurring on or after the Effective Date of coverage and while coverage is in force.

**Successive Periods of Disability:** separate periods of disability, if caused by the same or a related condition and not separated by 180 days or more, that are considered a continuation of the prior disability. Once the maximum benefit period has been paid, you will not be eligible for a new benefit period or any disability benefits due to the same or a related condition unless you have been released by a physician from the prior disability and are no longer qualified to receive disability benefits for a period of 180 days. Separate periods of disability resulting from unrelated causes are considered a continuation of the prior disability unless they are separated by your returning to work at a Full-Time Job for 14 working days, during which you are performing the material and substantial duties of such job and are no longer qualified to receive disability benefits. Periods of disability meeting either of these separation requirements will begin a new benefit period, subject to a new elimination period.

**Total Disability:** being under the care and attendance of a physician due to a condition that causes you to be unable to perform the material and substantial duties of your Full-Time Job and not working at any job.

**Transitional Disability:** being under the care and attendance of a physician due to a condition that causes you to be unable to perform the material and substantial duties of any job.

**FOR ILLUSTRATION ONLY**

**SHORT-TERM DISABILITY POLICY  
LIMITED BENEFIT SUPPLEMENTAL HEALTH INSURANCE COVERAGE**

**NOTICE TO BUYER: This policy pays benefits for short-term Disability caused by Sickness or Off-the-Job Injury. Read it carefully with the Outline of Coverage, if applicable.**

**THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY.  
If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide furnished by Aflac.**

The Named Insured shown in the Policy Schedule will be referred to as "you," "your," or "yours." American Family Life Assurance Company of Columbus (Aflac), a stock company, will be referred to as "we," "our," "us," or "Aflac."

**CONSIDERATION**

This policy is issued in consideration of statements made in your application and the payment of the premium shown in the Policy Schedule. A copy of your application is attached and is a part of this policy. The following paragraphs set forth the definitions of terms, the limitations and exclusions, the insurance benefits, and other provisions.

**YOUR RIGHT TO EXAMINE THIS POLICY**

It is important to us that you are satisfied with this policy. If you are not satisfied, you may return it within 30 days after you receive it. Send it to your associate (duly licensed agent) or to Aflac Worldwide Headquarters, 1932 Wynnton Road, Columbus, Georgia 31999. You will receive a full refund of all premiums paid, and your policy will be void from its Effective Date. If you return this policy, please note in writing: "This policy is returned for cancellation and refund of premium."

**IMPORTANT NOTICE**

**Please read your application attached to this policy. This policy is issued on the basis that the information shown on the application is correct and complete. Statements made in the application are deemed representations and not warranties. Carefully check the application. Write to us within 30 days of the date you receive this policy if any information on the application is not correct or complete. Incorrect or incomplete information may result in the denial of claims or voiding of the policy. No associate (duly licensed agent) may change this policy or waive any of its provisions.**

**THIS POLICY IS GUARANTEED-RENEWABLE TO AGE 70, SUBJECT TO AFLAC'S RIGHT TO CHANGE PREMIUMS BY CLASS UPON ANY RENEWAL DATE.**

We agree that this policy will never be restricted by the addition of any rider without your consent, nor will continuation of coverage be refused because of any change in your health or physical condition. You are guaranteed the right to continue this policy in force until the policy anniversary date following your 70th birthday by the timely payment of premiums at the rate in effect at the beginning of each term. **Your coverage will terminate on the policy anniversary date following your 70th birthday.**

Aflac may change the established premium rate, but only if the rate is changed for all policies of this class. While this policy is in force, no change will be made in your class because of age, sex, or physical condition. "Class" means all policies of this form number and premium classification in your state that are then in force. If the established premium rate changes, Aflac will notify you in writing at your last known address, as shown in our records, at least 30 days before the change becomes effective.

**PRE-EXISTING CONDITION LIMITATIONS**

A Pre-existing Condition is 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 or reinjuries to a Pre-existing Condition, including deliveries for children conceived prior to the Effective Date of coverage, will not be covered unless it begins more than 12 months after the Effective Date of coverage.

**American Family Life Assurance Company of Columbus (Aflac)  
Worldwide Headquarters • 1932 Wynnton Road • Columbus, Georgia 31999  
For assistance or information about this policy, call 1-800-99-AFLAC (1-800-992-3522).  
For claim forms, visit our Web site at aflac.com.**



## Exhibit B: Plans

**This policy is a legal contract between you and Aflac.  
READ YOUR POLICY CAREFULLY.**

### **Part 1 DEFINITIONS**

- A. BASE PAY EARNINGS:** your gross salary or wages for your Full-Time Job. This does not include variable pay such as overtime (unless contractual), bonuses, or other incentives. If you are self-employed, the term "Base Pay Earnings" means your business's gross income minus the allowable business deductions from that business. (For tax purposes, Base Pay Earnings is referred to as "net earnings.")
- B. BENEFIT PERIOD:** the maximum number of days after the Elimination Period, if any, for which you can be paid benefits for any one or Successive Periods of Disability. Each new Benefit Period is subject to a new Elimination Period. See the Policy Schedule for the Benefit Period you selected. For the purposes of this calculation, a "month" is defined as 30 days for which benefits are paid. See definition of "Successive Periods of Disability."
- C. COMPLICATIONS OF PREGNANCY:** (1) conditions requiring medical treatment prior to or subsequent to the termination of a pregnancy whose diagnoses are distinct from pregnancy but that are adversely affected by pregnancy or caused by pregnancy, such as nonelective cesarean deliveries, acute nephritis; nephrosis; cardiac decompensation; missed abortion; disease of the vascular, hemopoietic, nervous, or endocrine systems; and similar medical and surgical conditions of comparable severity; (2) hyperemesis gravidarum and pre-eclampsia requiring hospital confinement, ectopic pregnancy that is terminated, and spontaneous termination of pregnancy that occurs during a period of gestation in which a viable birth is not possible. Complications of Pregnancy will be covered to the same extent as a Sickness.
- Complications of Pregnancy do not include premature delivery without incidence, multiple gestation pregnancy, false labor, occasional spotting, prescribed rest during pregnancy, morning sickness and similar conditions associated with the management of a difficult pregnancy not constituting a classifiably distinct pregnancy complication. Elective cesarean deliveries are not considered Complications of Pregnancy.
- D. DAILY DISABILITY BENEFIT:** one-thirtieth of the applicable monthly Disability Benefit shown in the Policy Schedule.
- E. DISABILITY:**
- 1. TOTAL DISABILITY:** being under the care and attendance of a Physician due to a condition that causes you to be unable to perform the material and substantial duties of your Full-Time Job and not working at any job.
  - 2. PARTIAL DISABILITY:** being under the care and attendance of a Physician due to a condition that causes you to be unable to perform the material and substantial duties of your Full-Time Job, but able to work at any job earning less than 80 percent of your Base Pay Earnings of your Full-Time Job at the time you became disabled.
  - 3. TRANSITIONAL DISABILITY:** being under the care and attendance of a Physician due to a condition that causes you to be unable to perform the material and substantial duties of any job.

## Exhibit B: Plans

- F. EFFECTIVE DATE:** the date(s) coverage begins as shown in the Policy Schedule. The Effective Date of this policy is **not** the date you signed the application for coverage.
- G. ELIMINATION PERIOD:** the number of consecutive days at the beginning of your period of Disability for which no benefits are payable. See the Policy Schedule for the Elimination Period you selected. Each new Benefit Period is subject to a new Elimination Period.
- H. FULL-TIME JOB:** your primary job at which you work 19 or more hours per week for pay or benefits.
- I. IMMEDIATE FAMILY:** anyone related to you in the following manner: spouse; brothers or sisters (includes stepbrothers and stepsisters); children (includes stepchildren); parents (includes stepparents); grandchildren; father- or mother-in-law; brother- or sister-in-law; and spouses, as applicable, of any of these.
- J. INJURY:** a bodily injury caused directly by an accident, independent of Sickness, disease, bodily infirmity, or any other cause, occurring on or after the Effective Date of coverage and while coverage is in force.
- K. MEDICALLY NECESSARY:** treatment, services, or supplies necessary and appropriate for the diagnosis or treatment of a Sickness or an Injury based upon generally accepted medical practice.
- L. OFF-THE-JOB INJURY:** an Injury that occurs while you are not working at any job for pay or benefits.
- M. ON-THE-JOB INJURY:** an Injury that occurs while you are working at any job for pay or benefits.
- N. PHYSICIAN:** a person legally qualified to practice medicine, other than you or a member of your Immediate Family, who is licensed as a Physician by the state where treatment is received to treat the type of condition for which a claim is made.
- O. SICKNESS:** an illness, disease, infection, or any other abnormal physical condition, independent of Injury, occurring on or after the Effective Date of coverage and while coverage is in force.
- P. SUCCESSIVE PERIODS OF DISABILITY:** separate periods of Disability, if caused by the **same or a related condition** and not separated by 180 days or more, are considered a continuation of the prior Disability. Once the maximum Benefit Period has been paid, you will not be eligible for a new Benefit Period or any Disability benefits due to the same or a related condition unless you have been released by a Physician from the prior Disability and are no longer qualified to receive Disability benefits for a period of 180 days. Separate periods of Disability resulting from **unrelated causes** are considered a continuation of the prior Disability unless they are separated by your returning to work at a Full-Time Job for 14 working days, during which you are performing the material and substantial duties of such job and are no longer qualified to receive Disability benefits. Periods of Disability meeting either of these separation requirements will begin a new Benefit Period, subject to a new Elimination Period.

## Exhibit B: Plans

### **Part 2** **LIMITATIONS AND EXCLUSIONS**

- A.** Disability caused by a Pre-existing Condition or reinjuries to a Pre-existing Condition will not be covered unless it begins more than 12 months after the Effective Date of coverage.
- B.** Aflac will not pay benefits for a Disability that is being treated outside the territorial limits of the United States.
- C.** Aflac will not pay benefits whenever coverage provided by this policy is in violation of any U.S. economic or trade sanctions. If the coverage violates U.S. economic or trade sanctions, such coverage shall be null and void.
- D.** Aflac will not pay benefits for a Disability that is caused by or occurs as a result of any bacterial, viral, or microorganism infection or infestation or any condition resulting from insect, arachnid, or other arthropod bites or stings as a Disability due to an Injury; such disability will be covered to the same extent as a Disability due to Sickness.
- E. Aflac will not pay benefits for a disability that is caused by or occurs as a result of your:**
  - 1. Pregnancy or childbirth within the first ten months of the Effective Date of coverage. (Complications of Pregnancy will be covered to the same extent as a Sickness);
  - 2. Using any drug, narcotic, hallucinogen, or chemical substance (unless administered by a Physician and taken according to the Physician's instructions), or voluntarily taking any kind of poison or inhaling any kind of gas or fumes;
  - 3. Participating in any activity or event, including the operation of a vehicle, while under the influence of a controlled substance (unless administered by a Physician and taken according to the Physician's instructions) or while intoxicated ("intoxicated" means that condition as defined by the law of the jurisdiction in which the accident occurred);
  - 4. Participating in, or attempting to participate in, an illegal activity that is defined as a felony ("felony" is as defined by the law of the jurisdiction in which the activity takes place); or being incarcerated in any type penal institution;
  - 5. Intentionally self-inflicting a bodily injury or committing or attempting suicide, while sane or insane;
  - 6. Having cosmetic surgery or other elective procedures that are not Medically Necessary;
  - 7. Having dental treatment except as a result of Injury;
  - 8. Being exposed to war or any act of war, declared or undeclared;
  - 9. Actively serving in any of the armed forces, or units auxiliary thereto, including the National Guard or Reserve;
  - 10. Donating an organ within the first 12 months of the Effective Date of this policy; or

## Exhibit B: Plans

11. Mental or emotional disorders, including but not limited to the following: bipolar affective disorder (manic-depressive syndrome), delusional (paranoid) disorders, psychotic disorders, somatoform disorders (psychosomatic illness), eating disorders, schizophrenia, anxiety disorders, depression, stress or post-partum depression. This policy will pay, however, for covered disabilities resulting from Alzheimer's disease, or similar forms of senility or senile dementia, first manifested while coverage is in force.

**Benefits will be paid for only one Disability at a time even if the Disability is caused by more than one Sickness, more than one Injury, or a Sickness and an Injury.**

### Part 3 UNIFORM PROVISIONS

- A. ENTIRE CONTRACT; CHANGES:** This policy, together with the application, endorsements, benefit agreements, riders, and attached papers, if any, constitutes the entire contract of insurance. No change in this policy is valid until approved in writing by the president and secretary of Aflac at our worldwide headquarters. Any such change must be noted hereon or attached hereto. No associate (duly licensed agent) has the authority to change this policy or to waive any of its provisions.
- B. TIME LIMIT ON CERTAIN DEFENSES:** After two years from the Effective Date of this policy, no misstatements, except fraudulent misstatements, made by you in the application shall be used to void this policy or to deny a claim for Disability commencing after the expiration of such two-year period. No claim for loss incurred or Disability commencing after 12 months from the Effective Date of coverage shall be reduced on the grounds that a sickness or physical condition, not excluded from coverage by name or specific description, had existed prior to the Effective Date of coverage. Coverage for Pre-existing Conditions will not be reduced or denied after the policy has been in force 12 months.
- C. TERM:** You are guaranteed the right to continue this policy in force until the policy anniversary date following your 70th birthday by the timely payment of premiums at the rate in effect at the beginning of each term. Your coverage will terminate on the policy anniversary date following your 70th birthday. The term of this policy begins at midnight, standard time, at the place where you reside on the Effective Date shown in the Policy Schedule. It ends at midnight, at the same standard time, on the first premium due date. Each succeeding term ends at midnight, at the same standard time, on the next following premium due date. Premium due dates are determined by the mode of payment. The mode of payment for the original term of this policy is shown in the Policy Schedule. An annual premium will maintain this policy in force for 12 months, semiannual for six months, quarterly for three months, and monthly for one month. Premium for a term is due on the first day of that term. **If you fail to pay your premium by the end of the grace period, coverage under this policy will terminate.** If you are receiving short-term Disability benefits on the date coverage would otherwise terminate, coverage under this policy will be extended to the earlier of the date you are no longer qualified to receive Disability benefits or to the end of the Benefit Period, whichever occurs first.
- D. GRACE PERIOD:** A grace period of 31 days will be granted for the payment of each premium falling due after the first premium. During the grace period, this policy will continue in force.

## Exhibit B: Plans

- E. MISSTATEMENT OF AGE:** If your age has been misstated on the application, the benefits will be those the premium paid would have purchased at the correct age. Aflac will refund all unearned premiums paid, less any benefits paid, if your misstated age at the time of application was outside the age limits for this policy.
- F. REINSTATEMENT:** You may request reinstatement of your policy from your associate (duly licensed agent) or from Aflac. If your policy has lapsed for nonpayment of premium and we accept a later payment without requiring an application, your policy will be reinstated. If we require a written application and provide you with a conditional receipt, your policy will be reinstated upon our approval of the application. If we do not notify you of our disapproval in writing within 45 days of the date your application is received at our worldwide headquarters, your policy will be deemed reinstated. The reinstated policy will cover only loss resulting from a condition that begins on or after the date of reinstatement. In all other respects, you and Aflac will have the same rights as provided under the policy immediately before the due date of the defaulted premium, subject to any provisions added in connection with the reinstatement. Any premium accepted in connection with a reinstatement will be applied to a period for which premium has not been previously paid, but not to any period more than 60 days prior to the date of reinstatement.
- G. MISSTATEMENT OF OCCUPATION OR INCOME:** If your occupation has been misstated, the benefits will be those that the premiums paid would have purchased for your correct occupation. If your income has been misstated, the benefit payable will be that which would have been allowed for your true income level and any overpayment of premium will be refunded.
- H. NOTICE OF CLAIM:** Written notice of claim must be given within 60 days after a covered loss starts or as soon as reasonably possible. The notice can be given to Aflac at our worldwide headquarters, 1932 Wynnton Rd, Columbus, GA 31999, or to your associate (duly licensed agent). The notice of claim should include the name of the covered person and the policy number.
- I. CLAIM FORMS:** When we receive a notice of claim, we will send you forms for filing proof of loss. If the forms are not sent to you within ten working days after the giving of such notice, you will meet the proof-of-loss requirements by giving us a written statement of the nature and extent of the loss within the time limit stated in the Proof of Loss provision.
- J. PROOF OF LOSS:** Written proof of loss must be furnished to Aflac at our worldwide headquarters within 90 days after the date of such loss. Failure to furnish such proof within the time required will not invalidate or reduce any claim if it was not reasonably possible to give proof within such time. However, such proof must be furnished as soon as reasonably possible and in no event (except in the absence of legal capacity) later than 15 months from the time proof is otherwise required.
- K. TIME OF PAYMENT OF CLAIMS:** All benefits payable under this policy will be paid immediately upon receipt of due written proof of loss.
- L. PAYMENT OF CLAIMS:** All benefits will be payable to you unless assigned by you or by operation of law. Any accrued benefits unpaid at your death will be paid to your estate.
- M. LEGAL ACTIONS:** No legal action may be brought to recover on this policy within 60 days after written proof of loss has been furnished in accordance with the requirements of this

## Exhibit B: Plans

policy. No such action may be brought after three years from the time written proof of loss is required to be furnished.

- N. CONFORMITY WITH STATUTES:** Any provision of this policy that, on its Effective Date, is in conflict with the statutes of the state or territory in which the Named Insured resides on such date is hereby amended to conform to the minimum requirements of such statutes.
- O. PHYSICAL EXAMINATIONS AND AUTOPSY:** Aflac, at its own expense, will have the right and opportunity to examine a covered person when and as often as it may be reasonably required during the pendency of a claim hereunder, and to make an autopsy in the case of death where autopsy is not forbidden by law.
- P. ASSIGNMENT:** Aflac will not assume responsibility for determining the validity of an assignment of your benefits to a provider of services. No such assignment of benefits will be recognized until we receive notice at our worldwide headquarters that you have specifically assigned the benefits of your Aflac policy.
- Q. OTHER INSURANCE WITH AFLAC:** If you are covered under more than one Aflac policy with disability benefits, only one disability benefit chosen by you or your estate, as the case may be, will be effective. Aflac will return all premiums paid for the canceled benefits from the date of duplication, less any benefits paid under these policies from such date.

### **Part 4** **BENEFITS**

**Aflac will pay the following benefits, as applicable, if your Disability is caused by a covered Sickness or covered Off-the-Job Injury and occurs while this coverage is in force. All benefits are subject to the Limitations and Exclusions, Pre-existing Condition Limitations, and other policy terms.**

Disability due to pregnancy and childbirth is payable to the same extent as a covered Sickness. Disability benefits for childbirth will only be payable after this policy has been in force ten months. The maximum Benefit Period allowed for childbirth is six weeks for noncesarean delivery and eight weeks for cesarean delivery, less the Elimination Period, unless you furnish proof that your Disability continues beyond these time frames.

Benefits will be paid for only one Disability at a time even if the Disability is caused by more than one Sickness, more than one Injury, or a Sickness and an Injury. **We reserve the right to meet with you during the pendency of a claim or to use an independent consultant and Physician's statement to determine whether you are qualified to receive Disability benefits. You must be under the care and attendance of a Physician for these benefits to be payable. Benefits will cease on the date of your death.**

- A. TOTAL DISABILITY BENEFIT:** If you have a Full-Time Job at the time of your Sickness or Off-the-Job Injury, we will insure you as follows while coverage is in force:

If your covered Sickness or covered Off-the-Job Injury causes your Total Disability within 90 days of your last treatment for your covered Sickness or covered Off-the-Job Injury, we will pay you the Daily Disability Benefit for each day of your Disability or your Successive Periods of Disability. This benefit is payable up to the Benefit Period you selected and is subject to the

## Exhibit B: Plans

Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled "Term", and the definitions of "Benefit Period" and "Successive Periods of Disability."

You will no longer be qualified to receive this benefit upon the earlier of your: (1) being released by your Physician to perform the material and substantial duties of your Full-Time Job or (2) working at any job.

- B. PARTIAL DISABILITY BENEFIT:** If you have a Full-Time Job at the time of your Sickness or Off-the-Job Injury, we will insure you as follows while coverage is in force:

If your covered Sickness or covered Off-the-Job Injury causes your Partial Disability within 90 days of your last treatment for your covered Sickness or covered Off-the-Job Injury, we will pay you the Daily Disability Benefit for each day of your Disability or your Successive Periods of Disability. This benefit is payable up to the Benefit Period you selected and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled "Term", and the definitions of "Benefit Period" and "Successive Periods of Disability."

You will no longer be qualified to receive this benefit upon the earlier of your: (1) being released by your Physician to perform the material and substantial duties of your Full-Time Job or (2) working at any job earning 80 percent or more of your pre-Disability Base Pay Earnings.

- C. TRANSITIONAL DISABILITY BENEFIT:** If you do not have a Full-Time Job at the time of your Sickness or Off-the-Job Injury, we will insure you as follows while coverage is in force:

If your covered Sickness or covered Off-the-Job Injury causes your Transitional Disability within 15 days of your last treatment for your covered Sickness or covered Off-the-Job Injury, we will pay you one-half of the Daily Disability Benefit for each day you remain unable to work at any job. This benefit is payable for a maximum period of three months of Disability or Successive Periods of Disability and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled "Term", and the definition of "Successive Periods of Disability."

You will no longer be qualified to receive this benefit upon the earlier of your: (1) being released by your Physician to perform the material and substantial duties of any job or (2) working at any job. **This benefit is limited to a lifetime maximum period of a total of three months, regardless of the number of Disabilities or the duration of any Disability.**

**IF YOU HAVE ANY OTHER DISABILITY BENEFIT IN FORCE WITH US, ONLY ONE DISABILITY BENEFIT IS PAYABLE.**

**NOTICE TO BUYER: This policy pays benefits for short-term Disability caused by Sickness or Off-the-Job Injury.**

Exhibit B: Plans

FOR ILLUSTRATION ONLY

Payroll

Application for Short-Term Disability Insurance (A57500 Series)
Limited Benefit Supplemental Health Insurance Coverage
Application to American Family Life Assurance Company of Columbus (Aflac)
Worldwide Headquarters • Columbus, Georgia 31999

Form with checkboxes: New, Conversion, Additional Units, and Policy Number field.

Please Print in Black Ink - To Be Completed by Proposed Insured/Employee

Form for insured/employee information including Name, State of Birth, DOB, Sex, SSN, Address, City, State, ZIP, Home Telephone, Business Telephone, Best Time to Call, and E-Mail Address.

Form for employer information including Payroll Account Name, Payroll Account No., Name of Employer, Type of Business, Job Duties, Job Title, Occupation Class, and Industry Code.

Form asking if the purchase of this coverage is intended to replace any other disability insurance now in force, with Yes/No/Not applicable options and a field for policy number.

TO BE COMPLETED BY AFLAC ASSOCIATE/AGENT

Form for billing and payment information including Billing Method (Payroll Deduction, Bank Draft, Credit Card), Mode (01 Weekly, 01 14-Day Biweekly, 01 Semimonthly, 01 28-Day Biweekly, 01 Monthly, 03 Quarterly, 06 Semiannual, 12 Annual), and fields for Employee No., Dept. No., Assoc./Agent No., Billable Premium \$, Premium Collected \$, and Sit. Code.

**Exhibit B: Plans**

<b>CHECK COVERAGE DESIRED:</b>	Class: <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> E
--------------------------------	--

Benefit Periods:	<input type="checkbox"/> 3 Months <input type="checkbox"/> 12 Months <input type="checkbox"/> 24 Months (maximum of 30 units)
	<input type="checkbox"/> 6 Months <input type="checkbox"/> 18 Months (maximum of 30 units)
Elimination Periods: Injury/Sickness	<input type="checkbox"/> 0/7 Days <input type="checkbox"/> 0/14 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 Benefit Period)
	<input type="checkbox"/> 60/60 Days** <input type="checkbox"/> 90/90 Days** <input type="checkbox"/> 180/180 Days** (**not available with 3- or 6-month Benefit Period)

	No. of Units Purchased for this Application	Premium	<input type="checkbox"/> Pre-Tax or <input type="checkbox"/> After-Tax
<input type="checkbox"/> Base Policy Series A57500			
<input type="checkbox"/> On-the-Job Injury Rider Series A57550			
<input type="checkbox"/> Additional Units of Disability Benefit Rider Series A57551 (applies to base policy only) <b>Current Units:</b> _____ (includes any additional units previously purchased) (must match policy elimination and benefit periods)			
<b>NOTE: Each unit is equal to a \$100 monthly benefit.</b>	<b>Total Premium</b>		

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

- Do you work fewer than 19 hours per week in your primary job at which you work for pay or benefits and which is considered full time employment by your employer listed on the first page of this application?  Yes  No
- Do you have disability coverage that you purchased that will remain in force, which combined with this applied for coverage, will exceed 70 percent of your gross monthly income?  Yes  No
- If your Industry Class is E, have you been employed for less than 12 months with the employer listed on the front page of this application?  Yes  No  N/A
- I certify that my gross annual income (without overtime, unless contractual; bonuses; or other incentives) for my full-time job is \$\_\_\_\_\_. If you are self-employed, your gross annual income is your net earnings. I understand that this information will be verified at the time of claim. **Annual income must be \$15,000 or greater for coverage to be issued.**

**If you answered Yes to any Question 1–3, a policy will not be issued; therefore, do not submit this application.**

- Do you have any of Aflac's accident policies with disability benefits?  Yes  No  
If yes, please complete the Supplemental Notification section at the end of this application and be aware that you cannot have this policy without canceling those disability benefits with Aflac.

Form A575PAPPAZ

**PLEASE COMPLETE THE FOLLOWING QUESTIONS**

- Is anyone to be covered currently disabled due to sickness or injury, or has anyone to be covered been out of work or disabled due to sickness or injury more than 5 consecutive days within the last 12 months (excluding routine childbirth)?  Yes  No
- Has anyone to be covered been hospitalized more than 24 hours within the last 12 months for reasons other than routine childbirth?  Yes  No
- Does anyone to be covered have any condition for which any medical procedure (including but not limited to surgery, child delivery, organ or bone marrow transplant) has been planned or the possibility of which has been discussed with medical personnel?  Yes  No
- Has anyone to be covered been to see a member of the medical profession about a medical condition that has yet to be diagnosed?  Yes  No

## Exhibit B: Plans

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

6. Does anyone to be covered currently have or in the last 12 months, has anyone to be covered been diagnosed with or treated for any of the following conditions or had any of the following procedures:  Yes  No

- |  |   |
|--|---|
| AIDS<br>Systemic lupus<br>muscular dystrophy<br>Parkinson's Disease<br>cystic fibrosis<br>pulmonary hypertension<br>renal hypertension<br>Crohn's disease<br>Ileitis<br>regional enteritis | ulcerative colitis<br>ulcerative proctitis<br>vascular insufficiency (circulatory problems)<br>diabetes (Type II) diagnosed prior to age 30<br>any sort of back, neck, or joint disorder<br>carpal tunnel syndrome<br>psoriatic arthritis<br>rheumatoid arthritis<br>sciatica |
|--|---|

7. Within the last 5 years, has anyone to be covered been diagnosed with or treated for any of the following conditions or had any of the following procedures:  Yes  No

- |   |  |
|---|--|
| heart attack<br>cardiomyopathy<br>bypass/stents/angioplasty<br>atrial fibrillation<br>implant of pacemaker/defibrillator<br>heart surgery (including valve replacement or correction)<br>congestive heart failure<br>stroke/TIA<br>chronic obstructive pulmonary disease (COPD)<br>emphysema<br>pulmonary fibrosis<br>diabetes and used tobacco after diagnosis | diabetes treated with insulin<br>diabetes with complications to include nephropathy, neuropathy; or retinopathy<br>kidney disease or disorder (not including stones)<br>liver disease or disorder (excluding Hepatitis A)<br>fibromyalgia<br>chronic fatigue syndrome<br>sarcoidosis<br>multiple sclerosis<br>alcohol or drug abuse<br>internal cancer (to include myelodysplastic blood disorder and myeloproliferative blood disorder)<br>melanoma (Clark's Level III or higher, or a Breslow Level greater than 1.5 mm) |
|---|--|

**If you answered Yes to any question 1 - 7, you are not eligible for any disability coverage; therefore, do not submit this application.**

8. Has anyone to be covered ever tested positive for human immunodeficiency virus (HIV)?  Yes  No  
 If yes, has the result been substantiated by one ELISA test and one Western Blot Blood Test? Please  Yes  No  
 complete Supplemental Questionnaire A-14394-AZ and if applicable, Consent Notice A-14393AZR.

**PLEASE COMPLETE THE FOLLOWING QUESTIONS IF YOU ARE APPLYING FOR MORE THAN 20 UNITS OF COVERAGE OR A BENEFIT PERIOD GREATER THAN 12 MONTHS.**  
**Additional underwriting may be required.**

9. During the last 6 months, have you received any medical treatment, including injections, or been prescribed or taken medications (other than prescription contraceptives)?  Yes  No  
 If yes, please provide descriptive information below.

Medical Conditions/Treatments	Onset (mo/yr)	Surgery Performed? (If yes, provide the type of procedure and date)	Date Last Treated	Released by Physician	For Hypertension and Diabetes, List the Average Reading (for the last three months)
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	

**Exhibit B: Plans**

				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	

Medication Name	Dosage	Date First Prescribed	Medical Condition

10. Has anyone to be covered used tobacco products or products containing nicotine of any type in the last 12 months?  Yes  No
11. a. Do you have any individual disability income coverage in force?  Yes  No  
 b. Do you have any group disability income coverage in force?  Yes  No
- If yes to 11a or 11b, please list your monthly benefit amounts/percentages: \_\_\_\_\_, your benefit period: \_\_\_\_\_, and your Elimination Period: \_\_\_\_\_.

<b>PLEASE COMPLETE THE FOLLOWING QUESTION IF YOU ARE APPLYING FOR THE ON-THE-JOB INJURY RIDER.</b>
--

12. Are you covered by worker's compensation or a similar law in your full-time job?  Yes  No
- Similar laws include but are not limited to the following:**  
 Railroad Retirement Act  
 Jones Act  
 Maritime Doctrine of Maintenance  
 Wages or Cure  
 Longshoremen's and Harbor Worker's Acts

<b>If you answered Yes, you are not eligible for On-the-Job Injury Rider coverage; and therefore, this rider will not be issued.</b>
--

Form AuwallAZ

<b>APPLICANT'S STATEMENTS AND AGREEMENTS</b>
--

- 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 coverage is not provided for an illness, disease, infection, disorder, 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 or reinjuries to a Pre-existing Condition, including deliveries for children conceived prior to the Effective Date of coverage, will not be covered unless it begins more than 12 months after the Effective Date of coverage.
- I acknowledge receipt of, if applicable:
 

<input type="checkbox"/> Replacement Notice	<input type="checkbox"/> <i>Guide to Health Insurance for People With Medicare</i>
<input type="checkbox"/> Outline of Coverage	<input type="checkbox"/> Fair Credit Reporting Notice

## Exhibit B: Plans

- 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. 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 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.
- 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 any fraudulent material misrepresentations herein may result in loss of coverage under this policy. I further understand that I am signing this application one time even though I may have used it to apply for more than one policy.

### SUPPLEMENTAL NOTIFICATION

#### COMPLETE IF YOU ARE REPLACING/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 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.

### INFORMATION REGARDING THE MEDICAL INFORMATION BUREAU (MIB) PRENOTICE

Information regarding your insurability will be treated as confidential. Aflac may, however, make a brief report thereon to MIB, Inc., formerly known as the Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file. Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB toll-free at 1-866-692-6901 (TTY 1-866-346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

Aflac may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its web site at [www.mib.com](http://www.mib.com).

Exhibit B: Plans

**AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION**

I authorize the following to give information (as defined below) to American Family Life Assurance Company of Columbus (Aflac) or any person or entity acting on its part: any medical professional, medical care institution, 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 I may request an interview in connection with the preparation of the investigative consumer report and that upon request, receive a copy.

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, should coverage be 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 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 decline 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 and that I or an authorized representative may request a copy of this authorization.

Form A575PAPPAZ

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

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



§ 87(2)(b) [REDACTED]

1. The accident rates are guaranteed for five years. While the rates are guaranteed, we cannot guarantee the availability of this plan.
2. The County's industry code has changed from a "B" to an "A, which decreased the accident premiums.
3. We have expanded coverage for dependent children on new and existing policies to age 26 regardless of marital, IRS, or education status.

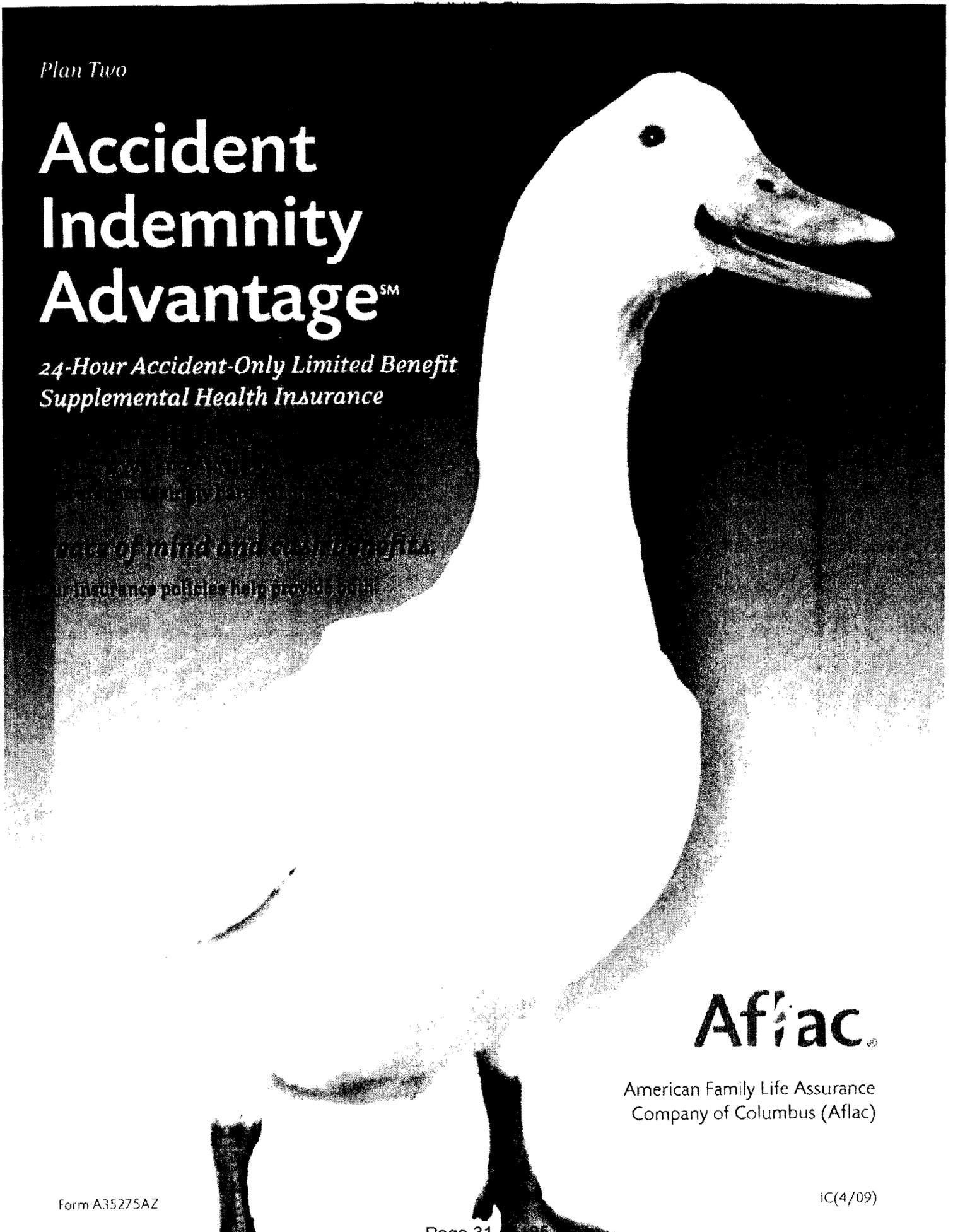
Plan Two

# Accident Indemnity Advantage<sup>SM</sup>

*24-Hour Accident-Only Limited Benefit  
Supplemental Health Insurance*

*...of mind and cash benefits.*

*...insurance policies help provide with*



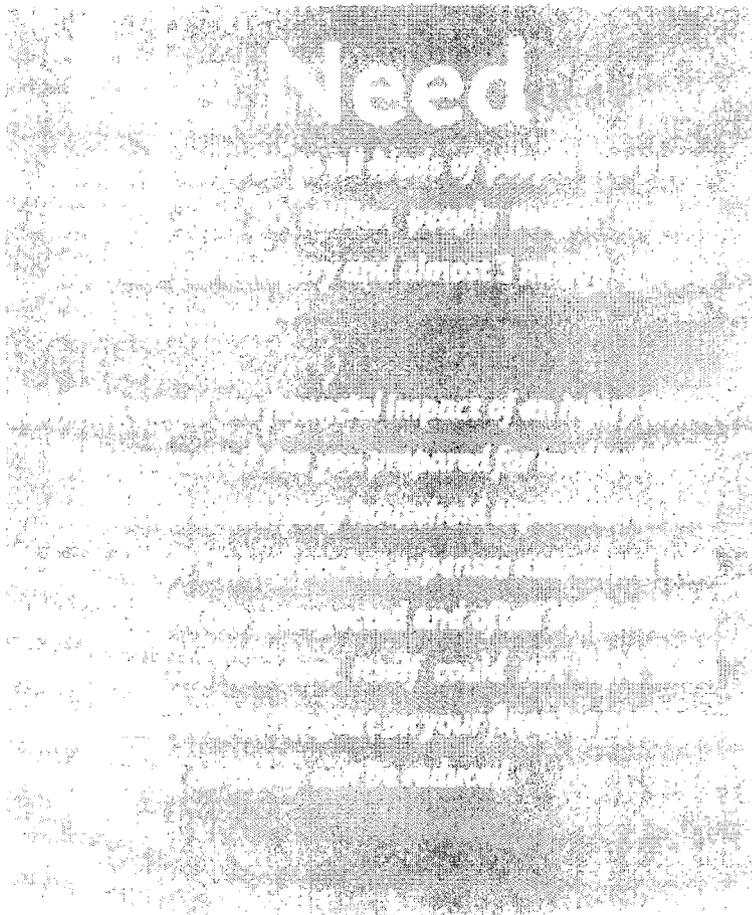
**Aflac**<sup>®</sup>

American Family Life Assurance  
Company of Columbus (Aflac)

Plan Two

# Accident Indemnity Advantage<sup>SM</sup>

24-Hour Accident-Only Limited Benefit Supplemental Health Insurance  
Policy Series A35000



Aflac pays cash benefits directly to you, unless you choose otherwise. This means that you will have added financial resources to help with expenses incurred due to an injury, to help with ongoing living expenses, or to help with any purpose you choose. Aflac Accident Indemnity Advantage is designed to provide you with cash benefits throughout the different stages of care, regardless of the severity of the injury.

## The Accident Indemnity Advantage Insurance Policy has:

- No deductibles and no copayments.
- No lifetime limits.
- No network restrictions—you choose your own medical treatment provider.
- No coordination of benefits—we pay regardless of any other insurance.

Aflac enables you to take charge and to help provide for an unpredictable future by paying cash benefits for accidental injuries. Your own peace of mind and the assurance that your family will have help financially are powerful reasons to consider Aflac.

When you consider the competitive cost of providing your family with Aflac, it's truly remarkable that this policy could potentially save you and your loved ones from financial uncertainty during a very stressful time. Knowing that you have prepared for the many financial consequences of an accident is an assurance in itself, yielding strength and confidence for uncertain possibilities.

Aflac is a market leader with more than 50 years in the insurance industry. We continue to be ranked the number one provider of individual health and guaranteed-renewable insurance in the United States ("Life and Health Statistical Report," *National Underwriter*, August 2008), and we work hard to help meet your insurance needs.

The policy to which this sales material pertains is written only in English; the policy prevails if interpretation of this material varies.

Benefit	Benefit Amount	Additional Benefit Information
<b>Wellness</b>	\$60 once per policy, per 12-month period, payable after the policy has been in force for 12 months	Payable if you or any one family member undergoes routine examinations or other preventive testing during the following policy year. Eligible family members are your Spouse and the Dependent Children of either you or your Spouse. Services covered are annual physical examinations, dental examinations, mammograms, Pap smears, eye examinations, immunizations, flexible sigmoidoscopies, ultrasounds, prostate-specific antigen tests (PSAs), and blood screenings. This benefit will become available following each anniversary of the policy's effective date for service received during the following policy year and is payable only once per policy each 12-month period following your policy anniversary date. Service must be under the supervision of or recommended by a physician, received while your policy is in force, and a charge must be incurred.

<b>Accident Emergency Treatment</b>	\$120 once per 24-hour period and once per covered accident, per Covered Person	Payable when a Covered Person receives treatment for Injuries sustained in a covered accident. This benefit is payable for treatment by a physician or treatment received in a hospital emergency room. Treatment must be received within 72 hours of the accident for benefits to be payable.
<b>X-Ray</b>	\$25 once per covered accident, per Covered Person	Payable when a Covered Person requires an X-ray while receiving emergency treatment in a hospital or a hospital emergency room for Injuries sustained in a covered accident. This benefit is not payable for X-rays received in a physician's office. The X-Ray Benefit is not payable for exams listed in the Major Diagnostic Exams Benefit.
<b>Accident Follow-Up Treatment</b>	\$35 for one treatment per day, up to a maximum of six treatments per covered accident, per Covered Person	Payable when a Covered Person receives emergency treatment for Injuries sustained in a covered accident and later requires additional treatment over and above emergency treatment administered in the first 72 hours following the accident. The treatment must begin within 30 days of the covered accident or discharge from the hospital. Treatments must be furnished by a physician in a physician's office or in a hospital on an outpatient basis. This benefit is payable for acupuncture when furnished by a licensed, certified acupuncturist. The Accident Follow-Up Treatment Benefit is not payable for the same days the Physical Therapy Benefit is paid.
<b>Initial Accident Hospitalization</b>	\$1,000 once per period of Hospital Confinement or \$2,000 once when a Covered Person is admitted directly to an intensive care unit; payable once per calendar year, per Covered Person	Payable when a Covered Person is admitted for a Hospital Confinement of at least 18 hours for treatment of Injuries sustained in a covered accident or if a Covered Person is admitted directly to an intensive care unit of a hospital for treatment of Injuries sustained in a covered accident. Hospital Confinements must start within 30 days of the accident.
<b>Accident Hospital Confinement</b>	\$250 per day up to 365 days per covered accident, per Covered Person	Payable when a Covered Person is admitted for a Hospital Confinement of at least 18 hours for treatment of Injuries sustained in a covered accident. Hospital Confinements must start within 30 days of the accident. The Accident Hospital Confinement Benefit and the Rehabilitation Unit Benefit will not be paid on the same day. The highest eligible benefit will be paid.
<b>Intensive Care Unit Confinement</b>	An additional \$400 per day for up to 15 days per covered accident, per Covered Person	Payable for each day a Covered Person receives the Accident Hospital Confinement Benefit, and is confined and charged for a room in an intensive care unit for treatment of Injuries sustained in a covered accident. Hospital Confinements must start within 30 days of the accident.

Benefit	Benefit Amount	Additional Benefit Information
<b>Accident Specific-Sum Injuries</b>	\$35 - \$12,500 (according to the policy) for: <ul style="list-style-type: none"> <li>• Dislocations</li> <li>• Burns</li> <li>• Skin grafts</li> <li>• Eye injuries</li> <li>• Lacerations</li> <li>• Fractures</li> <li>• Concussions</li> <li>• Emergency dental work</li> <li>• Coma</li> <li>• Paralysis</li> <li>• Surgical procedures</li> <li>• Miscellaneous surgical procedures</li> </ul>	Treatment must be performed on a Covered Person for Injuries sustained in a covered accident. We will pay for no more than two dislocations per covered accident, per Covered Person. Benefits are payable for only the first dislocation of a joint. If a dislocation is reduced with local anesthesia or no anesthesia by a physician, we will pay 25 percent of the amount shown for the closed reduction dislocation. Burns must be treated by a physician within 72 hours after a covered accident. If a Covered Person receives one or more skin grafts for a covered burn, we will pay a total of 50 percent of the burn benefit amount that we paid for the burn involved. Lacerations must be repaired within 72 hours after the accident and repaired under the attendance of a physician. We will pay 25 percent of the benefit amount shown for the closed reduction of chip fractures and other fractures not reduced by open or closed reduction. We will pay for no more than two fractures per covered accident, per Covered Person. Emergency dental work does not include false teeth such as dentures, bridges, veneers, partials, crowns, or implants. We will pay for no more than one emergency dental work benefit per covered accident, per Covered Person. The duration of paralysis must be a minimum of 30 days, and this benefit will be payable once per Covered Person. Coma must last a minimum of seven days. Coma does not include any medically induced coma. Treatment for surgical procedures must be performed within one year of a covered accident. Two or more surgical procedures performed through the same incision will be considered one operation, and benefits will be paid based upon the most expensive procedure. Only one miscellaneous surgery benefit is payable per 24-hour period even though more than one surgical procedure may be performed.
<b>Major Diagnostic Exams</b>	\$200 once per calendar year, per Covered Person	Payable when a Covered Person requires one of the following exams for Injuries sustained in a covered accident and a charge is incurred: computerized tomography (CT scan), computerized axial tomography (CAT), magnetic resonance imaging (MRI), or electroencephalography (EEG). These exams must be performed in a hospital or a physician's office. Exams listed in the Major Diagnostic Exams Benefit are not payable under the X-Ray Benefit.
<b>Epidural Pain Management</b>	\$100 paid no more than twice per covered accident, per Covered Person	Payable when a Covered Person is prescribed, receives, and incurs a charge for an epidural administered for pain management in a hospital or a physician's office for Injuries sustained in a covered accident. This benefit is not payable for an epidural administered during a surgical procedure.
<b>Physical Therapy</b>	\$35 per treatment for one treatment per day, up to a maximum of ten treatments per covered accident, per Covered Person	Payable when a Covered Person receives emergency treatment for Injuries sustained in a covered accident and later a physician advises the Covered Person to seek treatment from a licensed physical therapist. Physical therapy must be for Injuries sustained in a covered accident and must start within 30 days of the covered accident or discharge from the hospital. The treatment must take place within six months after the accident. The Physical Therapy Benefit is not payable for the same days that the Accident Follow-Up Treatment Benefit is paid.
<b>Rehabilitation Unit</b>	\$150 per day, limited to 30 days for each Covered Person per period of Hospital Confinement and limited to a calendar year maximum of 60 days	Payable when a Covered Person is admitted for a Hospital Confinement and is transferred to a bed in a rehabilitation unit of a hospital for treatment of Injuries sustained in a covered accident and a charge is incurred. The Rehabilitation Unit Benefit will not be payable for the same days that the Accident Hospital Confinement Benefit is paid. The highest eligible benefit will be paid. No lifetime maximum.
<b>Appliances</b>	\$125 once per covered accident, per Covered Person	Payable when a Covered Person receives a medical appliance, prescribed by a physician, as an aid in personal locomotion for Injuries sustained in a covered accident. Benefits are payable for the following types of appliances: a wheelchair, a leg brace, a back brace, a walker, and/or a pair of crutches.

The policy has limitations and exclusions that may affect benefits payable.

This brochure is for illustrative purposes only. See the policy for complete details, definitions, limitations, and exclusions.

Benefit	Benefit Amount	Additional Benefit Information																
<b>Prosthesis</b>	\$750 once per covered accident, per Covered Person	Payable when a Covered Person requires use of a prosthetic device as a result of Injuries sustained in a covered accident. This benefit is not payable for repair or replacement of prosthetic devices, hearing aids, wigs, or dental aids, to include false teeth.																
<b>Blood/ Plasma/ Platelets</b>	\$200 once per covered accident, per Covered Person	Payable when a Covered Person receives blood/plasma and/or platelets for the treatment of Injuries sustained in a covered accident. This benefit does not pay for immunoglobulins.																
<b>Ambulance</b>	\$200 when a Covered Person requires ambulance transportation \$1,500 when a Covered Person requires air ambulance transportation	Payable when a Covered Person requires ambulance transportation or air ambulance transportation to a hospital for Injuries sustained in a covered accident. Ambulance transportation must be within 72 hours of the covered accident. A licensed professional ambulance company must provide the ambulance service.																
<b>Transportation</b>	\$600 per round trip, up to three round trips per calendar year, per Covered Person	Payable per round trip to a hospital when a Covered Person requires Hospital Confinement for medical treatment due to an Injury sustained in a covered accident. This benefit is also payable when a covered Dependent Child requires hospital confinement for medical treatment due to an Injury sustained in a covered accident if commercial travel is necessary and such Dependent Child is accompanied by any immediate family member. This benefit is not payable for transportation to any hospital located within a 50-mile radius from the site of the accident or the residence of the Covered Person. The local attending physician must prescribe the treatment requiring Hospital Confinement, and the treatment must not be available locally. This benefit is not payable for transportation by ambulance or air ambulance to the hospital.																
<b>Family Lodging</b>	\$125 per night, limited to one motel/hotel room per night, up to 30 days per covered accident	Payable for one motel/hotel room for a member of the immediate family who accompanies a Covered Person who is admitted for a Hospital Confinement for the treatment of Injuries sustained in a covered accident. This benefit is payable only during the same period of time the injured Covered Person is confined to the hospital. The hospital and motel/hotel must be more than 50 miles from the residence of the Covered Person.																
<b>Accidental- Death</b>	<table border="1"> <thead> <tr> <th></th> <th>Common-Carrier Accident</th> <th>Other Accident</th> <th>Hazardous Activity Accident</th> </tr> </thead> <tbody> <tr> <td>Insured</td> <td>\$150,000</td> <td>\$40,000</td> <td>\$10,000</td> </tr> <tr> <td>Spouse</td> <td>\$150,000</td> <td>\$40,000</td> <td>\$10,000</td> </tr> <tr> <td>Child</td> <td>\$ 25,000</td> <td>\$ 12,500</td> <td>\$ 3,125</td> </tr> </tbody> </table>		Common-Carrier Accident	Other Accident	Hazardous Activity Accident	Insured	\$150,000	\$40,000	\$10,000	Spouse	\$150,000	\$40,000	\$10,000	Child	\$ 25,000	\$ 12,500	\$ 3,125	<p>We will pay the applicable lump sum benefit indicated for the Accidental Death of a Covered Person. Accidental Death must occur as a result of an Injury sustained in a covered accident and must occur within 90 days of such accident. Note: 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. If there is no beneficiary, Aflac will pay any applicable benefit to your estate.</p> <p>Please see the Terms You Need to Know section of the brochure for more details about Common-Carrier Accidents, Other Accidents, and Hazardous Activity Accidents.</p>
	Common-Carrier Accident	Other Accident	Hazardous Activity Accident															
Insured	\$150,000	\$40,000	\$10,000															
Spouse	\$150,000	\$40,000	\$10,000															
Child	\$ 25,000	\$ 12,500	\$ 3,125															

Benefit	Benefit Amount	Additional Benefit Information
<b>Accidental-Dismemberment</b>	\$625-\$40,000	We will pay the applicable lump sum benefit indicated in the policy for dismemberment. Dismemberment must occur as a result of Injuries sustained in a covered accident and must occur within 90 days of the accident. Only the highest single benefit per Covered Person will be paid for dismemberment. Benefits will be paid only once per Covered Person, per covered accident. If death and dismemberment result from the same accident, only the Accidental-Death Benefit will be paid. Loss of use does not constitute dismemberment, except for eye injuries resulting in permanent loss of vision such that central visual acuity cannot be corrected to better than 20/200.
<b>Continuation of Coverage</b>	Waive all monthly premiums for up to two months	We will waive all monthly premiums due for the policy and riders for up to two months if you meet all of the following conditions: (1) Your policy has been in force for at least six months; (2) We have received premiums for at least six consecutive months; (3) Your premiums have been paid through payroll deduction and you leave your employer for any reason; (4) You or your employer notifies us in writing within 30 days of the date your premium payments cease because of your leaving employment; and (5) You re-establish premium payments either through your new employer's payroll deduction process or direct payment to Aflac. You will again become eligible to receive this benefit after you re-establish your premium payments through payroll deduction for a period of at least six months, and we receive premiums for at least six consecutive months. ( <i>Payroll deduction</i> means your premium is remitted to Aflac for you by your employer through a payroll deduction process.)

**Limitations and Exclusions**

We will not pay benefits for services rendered by you or a member of the immediate family of a Covered Person. We will not pay benefits for treatment or loss due to Sickness, including (1) any bacterial, viral, or micro-organism infection or infestation, or any condition resulting from insect, arachnid, or other arthropod bites or stings; or (2) an error, mishap, or malpractice during medical, diagnostic, or surgical treatment or procedure for any Sickness. We will not pay benefits whenever coverage provided by the policy is in violation of any U.S. economic or trade sanctions. If the coverage violates U.S. economic or trade sanctions, such coverage shall be null and void.

We will not pay benefits for an Injury, treatment, disability, or loss that is caused by or occurs as a result of a Covered Person's:

- Participating in any activity or event, including the operation of a vehicle, while under the influence of a controlled substance (unless administered by a physician and taken according to the physician's instructions) or while intoxicated (*intoxicated* means that condition as defined by the law of the jurisdiction in which the accident occurred);
- Using any drug, narcotic, hallucinogen, or chemical substance (unless administered by a physician and taken according to the physician's instructions) or voluntarily taking any kind of poison or inhaling any kind of gas or fumes;
- Participating in, or attempting to participate in, an illegal activity that is defined as a felony (*felony* is as defined by the law of the jurisdiction in which the activity takes place); or being incarcerated in any type penal institution;
- Intentionally self-inflicting a bodily injury, or committing or attempting suicide, while sane or insane;
- Having cosmetic surgery or other elective procedures that are not medically necessary;
- Having dental treatment except as a result of Injury;
- Being exposed to war or any act of war, declared or undeclared;
- Actively serving in any of the armed forces, or units auxiliary thereto, including the National Guard or Reserve.

Hospital does not include any institution or part thereof used as a rehabilitation unit; a hospice unit, including any bed designated as a hospice or a swing bed; a convalescent home; a rest or nursing facility; an extended-care facility; a skilled nursing facility; or a facility primarily affording custodial or educational care, care or treatment for persons suffering from mental disease or disorders, care for the aged, or care for persons addicted to drugs or alcohol.

A physician or a physical therapist does not include you or a member of your immediate family.

## Exhibit B: Plans

**Guaranteed-Renewable:** The policy is guaranteed-renewable for your lifetime, subject to Aflac's right to change premiums by class upon any renewal date.

**Effective Date:** the date(s) coverage begins as shown in the Policy Schedule. The Effective Date of the policy is not the date you signed the application for coverage.

**Covered Person:** any person insured under the coverage type you applied for: individual (named insured listed in the Policy Schedule), named insured/Spouse only (named insured and Spouse), one-parent family (named insured and Dependent Children), or two-parent family (named insured, Spouse, and Dependent Children). *Spouse* is defined as the person to whom you are legally married and who is listed on your application. Newborn children are automatically covered under the terms of the policy from the moment of birth. If coverage is for individual/Spouse only, and you desire uninterrupted coverage, you must notify Aflac in writing within 31 days of the birth of your child, and Aflac will convert the policy to one-parent family or two-parent family coverage and advise you of the additional premium due. Coverage will include any other unmarried Dependent Child, regardless of age, who is incapable of self-sustaining employment by reason of mental retardation or physical handicap and who became so incapacitated prior to age 25 and while covered under the policy. *Dependent Children* are your natural children, stepchildren, or legally adopted children who are unmarried, under age 25, and your dependents. A Dependent Child (including persons incapable of self-sustaining employment by reason of mental retardation or physical handicap) must be under age 25 at the time of application to be eligible for coverage.

**Hospital Confinement:** a stay of a Covered Person confined to a bed in a hospital for which a room charge is made. The Hospital Confinement must be on the advice of a physician, medically necessary, and the result of a covered Injury. Treatment or confinement in a U.S. government hospital does not require a charge for benefits to be payable.

**Sickness:** an illness, disease, infection, or any other abnormal physical condition, independent of Injury, occurring on or after the Effective Date of coverage and while coverage is in force.

**Injury:** a bodily injury caused directly by an accident, independent of Sickness, disease, bodily infirmity, or any other cause, occurring on or after the Effective Date of coverage and while coverage is in force. See the Limitations and Exclusions section for Injuries not covered by the policy.

**Accidental Death:** death caused by a covered Injury.

**Common-Carrier Accident:** an accident, occurring on or after the Effective Date of coverage and while coverage is in force, directly involving a common-carrier vehicle in which a Covered Person is a passenger at the time of the accident. A common-carrier vehicle is limited to only an airplane, train, bus, trolley, or boat that is duly licensed by a proper authority to transport persons for a fee, holds itself out as a public conveyance, and is operating on a posted regularly scheduled basis between predetermined points or cities at the time of the accident. A *passenger* is a person aboard or riding in a common-carrier vehicle other than (1) a pilot, driver, operator, officer, or member of the crew of such vehicle; (2) a person having any duties aboard such vehicle; or (3) a person giving or receiving any kind of training or instruction. A Common-Carrier Accident does not include any Hazardous Activity Accident or any accident directly involving private, on demand, or chartered transportation in which a Covered Person is a passenger at the time of the accident.

**Hazardous Activity Accident:** an accident that occurs on or after the Effective Date of coverage, while coverage is in force, and while a Covered Person is participating in sky diving, scuba diving, hang gliding, motorized vehicle racing, cave exploration, bungee jumping, parachuting, or mountain or rock climbing, or while a Covered Person is a pilot, an officer, or a member of the crew of an aircraft and has any duties aboard an aircraft, or while giving or receiving any kind of training or instruction aboard an aircraft. A Hazardous Activity Accident does not include any Common-Carrier Accidents.

**Other Accident:** an accident occurring on or after the Effective Date of coverage and while coverage is in force that is not classified as either a Common-Carrier Accident or a Hazardous Activity Accident and that is not specifically excluded in the Limitations and Exclusions section.



**FOR ILLUSTRATION ONLY**

**ACCIDENT-ONLY POLICY  
LIMITED BENEFIT SUPPLEMENTAL HEALTH INSURANCE COVERAGE**

**NOTICE TO BUYER:** This is an Accident-Only Policy and it does not pay benefits for loss from Sickness or the medical or surgical treatment of Sickness. This policy provides limited benefits. Benefits provided are supplemental and are not intended to cover all medical expenses. Review your policy carefully with the Outline of Coverage, if applicable.

**THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY.  
If you are eligible for Medicare, review the Medicare Supplement  
Buyer's Guide furnished by Aflac.**

The Named Insured shown in the Policy Schedule will be referred to as "you," "your," or "yours." American Family Life Assurance Company of Columbus (Aflac), a stock company, will be referred to as "we," "our," "us," or "Aflac."

**CONSIDERATION**

This policy is issued in consideration of statements made in your application and the payment of the premium shown in the Policy Schedule. A copy of your application is attached and is a part of this policy. The following paragraphs set forth the definitions of terms, the limitations and exclusions, the insurance benefits, and other provisions.

**YOUR RIGHT TO EXAMINE THIS POLICY**

It is important to us that you are satisfied with this policy. If you are not satisfied, you may return it within 30 days after you receive it. Send it to your associate (duly licensed agent) or to Aflac Worldwide Headquarters, 1932 Wynnton Road, Columbus, Georgia 31999. You will receive a full refund of all premiums paid, and your policy will be void from its Effective Date. If you return this policy, please note in writing: "This policy is returned for cancellation and refund of premium."

**IMPORTANT NOTICE**

**Please read your application attached to this policy. This policy is issued on the basis that the information shown on the application is correct and complete. Statements made in the application are deemed representations and not warranties. Carefully check the application. Write to us within 30 days of the date you receive this policy if any information on the application is not correct or complete. Incorrect or incomplete information may result in the denial of claims or voiding of the policy. No associate (duly licensed agent) may change this policy or waive any of its provisions.**

**THIS POLICY IS GUARANTEED-RENEWABLE FOR YOUR LIFETIME, SUBJECT TO  
AFLAC'S RIGHT TO CHANGE PREMIUMS BY CLASS UPON ANY RENEWAL DATE.**

We agree that this policy will never be restricted by the addition of any rider without your consent, nor will continuation of coverage be refused because of any change in any Covered Person's health or physical condition. You are guaranteed the right to continue this policy in force for your lifetime by the timely payment of premiums at the rate in effect at the beginning of each term.

Aflac may change the established premium rate, but only if the rate is changed for all policies of this class. While this policy is in force, no change will be made in your class because of the age, sex, or physical condition of any Covered Person. "Class" means all policies of this form number and premium classification in your state that are then in force. If the established premium rate changes, Aflac will notify you in writing at your last known address, as shown in our records, at least 30 days before the change becomes effective.

**American Family Life Assurance Company of Columbus (Aflac)  
Worldwide Headquarters • 1932 Wynnton Road • Columbus, Georgia 31999  
For assistance or information about this policy,  
call 1.800.99.AFLAC (1.800.992.3522).  
For claim forms, visit our Web site at aflac.com.**

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**Policy Schedule**

**NAMED INSURED:** John A. Doe

**POLICY NUMBER:** 111-2222

**TYPE OF COVERAGE:** Individual

**COVERAGE:** XXXXXX  
AAABBB

**MODE OF PAYMENT:** Monthly

**PREMIUMS:**

Policy: \$XX  
Rider: \$XX  
Rider: \$XX

**EFFECTIVE DATES:**

Policy: XX/XX/XX  
Rider: XX/XX/XX  
Rider: XX/XX/XX

**DISABILITY BENEFIT PERIOD:**

Accident:  
Sickness:  
Rider:

**ELIMINATION PERIOD:**

Accident:  
Sickness:  
Rider:

**Monthly Benefit Payable**

**RIDERS**

Off-the-Job Accident Disability Benefit Rider:	\$XXX (units)	\$ _____
On-the-Job Accident Disability Benefit Rider:	\$XXX (units)	\$ _____
Sickness Disability Benefit Rider:	\$XXX (units)	\$ _____
Spouse Off-the-Job Accident Disability Benefit Rider:	\$XXX (units)	\$ _____

In witness whereof, Aflac's president and secretary signed this policy in Columbus, Georgia, as of the policy Effective Date shown in the Policy Schedule.

Paul S. Amos II, President

Joey M. Loudermilk, Secretary

## Exhibit B: Plans

**This policy is a legal contract between you and Aflac.  
READ YOUR POLICY CAREFULLY.**

### **Part 1 DEFINITIONS**

- A. ACCIDENTAL-DEATH:** death caused by a covered Injury. See the Limitations and Exclusions section for Injuries not covered by this policy.
- B. AMBULATORY SURGICAL CENTER:** a facility licensed to provide surgical services in an operating room environment on an outpatient basis. This does not include a Physician's or dentist's office, clinic, or other such location.
- C. CALENDAR YEAR:** January 1 through December 31 of the same year.
- D. CHIP FRACTURE:** a Fracture in which a piece of the bone is broken off near a joint at a place where a ligament is usually attached. It must be diagnosed by a Physician through the use of an X-ray.
- E. COMA:** a continuous state of profound unconsciousness, diagnosed or treated after the Effective Date of coverage, lasting for a period of seven or more consecutive days, and characterized by the absence of (1) spontaneous eye movements, (2) response to painful stimuli, and (3) vocalization. The condition must require intubation for respiratory assistance. The term "Coma" does not include any medically induced coma.
- F. COMMON-CARRIER ACCIDENT:** an accident, occurring on or after the Effective Date of coverage and while coverage is in force, directly involving a common-carrier vehicle in which a Covered Person is a passenger at the time of the accident. A "common-carrier vehicle" is limited to only an airplane, train, bus, trolley, or boat that is duly licensed by a proper authority to transport persons for a fee, holds itself out as a public conveyance, and is operating on a posted regularly scheduled basis between predetermined points or cities at the time of the accident. A "passenger" is a person aboard or riding in a common-carrier vehicle other than (1) a pilot, driver, operator, officer, or member of the crew of such vehicle; (2) a person having any duties aboard such vehicle; or (3) a person giving or receiving any kind of training or instruction. **A Common-Carrier Accident does not include any Hazardous Activity Accident or any accident directly involving private, on demand, or chartered transportation in which a Covered Person is a passenger at the time of the accident.**
- G. COVERED PERSON:** persons insured under Individual, Named Insured/Spouse Only, One-Parent Family, or Two-Parent Family coverage. See Type of Coverage definition.
- H. DEPENDENT CHILDREN:** your natural children, stepchildren, or legally adopted children who are: (1) unmarried; (2) under age 25; and (3) who are your dependent. **A Dependent Child must be under age 25 at the time of application to be eligible for coverage.** Coverage of a Dependent Child will terminate on the anniversary date of this policy following the child's 25th birthday. Coverage provided under any One-Parent or Two-Parent Family policy will include any other unmarried Dependent Child, regardless of age, who is incapable of self-sustaining employment by reason of mental retardation or physical handicap and who became so incapacitated prior to age 25 and while covered under this policy. You must furnish proof of such incapacity and dependency to Aflac within 31 days of the Dependent Child's 25th birthday. You must furnish proof of continued incapacity and dependency at

## Exhibit B: Plans

Aflac's request, but not more often than annually, after the two-year period following the Dependent Child's 25th birthday.

- I. **DISLOCATION:** a completely separated joint due to an Injury. The Dislocation must be diagnosed by a Physician within 72 hours after the date of the Injury and require correction by a Physician. It can be corrected by open or closed Reduction.
- J. **DISMEMBERMENT:** loss (with or without reattachment) of one or more of the following due to an Injury: (1) Arm – actual severance above the elbow; (2) Leg – actual severance above the knee; (3) Hand – actual severance above the wrist; (4) Foot – actual severance above the ankle; (5) Finger – actual severance at the joint (proximate to the first interphalangeal joint) where it is attached to the hand; (6) Toe – actual severance at the joint (proximate to the first interphalangeal joint) where it is attached to the foot; and (7) Eye – loss of the eye or permanent loss of vision such that central visual acuity cannot be corrected to better than 20/200. **Loss of use does not constitute Dismemberment, except as stated above in (7) Eye.**
- K. **EFFECTIVE DATE:** the date(s) coverage begins as shown in the Policy Schedule. The Effective Date of this policy is **not** the date you signed the application for coverage.
- L. **FRACTURE:** a break in a bone due to an Injury and that can be seen by X-ray. The Fracture must be diagnosed by a Physician within 14 days after the date of the Injury and require correction by a Physician. It can be corrected by open or closed Reduction.
- M. **HAZARDOUS ACTIVITY ACCIDENT:** an accident, occurring on or after the Effective Date of coverage and while coverage is in force, while a Covered Person is participating in sky diving, scuba diving, hang gliding, motorized vehicle racing, cave exploration, bungee jumping, parachuting, or mountain or rock climbing; or while a pilot, officer, or member of the crew of an aircraft, having any duties aboard an aircraft, or giving or receiving any kind of training or instruction aboard an aircraft. **A Hazardous Activity Accident does not include any Common-Carrier Accidents.**
- N. **HOSPITAL:** a legally operated institution licensed by the state in which it is located that maintains and uses a laboratory, X-ray equipment, and an operating room on its premises or in facilities available to it on a prearranged, written, contractual basis. The institution must also have permanent and full-time facilities for the care of overnight-resident bed patients under the supervision of one or more licensed Physicians, provide 24-hour-a-day nursing service by or under the supervision of a registered professional nurse, and maintain the patients' written histories and medical records on the premises. The term "Hospital" also includes Ambulatory Surgical Centers and satellite emergency centers. The term "Hospital" does not include any institution or part thereof used as a Rehabilitation Unit; a hospice unit, including any bed designated as a hospice or a swing bed; a convalescent home; a rest or nursing facility; an extended-care facility; a skilled nursing facility; or a facility primarily affording custodial or educational care, care or treatment for persons suffering from mental disease or disorders, care for the aged, or care for persons addicted to drugs or alcohol. **Benefits for confinement in a Rehabilitation Unit are payable under the Rehabilitation Unit Benefit (L), in Part 5.**
- O. **HOSPITAL CONFINEMENT:** a stay of a Covered Person confined to a bed in a Hospital for which a room charge is made. The Hospital Confinement must be on the advice of a Physician, Medically Necessary, and the result of a covered Injury. Treatment or confinement in a U.S. government Hospital does not require a charge for benefits to be payable.

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- P. IMMEDIATE FAMILY:** anyone related to you in the following manner: spouse; brothers or sisters (includes stepbrothers and stepsisters); children (includes stepchildren); parents (includes stepparents); grandchildren; father- or mother-in-law; brother- or sister-in-law; and spouses, as applicable, of any of these.
- Q. INJURY:** a bodily injury caused directly by an accident, independent of Sickness, disease, bodily infirmity, or any other cause, occurring on or after the Effective Date of coverage and while coverage is in force. See the Limitations and Exclusions section for Injuries not covered by this policy.
- R. INTENSIVE CARE UNIT (ICU):** a specifically designated facility of the Hospital that provides the highest level of medical care and that is restricted to those patients who are critically ill or injured. Such facilities must be separate and apart from the surgical recovery room and from rooms, beds, and wards customarily used for patient confinement. The ICU must be permanently equipped with special lifesaving equipment for the care of the critically ill or injured, and the patients must be under constant and continual observation by nursing staffs assigned exclusively to the ICU on a full-time basis. These units must be listed as Intensive Care Units in the current edition of the American Hospital Association Guide or be eligible to be listed therein. This guide lists three types of facilities that meet this definition: (1) Intensive Care Units, (2) Cardiac Intensive Care Units, and (3) Infant (Neonatal) Intensive Care Units.
- S. MEDICALLY NECESSARY:** treatment, services, or supplies necessary and appropriate for the diagnosis or treatment of an Injury based upon generally accepted medical practice.
- T. OTHER ACCIDENT:** an accident that occurs on or after the Effective Date of coverage and while coverage is in force that is not classified as either a Common-Carrier Accident or a Hazardous Activity Accident and that is not specifically excluded in the Limitations and Exclusions section.
- U. PARALYSIS:** complete and total loss of use of two or more limbs (paraplegia, quadriplegia, or hemiplegia) as the result of a spinal cord Injury for a continuous period of at least 30 days. The Paralysis must be confirmed by your attending Physician.
- V. PERIOD OF HOSPITAL CONFINEMENT:** the period of Hospital Confinement that starts while this policy is in force. If the Hospital Confinement follows a previously covered Hospital Confinement, it will be deemed a continuation of the first Hospital Confinement unless (1) the later Hospital Confinement is the result of an entirely unrelated Injury or (2) the Hospital Confinements are separated by 30 days or more. Hospitalization that begins prior to the end of one Calendar Year and continues into the next Calendar Year will be considered one Hospital Confinement.
- W. PHYSICAL THERAPIST:** a licensed specialist in physical therapy (also known as a "Physiotherapist") other than you or a member of your Immediate Family.
- X. PHYSICIAN:** a person legally qualified to practice medicine, other than you or a member of your Immediate Family, who is licensed as a Physician by the state where treatment is received to treat the type of condition for which a claim is made.
- Y. PROSTHETIC DEVICE/PROSTHESIS:** an artificial device designed to replace a missing part of the body.

## Exhibit B: Plans

- Z. REDUCTION:** open (surgical) or closed (manipulative) repair of a Fracture or Dislocation.
- AA. REHABILITATION UNIT:** a unit of a Hospital providing coordinated multidisciplinary physical restorative services to inpatients under the direction of a Physician who is knowledgeable and experienced in rehabilitative medicine. Beds must be set up and staffed in a unit specifically designated for this service.
- BB. SICKNESS:** an illness, disease, infection, or any other abnormal physical condition, independent of Injury, occurring on or after the Effective Date of coverage and while coverage is in force.
- CC. TYPE OF COVERAGE:** see your Policy Schedule to determine the Type of Coverage issued: Individual, Named Insured/Spouse Only, One-Parent Family, or Two-Parent Family.
- 1. Individual:** coverage for only you (the Named Insured listed in the Policy Schedule).
  - 2. Named Insured/Spouse Only:** coverage for you (the Named Insured) and your spouse. "Your spouse" is defined as the person to whom you are legally married and who is listed on your application.
  - 3. One-Parent Family:** coverage for you (the Named Insured) and all of your Dependent Children.
  - 4. Two-Parent Family:** coverage for you (the Named Insured), your spouse, and all of your Dependent Children (or those of your spouse).

Newborn children are automatically covered under the terms of this policy from the moment of birth. Adopted children are covered from adoption or date of placement for adoption, whichever is earliest. If Individual or Named Insured/Spouse Only coverage is in force and you desire uninterrupted coverage for a newborn or adopted child, you must notify Aflac in writing within 31 days of the child's birth or the date of adoption or date of placement for adoption of a child, whichever is earliest. Upon notification, Aflac will convert this policy to One-Parent Family or Two-Parent Family coverage and advise you of the additional premium due. If One-Parent Family or Two-Parent Family coverage is in force, it is not necessary for you to notify Aflac of the birth of your child or the date of adoption or date of placement for adoption, and an additional premium payment will not be required. If you desire any other person(s) to be covered after the Effective Date of this policy you must apply for such coverage, and that person must be added by endorsement. If Two-Parent Family coverage is already in force, an additional premium will not be required. Insurance for persons added by endorsement becomes effective on the date specified on the endorsement.

The insurance on any Dependent Child will terminate on the anniversary date of this policy following the Dependent Child's 25th birthday, on the date the child marries, or the child is no longer a dependent, whichever occurs first (for continuation of coverage information, see Part 3, Right of Conversion). Termination will be without prejudice to any claim originating prior to the date of termination. Aflac's acceptance of premium after such date will be considered as premium for only the remaining persons who qualify as Covered Persons under this policy. When coverage on all Dependent Children terminates, you must notify Aflac, in writing, and elect whether to continue this policy on 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. Coverage provided under any One-Parent Family or Two-Parent Family policy will continue to include any other unmarried Dependent Child, regardless

## Exhibit B: Plans

of age, who is incapable of self-sustaining employment by reason of mental retardation or physical handicap and who became so incapacitated prior to age 25 and while covered under this policy. You must furnish proof of such incapacity and dependency to Aflac within 31 days of the Dependent Child's 25th birthday. You must furnish proof of continued incapacity and dependency at Aflac's request, but not more often than annually, after the two-year period following the Dependent Child's 25th birthday.

### **Part 2** **LIMITATIONS AND EXCLUSIONS**

- A. Aflac will not pay benefits for services rendered by you or a member of the Immediate Family of a Covered Person.**
- B. Aflac will not pay benefits for treatment or loss due to Sickness including (1) any bacterial, viral, or microorganism infection or infestation or any condition resulting from insect, arachnid, or other arthropod bites or stings; or (2) an error, mishap, or malpractice during medical, diagnostic, or surgical treatment or procedure for any Sickness.**
- C. Aflac will not pay benefits whenever coverage provided by this policy is in violation of any U.S. economic or trade sanctions. If the coverage violates U.S. economic or trade sanctions, such coverage shall be null and void.**
- D. Aflac will not pay benefits for an Injury, treatment, disability, or loss that is caused by or occurs as a result of a Covered Person's:**
1. Participating in any activity or event, including the operation of a vehicle, while under the influence of a controlled substance (unless administered by a Physician and taken according to the Physician's instructions) or while intoxicated ("intoxicated" means that condition as defined by the law of the jurisdiction in which the accident occurred);
  2. Using any drug, narcotic, hallucinogen, or chemical substance (unless administered by a Physician and taken according to the Physician's instructions) or voluntarily taking any kind of poison or inhaling any kind of gas or fumes;
  3. Participating in, or attempting to participate in, an illegal activity that is defined as a felony ("felony" is as defined by the law of the jurisdiction in which the activity takes place); or being incarcerated in any type penal institution;
  4. Intentionally self-inflicting a bodily injury, or committing or attempting suicide, while sane or insane;
  5. Having cosmetic surgery or other elective procedures that are not Medically Necessary;
  6. Having dental treatment except as a result of Injury;
  7. Being exposed to war or any act of war, declared or undeclared; or
  8. Actively serving in any of the armed forces, or units auxiliary thereto, including the National Guard or Reserve.

**Part 3**

**RIGHT OF CONVERSION**

- A. DISSOLUTION OF MARRIAGE:** If you and your spouse dissolve your marriage by a valid decree of dissolution and your ex-spouse was covered under a Named Insured/Spouse Only or Two-Parent Family policy, your ex-spouse's coverage will terminate. Your ex-spouse may then apply for and receive, without evidence of insurability, a policy in his/her occupation class providing coverage not greater than the terminated coverage. To obtain the policy, your ex-spouse must make application to Aflac within 60 days following the entry of the decree of dissolution of marriage and pay the appropriate premium for the policy. If such dissolution of marriage occurs, the Named Insured under this policy at the time of the dissolution will retain that status. Any Dependent Children may be covered under either policy, but not both. Conversion rights do not apply to Off-the-Job Accident Disability Rider Series A35050, On-the-Job Accident Disability Rider Series A35051, and Sickness Disability Rider Series A35052. If your ex-spouse is covered under the Spouse Off-the-Job Rider Series A35053, this rider will terminate. However, if the ex-spouse applies to continue this coverage, the spouse rider will convert to the Off-the-Job Rider Series A35050 for the same amount of coverage as provided in the Spouse Off-the-Job Rider Series A35053. If additional coverage is desired, additional underwriting will be required. If neither you nor your ex-spouse wish to continue the coverage but wish to have coverage for the dependent children, your dependent children are eligible for a conversion policy.
- B. DEATH:** In the event of your death, your spouse, if alive and covered under this policy, will become the Named Insured and coverage will continue in the same occupation class. Conversion rights do not apply to Off-the-Job Accident Disability Rider Series A35050, On-the-Job Accident Disability Rider Series A35051, and Sickness Disability Rider Series A35052. If your spouse is covered under the Spouse Off-the-Job Rider Series A35053, this rider will terminate. However, the spouse rider will convert to the Off-the-Job Rider Series A35050 for the same amount of coverage as provided in the Spouse Off-the-Job Rider Series A35053. If additional coverage is desired, additional underwriting will be required.
- C. TERMINATION OF DEPENDENCY:** A Dependent Child whose dependency has terminated and who desires to continue coverage as a Named Insured under a separate policy may do so by notifying Aflac of the request in writing. Such person will have the right to apply for an equivalent policy in his/her occupation class without evidence of insurability and without interruption in coverage, provided Aflac receives written notification of the request prior to 31 days after the anniversary date of this policy following the date such person is no longer considered a Dependent Child. Conversion rights do not apply to Off-the-Job Accident Disability Rider Series A35050, On-the-Job Accident Disability Rider Series A35051, and Sickness Disability Rider Series A35052.

**Part 4**

**UNIFORM PROVISIONS**

- A. ENTIRE CONTRACT; CHANGES:** This policy, together with the application, endorsements, benefit agreements, riders, and attached papers, if any, constitutes the entire contract of insurance. No change in this policy is valid until approved in writing by the president and secretary of Aflac at our worldwide headquarters. Any such change must be noted hereon or attached hereto. No associate (duly licensed agent) has the authority to change this policy or to waive any of its provisions.
- B. TIME LIMIT ON CERTAIN DEFENSES:** After two years from the Effective Date of this policy, no misstatements, except fraudulent misstatements, made by you in the application shall be

## Exhibit B: Plans

used to void this policy or to deny a claim for loss incurred commencing after the expiration of such two-year period.

- C. TERM:** The term of this policy begins at midnight, standard time, at the place where you reside on the Effective Date shown in the Policy Schedule. It ends at midnight, at the same standard time, on the first premium due date. Each succeeding term ends at midnight, at the same standard time, on the next following premium due date. Premium due dates are determined by the mode of payment. The mode of payment for the original term of this policy is shown in the Policy Schedule. An annual premium will maintain this policy in force for 12 months, semiannual for six months, quarterly for three months, and monthly for one month. Premium for a term is due on the first day of that term. **If you fail to pay your premium by the end of the grace period, coverage under this policy will terminate.**
- D. MISSTATEMENT OF AGE:** If an age has been misstated on the application, the benefits will be those the premium paid would have purchased at the correct age. Aflac will refund all unearned premiums paid, less any benefits paid, if the misstated age at the time of application was outside the age limits for this policy.
- E. REINSTATEMENT:** You may request reinstatement of your policy from your associate (duly licensed agent) or from Aflac. If your policy has lapsed for nonpayment of premium and we accept a later payment without requiring an application, your policy will be reinstated. If we require a written application and provide you with a conditional receipt, your policy will be reinstated upon our approval of the application. If we do not notify you of our disapproval in writing within 45 days of the date your application is received at our worldwide headquarters, your policy will be deemed reinstated. The reinstated policy will cover only loss resulting from an Injury sustained on or after the date of reinstatement and loss resulting from Sickness (if you purchased the Optional Sickness Disability Rider Series A35052) that begins after the date of reinstatement. In all other respects, you and Aflac will have the same rights as provided under the policy immediately before the due date of the defaulted premium, subject to any provisions added in connection with the reinstatement. Any premium accepted in connection with a reinstatement will be applied to a period for which premium has not been previously paid, but not to any period more than 60 days prior to the date of reinstatement.
- F. GRACE PERIOD:** A grace period of 31 days will be granted for the payment of each premium falling due after the first premium. During the grace period, this policy will continue in force.
- G. MISSTATEMENT OF OCCUPATION OR INCOME:** If your occupation has been misstated, the benefits will be those that the premiums paid would have purchased for your correct occupation. If your income has been misstated, the benefit payable will be that which would have been allowed for your true income level, and any overpayment of premium will be refunded.
- H. NOTICE OF CLAIM:** Written notice of claim must be given within 60 days after a covered loss starts or as soon as reasonably possible. The notice can be given to Aflac at our worldwide headquarters, 1932 Wynnton Rd, Columbus, GA 31999, or to your associate (duly licensed agent). The notice of claim should include the name of the Covered Person and the policy number.
- I. CLAIM FORMS:** When we receive a notice of claim, we will send you forms for filing proof of loss. If the forms are not sent to you within ten working days after the giving of such notice,

## Exhibit B: Plans

you will meet the proof-of-loss requirements by giving us a written statement of the nature and extent of the loss within the time limit stated in the Proof of Loss provision.

- J. PROOF OF LOSS:** Written proof of loss must be furnished to Aflac at our worldwide headquarters within 90 days after the date of such loss. Failure to furnish such proof within the time required will not invalidate or reduce any claim if it was not reasonably possible to give proof within such time. However, such proof must be furnished as soon as reasonably possible and in no event (except in the absence of legal capacity) later than 15 months from the time proof is otherwise required.
- K. TIME OF PAYMENT OF CLAIMS:** All benefits payable under this policy will be paid immediately upon receipt of due written proof of loss.
- L. PAYMENT OF CLAIMS:** Except for the Accidental-Death Benefit payable due to your Accidental-Death, all benefits will be payable to you unless assigned by you or by operation of law. Any accrued benefits unpaid at your death will be paid to your estate. See the Accidental-Death Benefit for claim payment information regarding your Accidental-Death.
- M. LEGAL ACTIONS:** No legal action may be brought to recover on this policy within 60 days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action may be brought after three years from the time written proof of loss is required to be furnished.
- N. CONFORMITY WITH STATUTES:** Any provision of this policy that, on its Effective Date, is in conflict with the statutes of the state or territory in which the Named Insured resides on such date, is hereby amended to conform to the minimum requirements of such statutes.
- O. PHYSICAL EXAMINATIONS AND AUTOPSY:** Aflac, at its own expense, will have the right and opportunity to examine a Covered Person when and as often as it may be reasonably required during the pendency of a claim hereunder, and to make an autopsy in the case of death where autopsy is not forbidden by law.
- P. CHANGE OF BENEFICIARY:** Unless you made the beneficiary designation in the attached application irrevocable, you have the right to make a change by giving Aflac notice in a form satisfactory to Aflac. The beneficiary change will not be effective until we have recorded it at Aflac's Worldwide Headquarters. After it has been recorded, the beneficiary change will be effective as of the date it is signed. However, your dying before the request is recorded will not affect any benefit we have already paid. The consent of the beneficiary is not required to surrender the policy, assign the policy benefits, change the beneficiary, or make any other changes to this policy.
- Q. ASSIGNMENT:** Aflac will not assume responsibility for determining the validity of an assignment of your benefits to a provider of services. No such assignment of benefits will be recognized until we receive notice at our worldwide headquarters that you have specifically assigned the benefits of your Aflac policy.
- R. OTHER INSURANCE WITH AFLAC:** If a person is covered under more than one Aflac accident-only policy, only the one policy chosen by you, your beneficiary, or your estate, as the case may be, will be effective. Aflac will pay benefits under the policies for claims that may have been incurred since their respective Effective Dates. Aflac will also return all premiums paid for the canceled policies from the date of duplication, less any benefits paid under these policies from such date.

## Exhibit B: Plans

### Part 5 BENEFITS

Benefit A is a preventive benefit; the Accidental-Death, Dismemberment, or Injury of a Covered Person is not required for this benefit to be payable.

**A. WELLNESS BENEFIT:** After this policy has been in force for 12 months, Aflac will pay \$60 if you or any one family member undergoes routine examinations or other preventive testing during the following policy year. Services covered are annual physical examinations, dental examinations, mammograms, Pap smears, eye examinations, immunizations, flexible sigmoidoscopies, ultrasounds, prostate-specific antigen tests (PSAs), and blood screenings. This benefit will become available following each anniversary of this policy's Effective Date for service received during the following policy year and is payable only once per policy each 12-month period following your policy anniversary date. Eligible family members are your spouse and the Dependent Children of either you or your spouse. Service must be under the supervision of or recommended by a Physician, received while your policy is in force, and a charge must be incurred.

Aflac will pay the following benefits as applicable if a Covered Person's Accidental-Death, Dismemberment, or Injury is caused by a covered accident that occurs on or off the job. Accidental-Death, Dismemberment, or Injury must be independent of Sickness or the medical or surgical treatment of Sickness, or of any cause other than a covered accident. A covered Accidental-Death, Dismemberment, or Injury must also occur while coverage is in force and is subject to the Limitations and Exclusions. Treatment or confinement in a U.S. government Hospital does not require a charge for benefits to be payable.

**B. ACCIDENT EMERGENCY TREATMENT BENEFIT:** Aflac will pay \$120 when a Covered Person receives treatment for Injuries sustained in a covered accident. This benefit is payable for treatment by a Physician or treatment received in a Hospital emergency room. Treatment must be received within 72 hours of the accident for benefits to be payable. This benefit is payable once per 24-hour period and only once per covered accident, per Covered Person.

**C. X-RAY BENEFIT:** Aflac will pay \$25 when a Covered Person requires an X-ray while receiving emergency treatment in a Hospital or a Hospital emergency room for Injuries sustained in a covered accident. This benefit is not payable for X-rays received in a Physician's office. This benefit is limited to one payment per covered accident, per Covered Person. **The X-Ray Benefit (C) is not payable for exams listed in the Major Diagnostic Exams Benefit (I).**

**D. ACCIDENT FOLLOW-UP TREATMENT BENEFIT:** Aflac will pay \$35 per day when a Covered Person receives emergency treatment for Injuries sustained in a covered accident and later requires additional treatment over and above emergency treatment administered in the first 72 hours following the accident. Aflac will pay for one treatment per day for up to a maximum of six treatments per covered accident, per Covered Person. The treatment must begin within 30 days of the covered accident or discharge from the Hospital. Treatments must be furnished by a Physician in a Physician's office or in a Hospital on an outpatient basis. This benefit is payable for acupuncture when furnished by a licensed certified acupuncturist. **The Accident Follow-Up Benefit (D) is not payable for the same days that the Physical Therapy Benefit (K) is paid.**

**E. INITIAL ACCIDENT HOSPITALIZATION BENEFIT:** Aflac will pay \$1,000 when a Covered Person is admitted for a Hospital Confinement of at least 18 hours for treatment for Injuries sustained in a covered accident or Aflac will pay \$2,000 if a Covered Person is admitted directly to an Intensive Care Unit of a Hospital for treatment for Injuries sustained in a covered accident. This benefit is payable only once per Period of Hospital Confinement (including Intensive Care Unit confinement) and only once per Calendar Year, per Covered Person.

Exhibit B: Plans

Hospital Confinements must start within 30 days of the accident.

- F. ACCIDENT HOSPITAL CONFINEMENT BENEFIT:** Aflac will pay \$250 per day when a Covered Person is admitted for a Hospital Confinement of at least 18 hours for treatment of Injuries sustained in a covered accident. Aflac will pay this benefit up to 365 days per covered accident, per Covered Person. Hospital Confinements must start within 30 days of the accident. **The Accident Hospital Confinement Benefit (F) and the Rehabilitation Unit Benefit (L) will not be paid on the same day. The highest eligible benefit will be paid.**
- G. INTENSIVE CARE UNIT CONFINEMENT BENEFIT:** Aflac will pay an additional \$400 for each day a Covered Person receives the Accident Hospital Confinement Benefit and is confined and charged for a room in an Intensive Care Unit for treatment of Injuries sustained in a covered accident. This Intensive Care Unit Confinement Benefit is payable for up to 15 days per covered accident, per Covered Person. Hospital Confinements must start within 30 days of the accident.
- H. ACCIDENT SPECIFIC-SUM INJURIES BENEFITS:** Aflac will pay the following benefit for the treatment listed when a Covered Person receives treatment for Injuries sustained in a covered accident.

**1. Dislocation (reduced under general anesthesia):**

Aflac will pay for no more than two Dislocations per covered accident, per Covered Person.

**Benefits are payable for only the first Dislocation of a joint.**

	<b>Benefit:</b>	
	<b>Open Reduction</b>	<b>Closed Reduction</b>
a. Hip	\$2,500	\$625
b. Knee or shoulder	625	250
c. Collar bone	1,000	200
d. Ankle or foot (excluding toes)	625	200
e. Lower jaw	625	325
f. Wrist or elbow	500	250
g. Toe or finger	125	65

If a Dislocation is reduced with local anesthesia or no anesthesia by a Physician, Aflac will pay 25 percent of the amount shown for the closed Reduction Dislocation.

**2. Burns (treated by a Physician within 72 hours after a covered accident):**

	<b>Benefit:</b>	
	<b>2nd Degree</b>	<b>3rd Degree</b>
a. Less than 20 square centimeters of the body surface	\$125	\$250
b. More than 20 but less than 40 square centimeters of the body surface	250	625
c. More than 40 but less than 65 square centimeters of the body surface	500	1,250
d. More than 65 but less than 160 square centimeters of the body surface	750	3,750
e. More than 160 but less than 225 square centimeters of the body surface	1,000	8,750
f. More than 225 square centimeters of the body surface	1,250	12,500

Exhibit B: Plans

**3. Skin Grafts:**

If a Covered Person receives one or more skin grafts for a covered burn, Aflac will pay a total of 50 percent of the Burns benefit amount we paid for the burn involved.

**4. Eye Injury:**

	<b>Benefit:</b>
a. Surgical repair	\$300
b. Removal of foreign body by a Physician	65

**5. Lacerations (must be repaired within 72 hours after the accident and repaired under the attendance of a Physician):**

	<b>Benefit:</b>
a. Laceration(s) not requiring sutures and treated by a Physician (total of all lacerations)	\$35
b. Laceration(s) less than 5 centimeters (total of all lacerations)	65
c. Lacerations at least 5 centimeters but not more than 15 centimeters (total of all lacerations)	250
d. Lacerations over 15 centimeters (total of all lacerations)	500

**6. Fractures:**

Aflac will pay 25 percent of the benefit amount shown for the closed Reduction for Chip Fractures and other Fractures not reduced by open or closed Reduction.

Aflac will pay for no more than two Fractures per covered accident, per Covered Person.

	<b>Benefit:</b>	
	<b>Open Reduction</b>	<b>Closed Reduction</b>
a. Hip	\$2,500	\$1,250
b. Leg	1,250	625
c. Hand (excluding fingers)	625	325
d. Foot (excluding toes/heel)	625	325
e. Wrist, elbow, ankle, or kneecap	625	325
f. Shoulder blade or forearm	625	325
g. Lower jaw	625	325
h. Vertebrae (body of), pelvis (excluding coccyx), or sternum	1,250	625
i. Upper jaw, upper arm, or face (excluding nose)	750	375
j. Rib	1,250	125
k. Nose, heel, or finger	625	125
l. Coccyx	250	125
m. Toe	250	125
n. Vertebral processes	1,250	200
o. Skull		
(1) depressed	\$1,875	
(2) simple	625	

**7. Concussion (brain):**

**Benefit:**  
\$50

## Exhibit B: Plans

### 8. Emergency dental work:

	<b>Benefit:</b>
a. Broken tooth repaired with crown	\$400
b. Broken tooth resulting in extraction	130

Emergency dental work does not include false teeth such as dentures, bridges, veneers, partials, crowns, or implants. Aflac will pay for no more than one emergency dental work benefit per covered accident, per Covered Person.

### 9. Coma duration of at least seven days:

**Benefit:**  
\$12,500

### 10. Paralysis:

	<b>Benefit:</b>
a. Quadriplegia (Paralysis of four limbs)	\$12,500
b. Paraplegia (Paralysis of lower limbs)	6,250
c. Hemiplegia (Paralysis of one side of the body)	4,750

The duration of the Paralysis must be a minimum of 30 days. This benefit will be payable once per Covered Person.

### 11. Surgical Procedures:

Treatment must be performed within one year of a covered accident. Two or more surgical procedures performed through the same incision will be considered one operation, and benefits will be paid based upon the most expensive procedure.

	<b>Benefit:</b>
a. Arthroscopy without surgical repair	\$300
b. Open abdominal (including exploratory laparotomy)	1,250
c. Cranial	1,250
d. Hernia	1,250
e. Thoracic surgery	1,250
f. Repair of:	
(1) Tendons and/or ligaments	625
(2) Torn rotator cuffs	625
(3) Ruptured discs	625
(4) Torn knee cartilages	625

### 12. Miscellaneous Surgical Procedures:

Miscellaneous surgery that is not covered by any other specific-sum Injury benefit (Only one miscellaneous surgery benefit is payable per 24-hour period even though more than one surgical procedure may be performed.):

	<b>Benefit:</b>
a. Miscellaneous surgery with general anesthesia	\$300
b. Other miscellaneous surgery with conscious sedation	120

- I. MAJOR DIAGNOSTIC EXAMS:** Aflac will pay \$200 when a Covered Person requires one of the following exams for Injuries sustained in a covered accident and a charge is incurred: computerized tomography (CT scan), computerized axial tomography (CAT), magnetic resonance imaging (MRI), or electroencephalography (EEG). These exams must be

## Exhibit B: Plans

performed in a Hospital or a Physician's office. This benefit is limited to one payment per Calendar Year, per Covered Person. No lifetime maximum. **Exams listed in the Major Diagnostic Exams Benefit (I) are not payable under the X-Ray Benefit (C).**

- J. EPIDURAL PAIN MANAGEMENT BENEFIT:** Aflac will pay \$100 when a Covered Person is prescribed, receives, and incurs a charge for an epidural administered for pain management in a Hospital or a Physician's office for Injuries sustained in a covered accident. This benefit is not payable for an epidural administered during a surgical procedure. This benefit is payable no more than twice per covered accident, per Covered Person.
- K. PHYSICAL THERAPY BENEFIT:** Aflac will pay \$35 per treatment when a Covered Person receives emergency treatment for Injuries sustained in a covered accident and later a Physician advises the Covered Person to seek treatment from a licensed Physical Therapist. Physical therapy must be for Injuries sustained in a covered accident and must start within 30 days of the covered accident or discharge from the Hospital. Aflac will pay for one treatment per day for up to a maximum of ten treatments per covered accident, per Covered Person. The treatment must take place within six months after the accident. **The Physical Therapy Benefit (K) is not payable for the same days that the Accident Follow-Up Treatment Benefit (D) is paid.**
- L. REHABILITATION UNIT BENEFIT:** Aflac will pay \$150 per day when a Covered Person is admitted for a Hospital Confinement and is transferred to a bed in a Rehabilitation Unit of a Hospital for treatment of Injuries sustained in a covered accident and a charge is incurred. This benefit is limited to 30 days for each Covered Person per Period of Hospital Confinement and is limited to a Calendar Year maximum of 60 days. No lifetime maximum. **The Rehabilitation Unit Benefit (L) will not be payable for the same days that the Accident Hospital Confinement Benefit (F) is paid. The highest eligible benefit will be paid.**
- M. APPLIANCES BENEFIT:** Aflac will pay \$125 when a Covered Person receives a medical appliance, prescribed by a Physician, as an aid in personal locomotion, for Injuries sustained in a covered accident. Benefits are payable for the following types of appliances: wheelchair, leg brace, back brace, walker, and a pair of crutches. This benefit is payable once per covered accident, per Covered Person.
- N. PROSTHESIS BENEFIT:** Aflac will pay \$750 when a Covered Person requires use of a Prosthetic Device as a result of Injuries sustained in a covered accident. This benefit is not payable for repair or replacement of Prosthetic Devices, hearing aids, wigs, or dental aids to include false teeth. This benefit is payable once per covered accident, per Covered Person.
- O. BLOOD/PLASMA/PLATELETS BENEFIT:** Aflac will pay \$200 when a Covered Person receives blood/plasma and/or platelets for the treatment of Injuries sustained in a covered accident. This benefit does not pay for immunoglobulins and is payable only one time per covered accident, per Covered Person.
- P. AMBULANCE BENEFIT:** Aflac will pay \$200 when a Covered Person requires ambulance transportation to a Hospital for Injuries sustained in a covered accident. Ambulance transportation must be within 72 hours of the covered accident. Aflac will pay \$1,500 when a Covered Person requires transportation provided by an air ambulance for Injuries sustained in a covered accident. A licensed professional ambulance company must provide the ambulance service.
- Q. TRANSPORTATION BENEFIT:** Aflac will pay \$600 per round trip to a Hospital when a Covered Person requires Hospital Confinement for medical treatment due to an Injury sustained in a covered accident.

## Exhibit B: Plans

Aflac will also pay \$600 per round trip when a covered Dependent Child requires Hospital Confinement for medical treatment due to an Injury sustained in a covered accident if commercial travel (plane, train, or bus) is necessary and such Dependent Child is accompanied by any Immediate Family Member.

This benefit is not payable for transportation to any Hospital located within a 50-mile radius of the site of the accident or residence of the Covered Person. The local attending Physician must prescribe the treatment requiring Hospital Confinement, and the treatment must not be available locally. This benefit is payable for up to three round trips per Calendar Year, per Covered Person. This benefit is not payable for transportation by ambulance or air ambulance to the Hospital.

- R. FAMILY LODGING BENEFIT:** Aflac will pay \$125 per night for one motel/hotel room for a member(s) of the Immediate Family that accompanies a Covered Person who is admitted for a Hospital Confinement for the treatment of Injuries sustained in a covered accident. This benefit is payable only during the same period of time the injured Covered Person is confined to the Hospital. The Hospital and motel/hotel must be more than 50 miles from the residence of the Covered Person. This benefit is limited to one motel/hotel room per night and is payable up to 30 days per covered accident.
- S. ACCIDENTAL-DEATH BENEFIT:** Aflac will pay the applicable lump-sum benefit indicated below for an Accidental-Death. Accidental-Death must occur as a result of an Injury sustained in a covered accident and must occur within 90 days of such accident.

	<u>Insured</u>	<u>Spouse</u>	<u>Child</u>
Common-Carrier Accident	\$150,000	\$150,000	\$25,000
Other Accident	40,000	40,000	12,500
Hazardous Activity Accident	10,000	10,000	3,125

**In the event of the Accidental-Death of a covered spouse or Dependent Child,** Aflac will pay you the applicable lump-sum benefit indicated above. If you are disqualified from receiving the benefit by operation of law, then the benefit will be paid to the deceased Covered Person's estate unless Aflac has paid the benefit before receiving notice of your disqualification.

**In the event of your Accidental-Death,** Aflac will pay the applicable lump-sum benefit indicated above for your Accidental-Death to the beneficiary named in the application for this policy unless you subsequently changed your beneficiary. If you changed your beneficiary, then Aflac will pay this benefit to the beneficiary named in your last change of beneficiary request of record. If any beneficiary is a minor child, then any benefits payable to such minor beneficiary will not be paid 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 applicable state law. If any beneficiary is disqualified from receiving the benefit by operation of law, then the benefit will be paid as though that beneficiary died before you unless Aflac has paid the benefit before receiving notice of the beneficiary's disqualification. If a beneficiary dies before you do, the interest of that beneficiary terminates. If a beneficiary does not survive you by 15 days, then the benefit will be paid as though the beneficiary died before you unless Aflac has paid the benefit before receiving notice of the beneficiary's death. If no beneficiary survives you, Aflac will pay the benefit to your estate.

## Exhibit B: Plans

- T. ACCIDENTAL-DISEMBLEMENT BENEFIT:** Aflac will pay the applicable lump-sum benefit indicated below for Dismemberment. Dismemberment must occur as a result of Injuries sustained in a covered accident and must occur within 90 days of the accident.

**Dismemberment or complete loss of, with or without reattachment:**

	<u>Insured</u>	<u>Spouse</u>	<u>Child</u>
Both arms and both legs	\$40,000	\$40,000	\$12,500
Two eyes, feet, hands, arms, or legs	40,000	40,000	12,500
One eye, foot, hand, arm, or leg	10,000	10,000	3,750
One or more fingers and/or one or more toes	2,000	2,000	625

Only the highest single benefit per Covered Person will be paid for Dismemberment. Benefits will be paid only once per Covered Person, per covered accident. If death and Dismemberment result from the same accident, only the Accidental-Death Benefit will be paid.

- U. CONTINUATION OF COVERAGE BENEFIT:** Aflac will waive all monthly premiums due for this policy and riders for up to two months if you meet all of the following conditions:

1. Your policy has been in force for at least six months;
2. We have received premiums for at least six consecutive months;
3. Your premiums have been paid through payroll deduction and you leave your employer for any reason;
4. You or your employer notifies us in writing within 30 days of the date your premium payments cease because of your leaving employment; and
5. You re-establish premium payments through:
  - (a) your new employer's payroll deduction process or
  - (b) direct payment to Aflac.

You will again become eligible to receive this benefit after:

1. You re-establish your premium payments through payroll deduction for a period of at least six months, and
2. We receive premiums for at least six consecutive months.

**"Payroll deduction" means your premium is remitted to Aflac for you by your employer through a payroll deduction process.**

### **NOTICE TO BUYER:**

**This is an Accident-Only Policy and it does not pay benefits for loss from Sickness or the medical or surgical treatment of Sickness.**

Payroll

Exhibit B: Plans
FOR ILLUSTRATION ONLY

Application for Accident Insurance (A35000 Series)
Limited Benefit Supplemental Health Insurance Coverage
Application to American Family Life Assurance Company of Columbus (Aflac)
Worldwide Headquarters • Columbus, Georgia 31999

Form with checkboxes: New, Conversion, Additional Units

Policy Number

Please Print in Black Ink - To Be Completed by Proposed Insured/Employee

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

DOB Month/Day/Year Sex SSN (optional)

Address Street or Post Office Box Apt. No.

City State ZIP

Home Telephone Business Telephone Best Time to Call

E-Mail Address (optional)

Are you applying for Dependent Child(ren) coverage? Yes No
If Yes, Dependent Children must be under age 25 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 Last First MI DOB Month/Day/Year Sex

Payroll Account Name Payroll Account No.

Name of Employer Type of Business

Job Duties

Job Title

Occupation Class Industry Code (Completed by associate/agent)

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 our associate/agent, if applicable, and provide the policy number here: Not applicable

Does anyone to be covered have any other Accident coverage with Aflac? Yes No
If Yes, this must be a conversion of that coverage. Please give current policy number:

Do you or does anyone to be covered have a short-term disability policy with Aflac? Yes No
If Yes, please complete the Supplemental Notification section at the end of this application and be aware that you or anyone to be covered cannot have this policy with the disability riders without canceling your short-term disability policy with Aflac.

**Exhibit B: Plans**

**TO BE COMPLETED BY AFLAC ASSOCIATE/AGENT**

<b>Billing Method:</b>	<b>Mode:</b>	<b>Disability Benefit Period:</b>	<b>Accident Disability Elimination Period:</b>
<input type="checkbox"/> Payroll Deduction	<input type="checkbox"/> 01 Weekly	<input type="checkbox"/> 01 Monthly	<input type="checkbox"/> 0 Days
<input type="checkbox"/> Bank Draft (B/D, ACH)	<input type="checkbox"/> 01 14-Day Biweekly	<input type="checkbox"/> 03 Quarterly	<input type="checkbox"/> 7 Days
<input type="checkbox"/> Credit Card (C/C)	<input type="checkbox"/> 01 Semimonthly	<input type="checkbox"/> 06 Semiannual	
	<input type="checkbox"/> 01 28-Day Biweekly	<input type="checkbox"/> 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:**  Individual  Two-Parent Family  
 One-Parent Family  Named Insured/Spouse Only

Class: <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D <input type="checkbox"/> E			
<b>SELECT ONLY ONE POLICY SERIES</b>		<b>Premium</b>	
<b>24-Hour Accident</b>			<input type="checkbox"/> Pre-Tax or <input type="checkbox"/> After-Tax
<input type="checkbox"/> Accident Essentials Policy Series A35B24			
<input type="checkbox"/> Plan 1 Accident Policy Series A35100			
<input type="checkbox"/> Plan 2 Accident Policy Series A35200			
<b>Off-the-Job Accident ONLY</b>			
<input type="checkbox"/> Off-the-Job Accident Essentials Policy Series A35BOF			
<input type="checkbox"/> Plan 1 Off-the-Job Accident Policy Series A35300			
<input type="checkbox"/> Plan 2 Off-the-Job Accident Policy Series A35400			
<input type="checkbox"/> Additional Accidental-Death Benefit Rider Series A35054			<input checked="" type="checkbox"/> After-Tax Only

**The disability riders shown below apply only to the Proposed Insured/Employee.**

	No. of Units Purchased	Premium	
Off-the-Job Accident Disability Benefit Rider Series A35050 Options: <input type="checkbox"/> No rider <input type="checkbox"/> New rider <input type="checkbox"/> Retain current A35000 series rider			<input type="checkbox"/> Pre-Tax  or <input type="checkbox"/> After-Tax
On-the-Job Accident Disability Benefit Rider Series A35051 <b>Only available with Policy Series A35B24, A35100, or A35200</b> Options: <input type="checkbox"/> No rider <input type="checkbox"/> New rider <input type="checkbox"/> Retain current A35000 series rider			
Sickness Disability Benefit Rider Series A35052 14-Day Elimination Period Options: <input type="checkbox"/> No rider <input type="checkbox"/> New rider <input type="checkbox"/> Retain current A35000 series rider			

**The disability rider shown below applies only to your spouse.**

Spouse Off-the-Job Accident Disability Benefit Rider Series A35053 0-Day Elimination Period/6-Month Benefit Period Options: <input type="checkbox"/> No rider <input type="checkbox"/> New rider <input type="checkbox"/> Retain current A35000 series rider			<input checked="" type="checkbox"/> After-Tax Only
<b>Total Premium</b>			

Exhibit B: Plans

**PLEASE COMPLETE THIS SECTION ONLY IF APPLYING FOR ADDITIONAL UNITS OF COVERAGE:**

The disability riders shown below do not apply to your spouse or dependents. Any additional units of disability must match the rider elimination period and benefit period.

	No. of Units Purchased for This Application	Premium	
<input type="checkbox"/> Off-the-Job Accident Disability Benefit Rider Current Units: _____			<input type="checkbox"/> Pre-Tax or <input type="checkbox"/> After-Tax
<input type="checkbox"/> Sickness Disability Benefit Rider 14-Day Elimination Period Current Units: _____			
<b>Total Premium</b>			

**BENEFICIARY INFORMATION**

**PLEASE NOTE:** 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. If there is no beneficiary, Aflac will pay any applicable benefit to your estate.

**PRIMARY BENEFICIARY**

FULL NAME (Last, First, MI)	RELATIONSHIP	CITY/STATE	DATE OF BIRTH	% OF PROCEEDS

**CONTINGENT BENEFICIARY**

FULL NAME (Last, First, MI)	RELATIONSHIP	CITY/STATE	DATE OF BIRTH	% OF PROCEEDS

**TO BE COMPLETED BY PROPOSED INSURED/EMPLOYEE IF APPLYING FOR ANY DISABILITY RIDER**

- Do you work fewer than 19 hours per week in your primary job at which you work for pay or benefits and which is considered full-time employment by your employer listed on the first page of this application?  Yes  No
- Do you currently have disability coverage that you purchased that will remain in force which, combined with this applied-for coverage, exceeds 70 percent of your monthly gross (pre-tax) income?  Yes  No
- If your Industry Class is E, have you been employed for less than 12 months with the employer listed on the front page of this application?  Yes  No  
 N/A
- I certify that my gross annual income (without overtime, unless contractual; bonuses; or other incentives) for my full-time job is \$ \_\_\_\_\_. If you are self-employed, your gross annual income is your net earnings. I understand that this information will be verified at the time of claim. **Annual income must be \$12,000 or greater for coverage to be issued.**

If you answered Yes to any Question 1-3, you are not eligible for any disability rider coverage; and therefore, no disability rider will be issued.

Exhibit B: Plans

**TO BE COMPLETED BY PROPOSED INSURED/EMPLOYEE IF APPLYING FOR THE SPOUSE DISABILITY RIDER**

- 1. Does your spouse work fewer than 19 hours per week in his/her primary job at which he/she work for pay or benefits and which is considered full-time employment by his/her employer?  Yes  No
- 2. Does your spouse currently have disability coverage that he/she purchased that will remain in force which, combined with this applied-for coverage, exceeds 70 percent of his/her monthly gross (pre-tax) income?  Yes  No
- 3. I certify that my spouse's gross annual income (without overtime, unless contractual; bonuses; or other incentives) for his/her full-time job is \$ \_\_\_\_\_. If your spouse is self-employed, his/her gross annual income is his/her net earnings. I understand that this information will be verified at the time of claim. **Annual income must be \$12,000 or greater for coverage to be issued.**

Spouse's Employer \_\_\_\_\_ Spouse's Job Title \_\_\_\_\_

If you answered Yes to any Question 1 or 2 your spouse is not eligible for the spouse disability rider coverage; and therefore, no disability rider will be issued.

Form A35PAPPAZ

**PLEASE COMPLETE THE FOLLOWING QUESTIONS IF YOU ARE APPLYING FOR ANY DISABILITY RIDER.**

**IF YOU ARE APPLYING FOR THE ON-THE-JOB, OFF-THE-JOB, OR SICKNESS DISABILITY RIDER  
QUESTIONS 1 - 4 APPLY TO THE NAMED INSURED ONLY.**

**IF APPLYING FOR THE SPOUSE OFF-THE-JOB RIDER QUESTIONS 1 - 4 ALSO APPLY TO YOUR SPOUSE.**

- 1. Is anyone to be covered currently disabled due to sickness or injury, or has anyone to be covered been out of work or disabled due to sickness or injury more than 5 consecutive days within the last 12 months (excluding routine childbirth)?  Yes  No
- 2. Has anyone to be covered, within the last five years: been convicted of a felony; been charged two or more times with operating a vehicle while under the influence of alcohol or drugs; been charged three or more times with a moving violation; or is currently on parole or incarcerated in a correctional institution?  Yes  No
- 3. Does anyone to be covered currently have or in the last 12 months, has anyone to be covered been diagnosed with or treated for any of the following conditions or had any of the following procedures: any sort of back, neck, or joint disorder; carpal tunnel syndrome; psoriatic arthritis; rheumatoid arthritis; or sciatica?  Yes  No
- 4. Within the last 5 years, has anyone to be covered been diagnosed with or treated for any of the following conditions or had any of the following procedures: chronic fatigue syndrome or fibromyalgia?  Yes  No

If you answered Yes, to any Question 1 - 4, you are not eligible for any disability rider coverage; and therefore, no disability rider will be issued. Please indicate to which person any "Yes" answer applies.

Proposed Insured/Employee  Spouse

**The person indicated above will not be covered by any disability rider.**

**PLEASE COMPLETE THE FOLLOWING QUESTIONS IF YOU ARE APPLYING  
FOR THE SICKNESS DISABILITY BENEFIT RIDER.**

**THIS RIDER PROVIDES INDIVIDUAL COVERAGE ON THE PROPOSED INSURED/EMPLOYEE ONLY;  
THEREFORE, THE FOLLOWING QUESTIONS ONLY APPLY TO THE PROPOSED INSURED/EMPLOYEE.**

- 1. Has anyone to be covered been hospitalized more than 24 hours within the last 12 months for reasons other than routine childbirth?  Yes  No

**Exhibit B: Plans**

2. Does anyone to be covered have any condition for which any medical procedure (including but not limited to surgery, child delivery, organ or bone marrow transplant) has been planned or the possibility of which has been discussed with medical personnel?  Yes  No
3. Has anyone to be covered been to see a member of the medical profession about a medical condition that has yet to be diagnosed?  Yes  No
4. Does anyone to be covered currently have or in the last 12 months, has anyone to be covered been diagnosed with or treated for any of the following conditions or had any of the following procedures:  Yes  No

AIDS	regional enteritis
Systemic lupus	ulcerative colitis
muscular dystrophy	ulcerative proctitis
Parkinson's Disease	vascular insufficiency (circulatory problems)
cystic fibrosis	diabetes (Type II) diagnosed prior to age 30
pulmonary hypertension	
renal hypertension	
Crohn's disease	
ileitis	

5. Within the last 5 years, has anyone to be covered been diagnosed with or treated for any of the following conditions or had any of the following procedures:  Yes  No

heart attack	diabetes treated with insulin
cardiomyopathy	diabetes with complications to include nephropathy;
bypass/stents/angioplasty	neuropathy; or retinopathy
atrial fibrillation	kidney disease or disorder (not including stones)
implant of pacemaker/defibrillator	liver disease or disorder (excluding Hepatitis A)
heart surgery (including valve replacement or correction)	sarcoidosis
congestive heart failure	multiple sclerosis
stroke/TIA	alcohol or drug abuse
emphysema	internal cancer (to include myelodysplastic blood disorder and myeloproliferative blood disorder)
pulmonary fibrosis	melanoma (Clark's Level III or higher, or a Breslow Level greater than 1.5 mm)
chronic obstructive pulmonary disease (COPD)	
diabetes and used tobacco after diagnosis	

**If you answered Yes to any one of Questions 1 through 5 for the Sickness Disability Rider, you are not eligible for Sickness Disability coverage; therefore, this rider will not be issued.**

6. Has anyone to be covered ever tested positive for human immunodeficiency virus (HIV)?  Yes  No  
 If yes, has the result been substantiated by one ELISA test and one Western Blot Blood Test? Please  Yes  No  
 complete Supplemental Questionnaire A-14394-AZ and if applicable, Consent Notice A-14393AZR.

**PLEASE COMPLETE THE FOLLOWING QUESTION IF YOU ARE APPLYING FOR THE ON-THE-JOB DISABILITY BENEFIT RIDER. THIS QUESTION APPLIES TO THE NAMED INSURED ONLY.**

1. Are you covered by worker's compensation or a similar law in your full-time job?  Yes  No  
**Similar laws include but are not limited to the following:**  
 Railroad Retirement Act  
 Jones Act  
 Maritime Doctrine of Maintenance  
 Wages or Cure  
 Longshoremen's and Harbor Worker's Acts

**If you answered Yes to Question 1 above, you are not eligible for On-the-Job Rider coverage; and therefore, this rider will not be issued.**

## Exhibit B: Plans

### 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 acknowledge receipt of, if applicable:
  - Replacement Notice
  - Outline of Coverage
  - Guide to Health Insurance for People With Medicare*
  - Fair Credit Reporting Notice
- If I am applying for the Off-the-Job, On-the-Job or Spouse Off-the-Job Accident Disability Benefit Rider, I understand that coverage is not provided for an 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 or hospitalization caused by a Pre-existing Condition or reinjuries to a Pre-existing Condition will not be covered unless it begins more than 12 months after the Effective Date of coverage.
- If I am applying for the Sickness Disability Benefit Rider, I understand that coverage is not provided for an illness, disease, infection, or disorder 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 or hospitalization caused by a Pre-existing Condition, including deliveries for children conceived prior to the Effective Date of coverage, will not be covered unless it begins more than 12 months after the Effective Date of coverage.
- 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. 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 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.
- 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 any fraudulent material misrepresentations herein may result in loss of coverage under this policy. I further understand that I am signing this application one time even though I may have used it to apply for more than one 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.

#### SUPPLEMENTAL NOTIFICATION

##### COMPLETE IF YOU ARE REPLACING/TERMINATING EXISTING AFLAC DISABILITY COVERAGE.

I, \_\_\_\_\_, am applying for Aflac's policy with disability benefits. I currently have disability benefits under Aflac short-term disability policy number \_\_\_\_\_. I understand that I must cancel my existing Aflac short-term disability policy to purchase this policy.

- Please cancel my short-term disability policy so that this accident policy with disability benefits can be issued.

Exhibit B: Plans

**AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION**

I authorize the following to give information (as defined below) to American Family Life Assurance Company of Columbus (Aflac) or any person or entity acting on its part: any medical professional, medical care institution, 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 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 I may request an interview in connection with the preparation of the investigative consumer report and that upon request, receive a copy.

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, should coverage be 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 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 and that I or an authorized representative may request a copy of this authorization.

Form A35PAPPAZ

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

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

**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

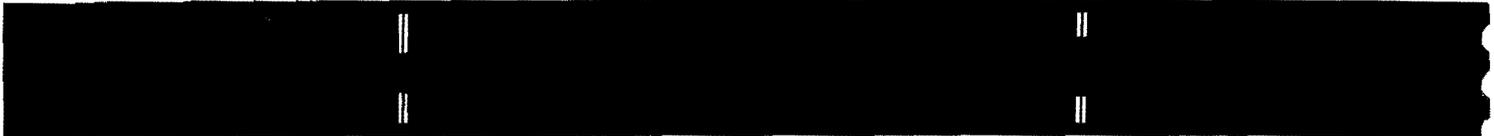
**This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.**

**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).

Form A35PAPPAZ

Exhibit B: Plans



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1. Our cancer rates are guaranteed for five years. While the rates are guaranteed, we cannot guarantee the availability of this plan.
2. We have expanded coverage for dependent children on new and existing policies to age 26 regardless of marital, IRS, or education status.

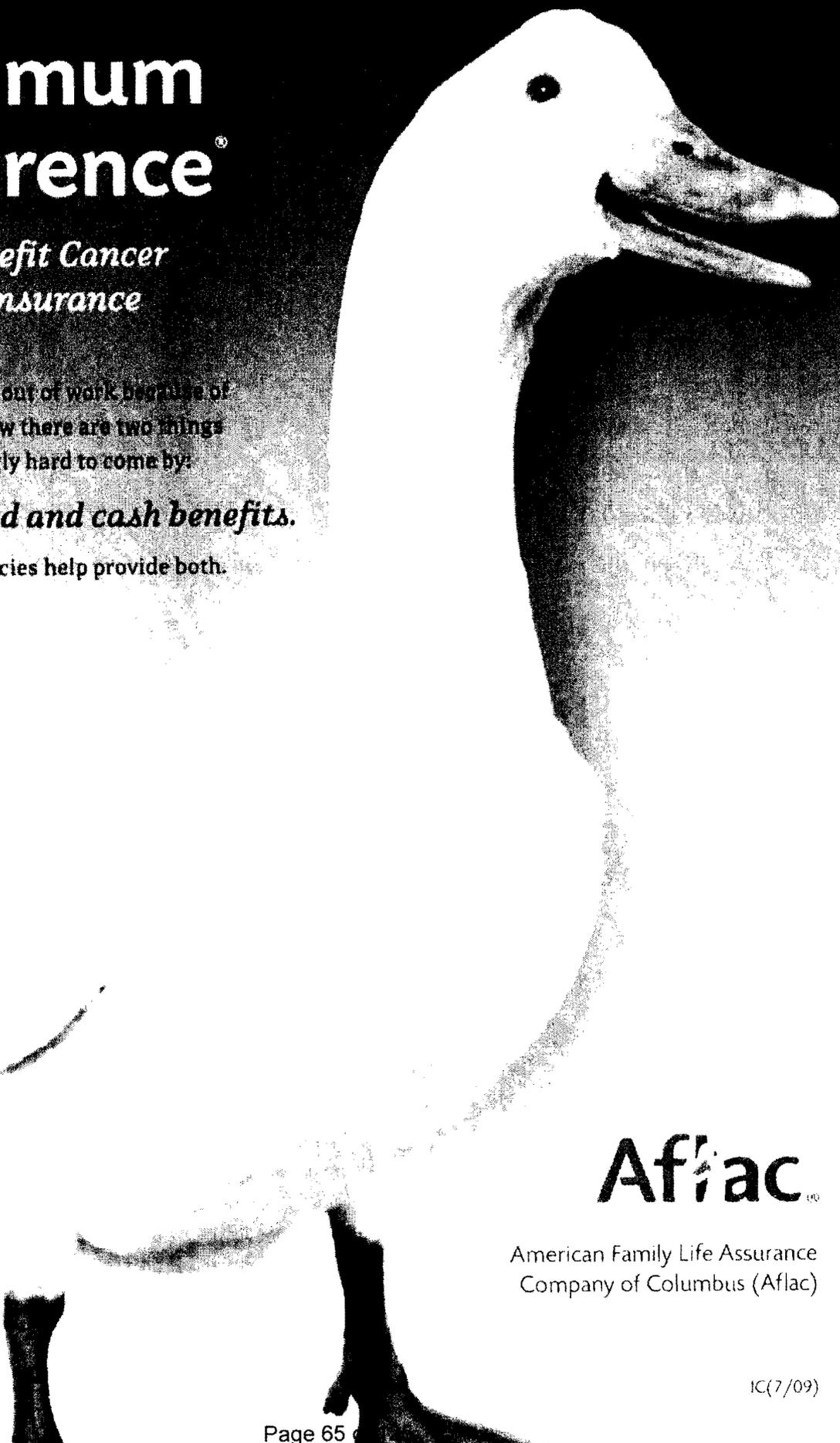
# Maximum Difference<sup>®</sup>

## *Limited Benefit Cancer Indemnity Insurance*

If you've ever been out of work because of an illness, you know there are two things that are increasingly hard to come by:

***Peace of mind and cash benefits.***

Our insurance policies help provide both.

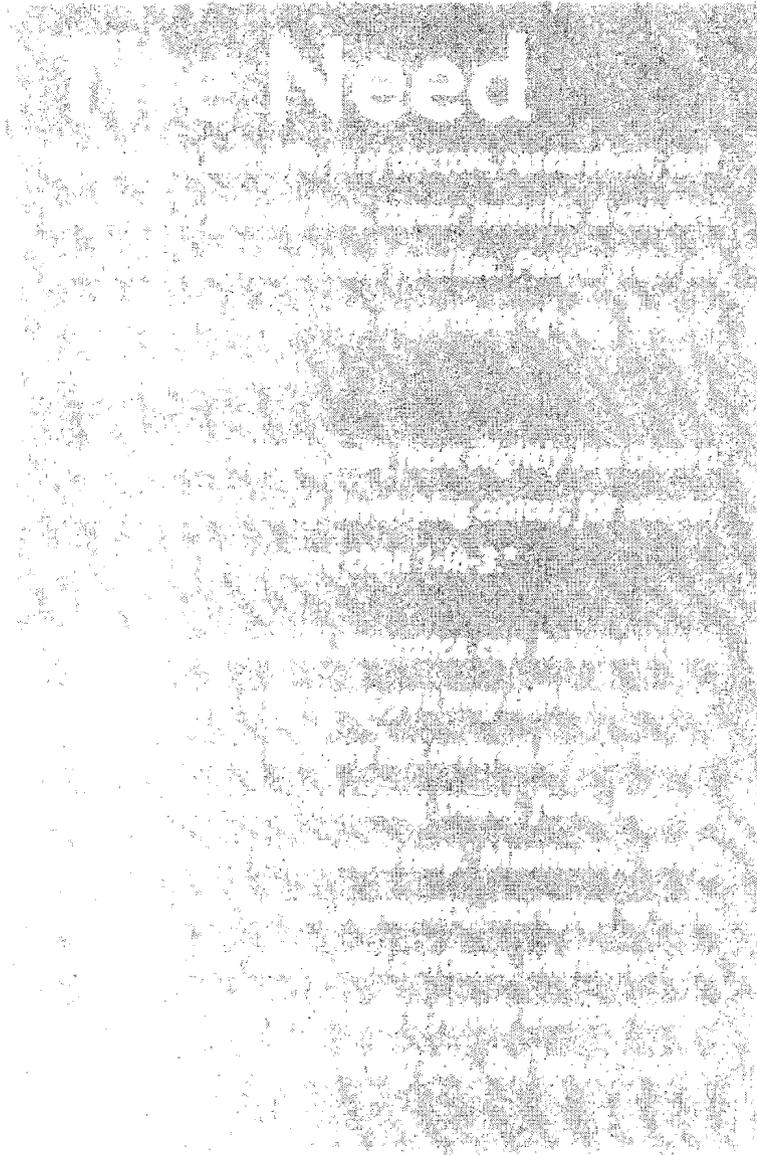


**Aflac<sup>®</sup>**

American Family Life Assurance  
Company of Columbus (Aflac)

# Maximum Difference<sup>®</sup>

*Cancer Indemnity Insurance*  
*Policy Series A76000*



## The Maximum Difference Cancer Insurance Policy:

- No deductibles or copayments.
- Fully portable.
- Guaranteed-renewable.
- No network restrictions—you choose your own medical treatment provider.

Aflac pays cash benefits directly to you, unless you choose otherwise. This means you will have additional resources to help with the financial consequences of cancer that may not be covered by major medical insurance.

## As long as cancer is in this world, Aflac will innovate to fight it.

In 1958, Aflac introduced its first cancer policy. The goal was to help protect individuals and their families from the damage that cancer can do both physically and financially. By paying cash benefits to its policyholders, unless they designated otherwise, Aflac's coverage provided a level of freedom that many major medical insurance companies simply could not.

Today, millions of individuals are still battling cancer, and about 1,437,180 new cancer cases were expected to be diagnosed in 2008.\* But the fight against cancer has changed in many ways. Advances in pharmaceuticals, surgical procedures, and alternative treatments have improved the odds for those diagnosed with the disease, and Americans diagnosed with cancer are living longer than ever. The five-year relative survival rate for all cancers diagnosed between 1996 and 2003 is 66 percent, up from 50 percent in 1975-77.\* But with improved treatments, increased costs have arrived as well. Aflac's **Maximum Difference** policy addresses these concerns with benefits that reflect evolving cancer treatments.

The policy to which this sales material pertains is written only in English;  
the policy prevails if interpretation of this material varies.

\**Cancer Facts and Figures 2008*, American Cancer Society.

Exhibit B: Plans

**QUICK REFERENCE CHART OF BENEFITS INFORMATION**

Benefits are paid only for Covered Persons who receive Physician-prescribed treatment approved by the National Cancer Institute (NCI) or the Food and Drug Administration for Cancer (FDA) or by the Centers for Disease Control and Prevention, as applicable. To be payable, the benefits listed below require a charge to be incurred for the applicable treatment or service, such as the Experimental Treatment Benefit (as detailed below), the Hospital Confinement Benefit, or a Medicare-covered inpatient Hospital Inpatient Care Benefit.

BENEFIT	BENEFIT AMOUNT	LIFETIME MAX PER INSURED	ADDITIONAL BENEFIT INFORMATION
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**DIRECT NONSURGICAL TREATMENT BENEFITS**

Benefits are payable the calendar week or calendar month, as applicable, during which a Covered Person receives and incurs a charge for the applicable treatment. Benefits will not be paid for each week of continuous infusion of medications dispensed by pump, implant, or patch. Benefits will not be paid for each week a radium implant or radioisotope remains in the body. The Initial Treatment, Injected Chemotherapy, Radiation Therapy, and Experimental Treatment Benefits are not payable based on the number, duration, or frequency of the medication(s), therapy, or treatment received by the Covered Person.

<p><b>Initial Treatment</b></p>	<p>\$3,000</p>	<p>\$3,000</p>	<p>Payable the first time Radiation Therapy, Injected Chemotherapy, or Oral Chemotherapy Benefits are received.</p>
<p><b>Injected Chemotherapy</b></p>	<p>\$900 once per calendar week</p>	<p>None</p>	<p>Limited to the calendar week in which the charge for medication(s) or treatment is incurred.</p>
<p><b>Oral Chemotherapy</b></p> <p><i>Nonhormonal</i></p> <p><i>Hormonal</i></p>	<p>\$400 per medication, per calendar month</p> <p>\$400 per medication, per calendar month up to 24 months</p> <p>\$100 per medication, per calendar month after 24 months of paid benefits of hormonal oral chemotherapy</p>	<p>None</p> <p>None</p>	<p>Total benefits (nonhormonal and hormonal) are payable for up to 3 different medications per calendar month, up to a maximum of \$1,200 per calendar month. Oral Chemotherapy Benefits are limited to the calendar month in which the charge for the medication(s) or treatment is incurred. Refills within the same calendar month are not considered a different chemotherapy medicine. Examples of hormonal oral chemotherapy are Nolvadex, Arimidex, Femara, and Lupron or generic versions such as Tamoxifen.</p>
<p><b>Radiation Therapy</b></p>	<p>\$500 once per calendar week</p>	<p>None</p>	<p>Benefit is limited to the calendar week in which the charge for the therapy is incurred.</p>
<p><b>Experimental Treatment</b></p>	<p>\$500 once per calendar week if a charge is incurred; \$125 once per calendar week if no charge is incurred for inclusion in a clinical trial</p>	<p>None</p>	<p>Benefit does not pay for laboratory tests, diagnostic X-rays, immunoglobulins, immunotherapy, colony-stimulating factors, and therapeutic devices or other procedures related to these experimental treatments. Benefit is limited to the calendar week in which the charge for the treatment is incurred, if there is a charge.</p>

The policy has limitations that may affect benefits payable.

This brochure is for illustrative purposes only. See the policy for complete definitions, details, limitations, and exclusions.  
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BENEFIT	BENEFIT AMOUNT	LIFETIME MAX PER INSURED	ADDITIONAL BENEFIT INFORMATION
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**INDIRECT/ADDITIONAL THERAPY BENEFITS**

The Immunotherapy and Anti-Nausea Benefits are not payable based on the number, duration, or frequency of immunotherapy or anti-nausea drugs received by the Covered Person. The Immunotherapy and Anti-Nausea Benefits are limited to the calendar month in which a Covered Person receives and incurs a charge for the applicable treatment.

<b>Immunotherapy</b>	\$500 once per calendar month	\$2,500	Benefit is payable for an immunotherapy treatment regimen for Internal Cancer or an Associated Cancerous Condition. Not payable for medications paid under the Injected Chemotherapy, Oral Chemotherapy, Radiation Therapy, or Experimental Treatment Benefits.
<b>Anti-Nausea</b>	\$150 once per calendar month	None	Anti-nausea drugs must be prescribed while receiving Radiation Therapy Benefits, Injected or Oral Chemotherapy Benefits, or Experimental Treatment Benefits.
<b>Stem Cell Transplantation</b>	\$10,000	\$10,000	Payable for a peripheral stem cell transplantation for the treatment of Internal Cancer or an Associated Cancerous Condition. Does not include bone marrow transplantations.
<b>Bone Marrow Transplantation</b>			
<i>Covered Person</i>	\$10,000	\$10,000	Payable for a bone marrow transplantation for the treatment of Internal Cancer or an Associated Cancerous Condition. Donor benefit is payable to the Covered Person's bone marrow donor for expenses incurred as a result of the transplantation procedure. Does not include stem cell transplantations.
<i>Donor</i>	\$ 1,000		
<b>Blood and Plasma</b>			
<i>Inpatient</i>	\$150 times the number of days paid under the Hospital Confinement Benefit	None	Inpatient benefit is payable for blood and/or plasma transfusions during a covered Hospital confinement. Outpatient benefit is payable for blood and/or plasma transfusions for the treatment of Internal Cancer or an Associated Cancerous Condition as an outpatient in a Physician's office, clinic, Hospital, or Ambulatory Surgical Center. Does not pay for immunoglobulins, immunotherapy, antihemophilia factors, or colony-stimulating factors.
<i>Outpatient</i>	\$250 per day		

**SURGICAL TREATMENT BENEFITS**

<b>Surgical/Anesthesia</b>	\$50-\$5,000 (based on the Schedule of Operations listed in the policy)  25% of the benefit amount shown in the Schedule of Operations will be paid for the administration of anesthesia during a covered surgical operation.	None	The maximum (Surgical/Anesthesia) daily benefit will not exceed \$6,250. Payable when a surgical operation is performed for a diagnosed Internal Cancer or an Associated Cancerous Condition. If any operation for the treatment of Internal Cancer or an Associated Cancerous Condition is performed other than those listed, Aflac will pay an amount comparable to the amount shown in the Schedule of Operations for the operation most nearly similar in severity and gravity. Two or more surgical procedures performed through the same incision will be considered one operation, and benefits will be paid based on the highest eligible benefit.
<b>Skin Cancer Surgery</b>	\$50-\$600	None	Payable when a surgical operation is performed for a diagnosed skin Cancer, including melanoma or Nonmelanoma Skin Cancer. The indemnity amount includes anesthesia services. Maximum daily benefit: \$600.

BENEFIT	BENEFIT AMOUNT	LIFETIME MAX PER INSURED	ADDITIONAL BENEFIT INFORMATION
<b>HOSPITALIZATION BENEFITS</b>			
<p><b>Hospital Confinement, Days 1-30</b></p> <p><i>Named Insured/ Spouse Dependent Child</i></p> <p><b>Hospital Confinement, Days 31+</b></p> <p><i>Named Insured/ Spouse Dependent Child</i></p>	<p>\$300 per day \$375 per day</p> <p>\$600 per day \$750 per day</p>	<p>None</p>	<p>For hospitalization of 30 days or less, Aflac will pay benefits for each day a Covered Person is confined to a Hospital for treatment and is charged for a room as an inpatient. During any continuous period of Hospital confinement for 31 days or more, Aflac will pay benefits as described for the first 30 days. Beginning with the 31st day of such continuous Hospital confinement, benefits for Days 31+ will be payable for each day a Covered Person is charged for a room as an inpatient. No charge is required for confinement in a U.S. government Hospital.</p>
<p><b>Outpatient Hospital Surgical Room Charge</b></p>	<p>\$300 per day</p>	<p>None</p>	<p>Payable when a surgical operation is performed for treatment of a diagnosed Internal Cancer or Associated Cancerous Condition. Benefit is not payable for any surgery performed in a Physician's office. Surgery must be performed on an outpatient basis in a Hospital or an Ambulatory Surgical Center. Benefit is payable once per day and is not payable on the same day as the Hospital Confinement Benefit. Benefit is payable in addition to the Surgical/Anesthesia Benefit. Benefit is also payable for Nonmelanoma Skin Cancer surgery involving a flap or graft. Maximum daily benefit: \$300.</p>
<b>CONTINUING CARE BENEFITS</b>			
<p><b>Extended-Care Facility</b></p>	<p>\$150 per day</p>	<p>None</p>	<p>Payable when hospitalized and receiving Hospital Confinement Benefits and later confined, within 30 days of the covered Hospital confinement, to an Extended-Care Facility, a skilled nursing facility, a rehabilitation unit or facility, a transitional care unit or any bed designated as a swing bed, or to a section of the Hospital used as such (an Extended-Care Facility). For each day this benefit is payable, Hospital Confinement Benefits are NOT payable. If more than 30 days separates confinements in an Extended-Care Facility, benefits are not payable for the second confinement unless the Covered Person again receives Hospital Confinement Benefits and is confined as an inpatient to the Extended-Care Facility within 30 days of that confinement. Benefits are limited to 30 days per calendar year, per Covered Person.</p>
<p><b>Home Health Care</b></p>	<p>\$150 per visit (Limit of 10 visits per hospitalization and 30 visits per calendar year for each Covered Person)</p>	<p>None</p>	<p>Payable when hospitalized for the treatment of Internal Cancer or an Associated Cancerous Condition and then has either home health care or health supportive services provided by a licensed, certified, or duly qualified person, other than an immediate family member. Visits must begin within 7 days of release from the Hospital. Benefit will not be payable unless the attending Physician prescribes such services to be performed in the home of the Covered Person and certifies that if these services were not available, the Covered Person would have to be hospitalized to receive the necessary care, treatment, and services. Benefit is not payable the same day the Hospice Care Benefit is payable.</p>

BENEFIT	BENEFIT AMOUNT	LIFETIME MAX PER INSURED	ADDITIONAL BENEFIT INFORMATION
<b>CONTINUING CARE BENEFITS</b>			
<b>Hospice Care</b> <i>Day 1</i> <i>Additional Days</i>	\$1,000 (one-time benefit) \$50 per day	\$12,000	Payable when diagnosed with Internal Cancer or an Associated Cancerous Condition and therapeutic intervention directed toward the cure of the disease is medically determined to be no longer appropriate. Medical prognosis must be one in which there is a life expectancy of 6 months or less as the direct result of Internal Cancer or an Associated Cancerous Condition. Benefit is not payable the same day the Home Health Care Benefit is payable.
<b>Nursing Services</b>	\$150 per day	None	Payable while confined in a Hospital and requiring full-time private care and attendance by private nurses (other than an immediate family member) for services other than those regularly furnished by the Hospital. Benefit is limited to the number of days the Hospital Confinement Benefit is payable.
<b>Surgical Prosthesis</b>	\$3,000	\$6,000	Surgically implanted prosthetic devices must be prescribed as a direct result of surgery for Internal Cancer or Associated Cancerous Condition treatment. Benefit does not include coverage for tissue expanders or a breast transverse rectus abdominis myocutaneous (TRAM) flap.
<b>Prosthesis Nonsurgical</b>	\$250 per occurrence	\$500	Up to two postoperative prosthetic devices (such as voice boxes, hairpieces, and removable breast prostheses) that are nonsurgically implanted.
<b>Reconstructive Surgery</b>	\$350-\$3,000 25% of the benefit amount will be paid for administration of anesthesia during a covered reconstructive surgical operation.	None	The specified indemnity listed in the policy is payable when a listed reconstructive surgical operation is performed. If any reconstructive surgery is performed other than those listed, Aflac will pay an amount comparable to the specified indemnity amount for the operation most nearly similar in severity and gravity. Maximum daily benefit: \$3,000.
<b>AMBULANCE, TRANSPORTATION, AND LODGING BENEFITS</b>			
<b>Ambulance</b> <i>Ground</i> <i>Air</i>	\$ 250 \$2,000	None	Payable for ambulance transportation to or from a Hospital where confined overnight. Limited to 2 trips per confinement. The ambulance service must be performed by a licensed, professional ambulance company.
<b>Transportation</b>	50 cents per mile, up to \$1,500	None	Payable for transportation of the Covered Person requiring treatment and a companion (if applicable), limited to the distance of miles between the Hospital or medical facility and the residence of the Covered Person. Benefit will pay for 2 adults if the Covered Person receiving treatment is a Dependent Child and commercial travel is necessary. Benefit is not payable for transportation to a facility located within a 50-mile radius of the Covered Person's residence. Does not cover transportation provided by ambulance.
<b>Lodging</b>	\$80 per day	None	Payable for lodging, in a room in a motel, hotel, or other commercial accommodation, for you or any one adult family member when a Covered Person receives treatment. Limited to 90 days per calendar year. Hospital or medical facility where treatment is received must be more than 50 miles from the Covered Person's residence. Benefit is not payable for lodging occurring more than 24 hours prior to treatment or more than 24 hours after treatment.

## Exhibit B: Plans

### Premium Waiver and Related Benefits

**Waiver of Premium:** If you, due to having Cancer or an Associated Cancerous Condition, are completely unable to perform all of the usual and customary duties of your occupation [or if not employed: are unable to perform 2 or more activities of daily living (ADLs) without the assistance of another person] for a period of 90 continuous days, Aflac will waive, from month to month, any premiums falling due during your continued inability. For premiums to be waived, Aflac will require an employer's statement (if applicable) and a Physician's statement of your inability to perform said duties or activities and may each month thereafter require a Physician's statement that total inability continues. Aflac may ask for and use an independent consultant to determine whether you can perform an ADL while this benefit is in force. Aflac will also waive, from month to month, any premiums falling due while you are receiving Hospice Benefits.

**Continuation of Coverage:** Aflac will waive all monthly premiums due for the policy and riders for 2 months if you meet all of the following conditions: your policy has been in force for at least 6 months; we have received premiums for at least 6 consecutive months; your premiums have been paid through payroll deduction; you or your employer has notified us in writing within 30 days of the date your premium payments ceased due to your leaving employment; and you re-establish premium payments with Aflac. You will again become eligible to receive this benefit after you re-establish your premium payments through payroll deduction for a period of at least 6 months, and we receive premiums for at least 6 consecutive months.

### What Is Not Covered

**Limitations and Exclusions:** We pay only for treatment of Cancer and Associated Cancerous Conditions diagnosed on or after the Effective Date of coverage, including direct extension, metastatic spread, or recurrence. Benefits are not provided for premalignant conditions or conditions with malignant potential (unless specifically covered); complications of either Cancer or an Associated Cancerous Condition; or any other disease, sickness, or incapacity.

*Hospital* does not include any institution or part thereof used as an emergency room; an observation unit; a rehabilitation unit; a hospice unit, including any bed designated as a hospice or a swing bed; a convalescent home; a rest or nursing facility; a psychiatric unit; an Extended-Care Facility; a skilled nursing facility; or a facility primarily affording custodial or educational care, care or treatment for persons suffering from mental disease or disorders, care for the aged, or care for persons addicted to drugs or alcohol.

An *Ambulatory Surgical Center* does not include a doctor's or dentist's office, clinic, or other such location.

### Terms You Need to Know

**Guaranteed-Renewable:** The policy is guaranteed-renewable for your lifetime, subject to Aflac's right to change premiums by class upon any renewal date.

**Effective Date:** The *Effective Date* is the date coverage begins, as shown in the Policy Schedule. It is not the date you signed the application for coverage.

**Covered Person:** A *Covered Person* is any person covered under individual (named insured listed in the Policy Schedule), named insured/Spouse only (named insured and Spouse), one-parent family (named insured and Dependent Children), or two-parent family (named insured, Spouse, and Dependent Children) coverage as applied for by you on the application. *Spouse* is defined as the person to whom you are legally married and who is listed on your application. Newborn children are automatically insured from the moment of birth. If coverage is for individual or named insured/Spouse only, and you desire uninterrupted coverage, you must notify Aflac in writing within 31 days of the birth of your child, and Aflac will convert the policy to one-parent family or two-parent family coverage and advise you of the additional premium due. Coverage will include any other unmarried Dependent Child, regardless of age, who is incapable of self-sustaining employment by reason of mental retardation or physical handicap and who became so incapacitated prior to age 25 and while covered under the policy. *Dependent Children* are your natural children, stepchildren, or legally adopted children who are unmarried, under age 25, and your dependents. **A Dependent Child (including persons incapable of self-sustaining employment by reason of mental retardation or physical handicap) must be under age 25 at the time of application to be eligible for coverage.**

**Cancer:** *Cancer* is a disease manifested by the presence of a malignant tumor and characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue. *Cancer* also includes but is not limited to leukemia, Hodgkin's disease, and melanoma. Cancer must receive a positive medical diagnosis.

1. *Internal Cancer* includes all Cancers other than Nonmelanoma Skin Cancer (see definition of Nonmelanoma Skin Cancer).

2. *Nonmelanoma Skin Cancer* is a Cancer other than a melanoma that begins in the upper part of the skin (epidermis).

Associated Cancerous Conditions, premalignant conditions, or conditions with malignant potential will not be considered Cancer.

**Associated Cancerous Condition:** An *Associated Cancerous Condition* is a myelodysplastic blood disorder, myeloproliferative blood disorder, or carcinoma in situ (in the natural or normal place, confined to the site of origin without having invaded neighboring tissue). An Associated Cancerous Condition must receive a positive medical diagnosis. **Premalignant conditions or conditions with malignant potential, other than those specifically named above, are not considered Associated Cancerous Conditions.**

**Physician:** A *Physician* is a person legally qualified to practice medicine, other than a member of your immediate family, who is licensed as a Physician by the state where treatment is received to treat the type of condition for which a claim is made.



American Family Life Assurance Company of Columbus (AFLAC)  
1325 Symantec Road • Columbus, Georgia 31906  
Phone: 706.321.2000 • Toll Free: 1.800.321.2000  
aflac.com

**FOR ILLUSTRATION ONLY**

**LIMITED BENEFIT CANCER INDEMNITY INSURANCE**

**IMPORTANT: This is a limited benefit, specified-disease policy. It pays benefits for Cancer and Associated Cancerous Condition treatment only.**

**Read it carefully with the Outline of Coverage, if applicable.**

**THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY.**

**If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide furnished by Aflac.**

The Named Insured shown in the Policy Schedule will be referred to as "you," "your," or "yours." American Family Life Assurance Company of Columbus (Aflac), a stock company, will be referred to as "we," "our," "us," or "Aflac."

**CONSIDERATION**

This policy is issued in consideration of statements made in your application and the payment of the premium shown in the Policy Schedule. A copy of your application is attached and is a part of this policy. The following paragraphs set forth the definitions of terms, the limitations and exclusions, the insurance benefits, and other provisions.

**YOUR RIGHT TO EXAMINE THIS POLICY**

It is important to us that you are satisfied with this policy. If you are not satisfied, you may return it within 30 days after you receive it. Send it to your associate (duly licensed agent) or to Aflac Worldwide Headquarters, 1932 Wynnton Road, Columbus, Georgia 31999. You will receive a full refund of all premiums paid, and your policy will be void from its Effective Date. If you return the policy, please note in writing: "This policy is returned for cancellation and refund of premium."

**IMPORTANT NOTICE**

**Please read your application attached to this policy. This policy is issued on the basis that the information shown on the application is correct and complete. Statements made in the application are deemed representations and not warranties. Carefully check the application. Write to us within 30 days of the date you receive this policy if any information on the application is not correct or complete. Incorrect or incomplete information may result in the denial of claims or voiding of the policy. No associate (duly licensed agent) may change this policy or waive any of its provisions.**

**THIS POLICY IS GUARANTEED-RENEWABLE FOR YOUR LIFETIME, SUBJECT TO AFLAC'S RIGHT TO CHANGE PREMIUMS BY CLASS UPON ANY RENEWAL DATE.**

We agree that this policy will never be restricted by the addition of any rider without your consent, nor will continuation of coverage be refused because of any change in any Covered Person's health or physical condition. You are guaranteed the right to continue this policy in force for your lifetime by the timely payment of premiums at the rate in effect at the beginning of each term.

Aflac may change the established premium rate, but only if the rate is changed for all policies of this class. While this policy is in force, no change will be made in your class because of the age, sex, or physical condition of any Covered Person. "Class" means all policies of this form number and premium classification in your state that are then in force. If the established premium rate changes, Aflac will notify you in writing at your last known address, as reflected in our records, at least 30 days before the change becomes effective.

**American Family Life Assurance Company of Columbus (Aflac)  
Worldwide Headquarters • 1932 Wynnton Road • Columbus, Georgia 31999**

**For assistance or information about this policy,  
call 1-800-99-AFLAC (1-800-992-3522).**

**For claim forms, visit our Web site at [aflac.com](http://aflac.com).**

Exhibit B: Plans

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**Policy Schedule**

**NAMED INSURED:** John A. Doe

**POLICY NUMBER:** 111-2222

**TYPE OF COVERAGE:** Individual

**COVERAGE:** XXXXXX  
AAABBB

**MODE OF PAYMENT:** Monthly

**PREMIUMS:**

Cancer Policy:	\$XX.xx
Initial Diagnosis Rider:	\$XX.xx
Cancer Screening and Annual Care Rider:	\$XX.xx
Specified-Disease Rider:	\$XX.xx
Return of Premium Rider:	\$XX.xx

**EFFECTIVE DATES:**

Cancer Policy:	XX/XX/XX
Initial Diagnosis Rider:	XX/XX/XX
Cancer Screening and Annual Care Rider:	XX/XX/XX
Specified-Disease Rider:	XX/XX/XX
Return of Premium Rider:	XX/XX/XX

**BENEFIT AMOUNT:**

XX.xx

In witness whereof, Aflac's president and secretary signed this policy in Columbus, Georgia, as of the policy Effective Date shown in the Policy Schedule.

Paul S. Amos II, President

Joey M. Loudermilk, Secretary

## Exhibit B: Plans

This is a legal contract between you and Aflac.  
**READ YOUR POLICY CAREFULLY.**

### **Part 1** **DEFINITIONS**

**A. ACTIVITIES OF DAILY LIVING (ADLs):** activities used in measuring your levels of personal functioning capacity. Normally, these activities are performed without assistance, allowing you personal independence in everyday living.

The ADLs are:

1. Bathing: washing oneself by sponge bath or in either a tub or shower, including the task of getting into or out of the tub or shower;
2. Maintaining continence: controlling urination and bowel movements, including your ability to use ostomy supplies or other devices such as catheters;
3. Transferring: moving between a bed and a chair, or a bed and a wheelchair;
4. Dressing: putting on and taking off all necessary items of clothing;
5. Toileting: getting to and from a toilet, getting on and off a toilet, and performing associated personal hygiene; and
6. Eating: performing all major tasks of getting food into your body.

**B. ASSOCIATED CANCEROUS CONDITION:** myelodysplastic blood disorder, myeloproliferative blood disorder, or carcinoma in situ (in the natural or normal place, confined to the site of origin without having invaded neighboring tissue). An Associated Cancerous Condition must receive a Positive Medical Diagnosis. **Premalignant conditions or conditions with malignant potential, other than those specifically named above, are not considered Associated Cancerous Conditions.**

**C. AMBULATORY SURGICAL CENTER:** facility licensed to provide surgical services in an operating room environment on an outpatient basis. This does not include a doctor's or dentist's office, clinic, or other such location.

**D. BONE MARROW TRANSPLANTATION:** harvesting, storage, and subsequent reinfusion of bone marrow from a transplant recipient or a matched donor in which chemotherapy and/or total body radiotherapy is administered to destroy residual bone marrow. **It does not include the Stem Cell Transplantation.**

**E. CALENDAR MONTH:** one of the 12 divisions of a year as determined by the Gregorian calendar.

**F. CALENDAR WEEK:** Sunday through Saturday of the same week.

**G. CALENDAR YEAR:** January 1 through December 31 of the same year.

**H. CANCER:** disease manifested by the presence of a malignant tumor and characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue. "Cancer" also includes, but is not limited to, leukemia, Hodgkin's disease, and melanoma. Cancer must receive a Positive Medical Diagnosis.

## Exhibit B: Plans

1. **INTERNAL CANCER:** all Cancers other than Nonmelanoma Skin Cancer (see definition of Nonmelanoma Skin Cancer).
2. **NONMELANOMA SKIN CANCER:** a Cancer other than a melanoma that begins in the upper part of the skin (epidermis).

**Associated Cancerous Conditions, premalignant conditions, or conditions with malignant potential will not be considered Cancer.**

### I. CHEMOTHERAPY:

1. **INJECTED CHEMOTHERAPY:** medications taken intravenously, including continuous infusion by pump or patch, that treat disease by means of chemicals that have a specific toxic effect that selectively destroys cancerous tissue.
2. **NONHORMONAL ORAL CHEMOTHERAPY:** medications taken orally, other than hormonal therapy medications, that treat disease by means of chemicals that have a specific toxic effect that selectively destroy cancerous tissue.
3. **HORMONAL ORAL CHEMOTHERAPY:** medications taken orally that alter the production or level of hormones to prevent the spread or recurrence of malignant cells.

J. **COVERED PERSON:** persons covered under Individual, Named Insured/Spouse Only, One-Parent Family, or Two-Parent Family. See Type of Coverage definition.

K. **DEPENDENT CHILDREN:** your natural children, stepchildren, or legally adopted children who are: (1) unmarried; (2) under age 25; and (3) who are your dependent. **A Dependent Child must be under age 25 at the time of application to be eligible for coverage.** Coverage will include any other unmarried Dependent Child, regardless of age, who is incapable of self-sustaining employment by reason of mental retardation or physical handicap and who became so incapacitated prior to age 25 and while covered under this policy. You must furnish proof of such incapacity and dependency to Aflac within 31 days of the Dependent Child's 25th birthday. You must furnish proof of continued incapacity and dependency at Aflac's request, but not more often than annually, after the two-year period following the Dependent Child's 25th birthday.

L. **EFFECTIVE DATE:** the date(s) coverage begins as shown in the Policy Schedule. The Effective Date of this policy **is not** the date you signed the application for coverage.

M. **HOSPICE:** licensed agency, organization, or unit that provides a centrally administered and autonomous continuum of palliative and supportive care to terminally ill persons and their families. The care must be directed and coordinated by the Hospice organization and received primarily in the patient's home, or on an outpatient or inpatient basis in a Hospice unit.

N. **HOSPITAL:** legally operated institution licensed by the state in which it is located that maintains and uses a laboratory, X-ray equipment, and an operating room on its premises or in facilities available to it on a prearranged, written, contractual basis. The institution must also have permanent and full-time facilities for the care of overnight-resident bed patients under the supervision of one or more licensed Physicians, provide 24-hour-a-day nursing service by or under the supervision of a registered professional nurse, and maintain the patients' written histories and medical records on the premises. The term "Hospital" also includes Ambulatory Surgical Centers. The term "Hospital" does not include any institution or part thereof used as an emergency room; an observation unit; a rehabilitation unit; a hospice

## Exhibit B: Plans

unit, including any bed designated as a hospice or a swing bed; a convalescent home; a rest or nursing facility; a psychiatric unit; an extended-care facility; a skilled nursing facility; or a facility primarily affording custodial or educational care, care or treatment for persons suffering from mental disease or disorders, care for the aged, or care for persons addicted to drugs or alcohol.

- O. IMMEDIATE FAMILY:** anyone related to you in the following manner: spouse; brothers or sisters (includes stepbrothers and stepsisters); children (includes stepchildren); parents (includes stepparents); grandchildren; father- or mother-in-law; and spouses, as applicable, of any of these.
- P. IMMUNOTHERAPY:** immunoglobulins or colony-stimulating factors given as a part of a treatment regimen for Internal Cancer or Associated Cancerous Condition to stimulate or restore the ability of the immune system to fight infection and disease.
- Q. NCI-DESIGNATED CANCER CENTER:** a treatment or research facility that currently holds a National Cancer Institute (NCI) designation.
- R. PHYSICIAN:** a person legally qualified to practice medicine, other than a member of your Immediate Family, who is licensed as a Physician by the state where treatment is received to treat the type of condition for which a claim is made.
- S. POSITIVE MEDICAL DIAGNOSIS:** a diagnosis of Cancer or an Associated Cancerous Condition that is diagnosed by a Physician who is certified by the American Board of Pathology to practice pathologic anatomy or by a certified osteopathic pathologist. Pathologic interpretation of the histology of skin lesions will be accepted from dermatologists certified by the American Board of Dermatopathology. The diagnosis must be based on a microscopic examination of fixed tissue or preparations from the hemic system (either during life or postmortem). The pathologist making the diagnosis will base judgment solely on the criteria of "malignancy" as accepted by the American Board of Pathology or the Osteopathic Board of Pathology after a study of the histocytologic architecture or pattern of the suspect tumor, tissue, or specimen.
- T. RADIATION THERAPY:** therapy using high doses of radiation to destroy cancerous cells.
- U. STEM CELL TRANSPLANTATION:** the harvesting, storage, and subsequent reinfusion of peripheral blood cells or stem cells from the transplant recipient or from a matched donor in which chemotherapy and/or total body radiotherapy is administered to destroy residual bone marrow. **It does not include the Bone Marrow Transplantation.**
- V. TYPE OF COVERAGE:** see your Policy Schedule to determine the Type of Coverage issued: Individual, Named Insured/Spouse Only, One-Parent Family, or Two-Parent Family.
- 1. Individual:** coverage for only you (the Named Insured listed in the Policy Schedule).
  - 2. Named Insured/Spouse Only:** coverage for you and your spouse. "Your spouse" is defined as the person to whom you are legally married and who is listed on your application.
  - 3. One-Parent Family:** coverage for you (the Named Insured) and all of your Dependent Children.
  - 4. Two-Parent Family:** coverage for you (the Named Insured), your spouse, and all of your Dependent Children (or those of your spouse).

## Exhibit B: Plans

Any One-Parent Family or Two-Parent Family member specifically excluded by name from coverage is not included in the One-Parent Family or Two-Parent Family definition. Any person who becomes a family member after the Effective Date of this policy, except a newborn, who is automatically covered from the moment of birth, or an adopted child, who is covered from adoption or date of placement for adoption, whichever is earliest, must be added by endorsement.

Persons added as family members by endorsement will be covered for only that Cancer or Associated Cancerous Condition diagnosed on or after the Effective Date of their endorsement. If this is an Individual or Named Insured/Spouse Only policy, newborn children are automatically covered from the moment of birth, and adopted children are covered from adoption or date of placement for adoption, whichever is earliest; however, if you desire uninterrupted coverage, you must notify Aflac in writing within 31 days of the birth of your child or the date of adoption or date of placement for adoption. Upon notification, Aflac will convert this policy to One-Parent Family or Two-Parent Family coverage and advise you of the additional premium due. If this is a One-Parent Family or a Two-Parent Family policy, it is not necessary to notify Aflac of the birth or adoption of a child, and no additional premium will be required for coverage of newborns or adopted children. If you wish any other person to be covered after the Effective Date of the policy, you must apply for such coverage, and that person must be added by endorsement. If Two-Parent Family coverage is already in force, an additional premium will not be required. Insurance for persons added by endorsement becomes effective on the date specified on the endorsement.

The insurance on any Dependent Child will terminate on the anniversary date of this policy following the Dependent Child's 25th birthday, on the date the child marries, or at the time the child is no longer a dependent, whichever occurs first (for continuation of coverage information, see Part 3, Right of Conversion). Termination will be without prejudice to any claim originating prior to the date of termination. Our acceptance of premium after such date will be considered as premium for only the remaining persons who qualify as Covered Persons under this policy. You must notify Aflac, in writing, of any changes that will affect the Type of Coverage. After such notice, Aflac will arrange for the payment of the appropriate premium due, including returning any unearned premium. Coverage provided under any One-Parent Family or Two-Parent Family policy will continue to include any other unmarried Dependent Child, regardless of age, who is incapable of self-sustaining employment by reason of mental retardation or physical handicap and who became so incapacitated while he or she was covered and before he or she reached age 25. You must furnish proof of such incapacity and dependency to Aflac within 31 days of the child's 25th birthday. Proof of continued incapacity and dependency must be furnished at Aflac's request, but not more often than annually, after the two-year period following the child's 25th birthday.

### **Part 2** **LIMITATIONS AND EXCLUSIONS**

- A.** We pay only for treatment of Cancer and Associated Cancerous Conditions, including direct extension, metastatic spread, or recurrence. Benefits are not provided for premalignant conditions or conditions with malignant potential (unless specifically covered); complications of either Cancer or an Associated Cancerous Condition; or any other disease, sickness, or incapacity.

## Exhibit B: Plans

Premium for a term is due on the first day of that term. **If you fail to pay your premium by the end of the grace period, coverage under this policy will terminate.**

- D. GRACE PERIOD:** A grace period of 31 days will be granted for the payment of each premium falling due after the first premium. During the grace period, this policy will continue in force.
- E. REINSTATEMENT:** You may request reinstatement of your policy from our associate (duly licensed agent) or from Aflac. If your policy has lapsed for nonpayment of premium and we accept a later payment without requiring an application, your policy will be reinstated. If we require a written application and provide you with a conditional receipt, your policy will be reinstated upon our approval of the application. If we do not notify you of our disapproval in writing within 45 days of the date of your application, your policy will be deemed reinstated. The reinstated policy will cover loss resulting only from hospitalization for and/or treatment of Cancer or an Associated Cancerous Condition that is diagnosed or treated more than ten days after the date of reinstatement. In all other respects, you and Aflac will have the same rights as provided under the policy immediately before the due date of the defaulted premium, subject to any provisions added in connection with the reinstatement. Any premium accepted in connection with a reinstatement will be applied to a period for which premium has not been previously paid, but not to any period more than 60 days prior to the date of reinstatement.
- F. NOTICE OF CLAIM:** Written notice of claim must be given within 60 days after a covered loss starts or as soon as reasonably possible. The notice can be given to Aflac at our worldwide headquarters or to our associate (duly licensed agent). Notice of claim should include the name of the Covered Person and the policy number.
- G. CLAIM FORMS:** When we receive a notice of claim, we will send you forms for filing proof of loss. If the forms are not given to you within ten working days, you will meet the proof-of-loss requirements by giving us a written statement of the nature and extent of the loss within the time limit stated in the Proof of Loss provision.
- H. PROOF OF LOSS:** Written proof of loss must be furnished to Aflac at our worldwide headquarters within 90 days after the date of such loss. Failure to furnish such proof within the time required will not invalidate or reduce any claim if it was not reasonably possible to give proof within such time. However, such proof must be furnished as soon as reasonably possible and in no event (except in the absence of legal capacity) later than 15 months from the time proof is otherwise required.
- I. TIME OF PAYMENT OF CLAIMS:** All benefits payable under this policy will be paid immediately upon receipt of due written proof of loss.
- J. PAYMENT OF CLAIMS:** All benefits will be payable to you unless assigned by you or by operation of law. Any accrued benefits unpaid at your death will be paid to your estate.
- K. LEGAL ACTIONS:** No legal action may be brought to recover on this policy within 60 days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action may be brought after three years from the time written proof of loss is required to be furnished.

## Exhibit B: Plans

### Part 3 RIGHT OF CONVERSION

- A. DISSOLUTION OF MARRIAGE:** If you and your spouse dissolve your marriage by a valid decree of dissolution and your ex-spouse was covered under a Named Insured/Spouse Only or Two-Parent Family policy, your ex-spouse's coverage will terminate. Your ex-spouse may then apply for and receive, without evidence of insurability, a policy providing coverage not greater than the terminated coverage. To obtain the policy, your ex-spouse must make application to Aflac within 60 days following the entry of the decree of dissolution of marriage and pay the appropriate premium for the policy. If such dissolution of marriage occurs, the Named Insured under this policy at the time of the dissolution will retain that status. Any Dependent Children may be covered under either policy, but not both. **Any such person who applies for another Cancer policy and has been diagnosed with Internal Cancer or an Associated Cancerous Condition will not be eligible for an Initial Diagnosis Benefit.** If neither you nor your ex-spouse wish to continue the coverage but wish to have coverage for the Dependent Children, your Dependent Children are eligible for a conversion policy.
- B. DEATH:** In the event of your death, your spouse, if alive and covered under this policy, will become the Named Insured.
- C. TERMINATION OF DEPENDENCY:** A Dependent Child whose dependency has terminated and who desires to continue coverage as a Named Insured under a separate policy may do so by notifying Aflac of the request in writing. Such person will have the right to apply for a Cancer policy without evidence of insurability and without interruption in coverage, provided Aflac receives written notification of the request prior to 31 days after the anniversary date of this policy following the date he or she is no longer considered a Dependent Child. **Any such person who applies for another Cancer policy and has been diagnosed with Internal Cancer or an Associated Cancerous Condition will not be eligible for an Initial Diagnosis Benefit.**

### Part 4 UNIFORM PROVISIONS

- A. ENTIRE CONTRACT; CHANGES:** This policy, together with the application, endorsements, benefit agreements, and riders, if any, constitutes the entire contract of insurance. No change in this policy is valid until approved in writing by the President and Secretary of Aflac at our worldwide headquarters. Any such change must be noted hereon or attached hereto. No associate (duly licensed agent) has the authority to change this policy or to waive any of its provisions.
- B. TIME LIMIT ON CERTAIN DEFENSES:** After two years from the Effective Date of this policy, any misstatements, except fraudulent misstatements, made by you in the application will not be used to void this policy or to deny a claim for care commencing after the expiration of such two-year period.
- C. TERM:** The term of this policy begins at midnight, standard time, at the place where you reside on the Effective Date shown in the Policy Schedule. It ends at midnight, at the same standard time, on the first premium due date. Each succeeding term ends at midnight, at the same standard time, on the next following premium due date. Premium due dates are determined by the mode of payment. The mode of payment for the original term of this policy is shown in the Policy Schedule. An annual premium will maintain this policy in force for 12 months, semiannual for six months, quarterly for three months, and monthly for one month.

## Exhibit B: Plans

- L. CONFORMITY WITH STATUTES:** Any provision of this policy that, on its Effective Date, is in conflict with the statutes of the state or territory in which the Named Insured resides on such date is hereby amended to conform to the minimum requirements of such statutes.
- M. OTHER INSURANCE WITH AFLAC:** If a person is covered under more than one Cancer policy or rider with us, only one Aflac policy chosen by you or your estate, as the case may be, will be effective. We will pay benefits under the policies for claims that may have been incurred since their respective Effective Dates. We will also return all premiums paid for the canceled policies from the date of duplication, less any benefits paid under these policies from such date.

### **Part 5** **ELIGIBILITY FOR BENEFITS**

- A.** If you or any Covered Person is diagnosed as having Cancer or an Associated Cancerous Condition while this policy is in force, we will pay for the treatment of Cancer or an Associated Cancerous Condition occurring while this policy remains in force, according to the Benefits section, Part 6, subject to all other limitations and exclusions, conditions, and provisions of this policy. The "diagnosis date" is the day the tissue specimen, culture, and/or titer is taken upon which the diagnosis of Cancer or an Associated Cancerous Condition is based. The "diagnosis date" is not the date the diagnosis is communicated to the Covered Person.
- B.** Outpatient and hospitalization benefits for the treatment of Cancer or an Associated Cancerous Condition will accrue as follows:

If Cancer or an Associated Cancerous Condition is diagnosed while a Covered Person is hospitalized or receiving outpatient treatment, benefits will accrue from the day of admission to the Hospital, but will not be retroactive more than 30 days before the date Cancer or Associated Cancerous Condition was diagnosed. **EXCEPTION: If Nonmelanoma Skin Cancer is diagnosed during hospitalization, benefits will be limited to the day(s) the Covered Person actually received treatment for Nonmelanoma Skin Cancer.**

### **Part 6** **BENEFITS**

All treatments listed below must be NCI or Food and Drug Administration approved for the treatment of Cancer or Associated Cancerous Condition, as applicable.

#### **A. CANCER TREATMENT BENEFITS:**

- 1. DIRECT NONSURGICAL TREATMENT BENEFITS:** All benefits listed below are not payable based on the number, duration, or frequency of the medication(s), therapy, or treatment received by the Covered Person (except as provided in Benefit A1c).
- a. INITIAL TREATMENT BENEFIT:** Aflac will pay \$3,000 (three thousand dollars) the first time a Covered Person receives one or more of the following: Radiation Therapy Benefits, Injected Chemotherapy Benefits, or Oral Chemotherapy Benefits. Lifetime maximum benefit of \$3,000 per Covered Person.
- b. INJECTED CHEMOTHERAPY BENEFIT:** Aflac will pay \$900 (nine hundred dollars) once per Calendar Week during which a Covered Person receives and incurs a charge for Physician-prescribed Injected Chemotherapy. The Surgical/Anesthesia Benefit provides amounts payable for insertion and removal of a pump. Benefits will

## Exhibit B: Plans

not be paid for each week of continuous infusion of medications dispensed by a pump, implant, or patch. This benefit is limited to the Calendar Week in which the charge for the medication(s) or treatment is incurred. No lifetime maximum.

### c. **ORAL CHEMOTHERAPY BENEFITS:**

(i) **NONHORMONAL ORAL CHEMOTHERAPY BENEFIT:** Aflac will pay \$400 (four hundred dollars) per Calendar Month during which a Covered Person is prescribed, receives, and incurs a charge for Non-Hormonal Oral Chemotherapy for the treatment of Cancer or an Associated Cancerous Condition.

(ii) **HORMONAL ORAL CHEMOTHERAPY BENEFIT:** Aflac will pay \$400 per Calendar Month for up to 24 months during which a Covered Person is prescribed, receives, and incurs a charge for Hormonal Oral Chemotherapy for the treatment of Cancer or an Associated Cancerous Condition. After 24 months of paid benefits of Hormonal Oral Chemotherapy for a Covered Person, Aflac will pay \$100 (one hundred dollars) per Calendar Month, during which a Covered Person is prescribed, receives, and incurs a charge for Hormonal Oral Chemotherapy for the treatment of Cancer or an Associated Cancerous Condition. Examples of Hormonal Oral Chemotherapy treatments include, but are not limited to, Nolvadex, Arimidex, Femara, and Lupron and their generic versions, such as Tamoxifen.

**Oral Chemotherapy benefits are limited to the Calendar Month in which the charge for the medication(s) or treatment is incurred. Total benefits are payable for up to three different Oral Chemotherapy medicines per Calendar Month, up to a maximum of \$1,200 (one thousand two hundred dollars) per Calendar Month. Refills within the same Calendar Month, are not considered a different Chemotherapy medicine. No lifetime maximum.**

d. **RADIATION THERAPY BENEFIT:** Aflac will pay \$500 (five hundred dollars) once per Calendar Week during which a Covered Person receives and incurs a charge for Radiation Therapy for the treatment of Cancer or an Associated Cancerous Condition. This benefit will not be paid for each week a radium implant or radioisotope remains in the body. This benefit is limited to the Calendar Week in which the charge for the therapy is incurred. No lifetime maximum.

e. **EXPERIMENTAL TREATMENT BENEFIT:** Aflac will pay \$500 (five hundred dollars) once per Calendar Week during which a Covered Person receives and incurs a charge for Physician-prescribed experimental Cancer treatments. Aflac will pay \$125 (one hundred twenty five dollars) once per Calendar Week during which a Covered Person receives Physician-prescribed experimental Cancer treatments as part of a clinical trial which does not charge patients for inclusion.

Treatments must be approved by the NCI as a viable experimental treatment for Cancer. This benefit does not pay for laboratory tests, diagnostic X-rays, immunoglobulins, Immunotherapy, colony-stimulating factors, and therapeutic devices or other procedures related to these experimental treatments. Benefits will not be paid for each week of continuous infusion of medications dispensed by a pump, implant, or patch. This benefit is limited to the Calendar Week in which the charge for the treatment is incurred. No lifetime maximum.

## Exhibit B: Plans

**2. INDIRECT/ADDITIONAL THERAPY BENEFITS: The following benefits are not payable based on the number, duration, or frequency of Immunotherapy or anti-nausea drugs received by the Covered Person.**

- a. **IMMUNOTHERAPY BENEFIT:** Aflac will pay \$500 (five hundred dollars) per Calendar Month during which a Covered Person receives and incurs a charge for Physician-prescribed Immunotherapy as part of a treatment regimen for Internal Cancer or an Associated Cancerous Condition. This benefit is payable only once per Calendar Month. It is limited to the Calendar Month in which the charge for Immunotherapy is incurred. Lifetime maximum of \$2,500 (two thousand five hundred dollars) per Covered Person.

**Any medications paid under the Injected Chemotherapy, Oral Chemotherapy, Radiation Therapy Benefit, or the Experimental Treatment Benefit will not be paid under the Immunotherapy Benefit.**

- b. **ANTI-NAUSEA BENEFIT:** Aflac will pay \$150 (one hundred fifty dollars) per Calendar Month during which a Covered Person receives and incurs a charge for anti-nausea drugs that are prescribed while receiving Radiation Therapy Benefits, Injected Chemotherapy Benefits, Oral Chemotherapy Benefits, or Experimental Treatment Benefits. This benefit is payable only once per Calendar Month and is limited to the Calendar Month in which the charge for anti-nausea drugs is incurred. No lifetime maximum.
- c. **STEM CELL TRANSPLANTATION BENEFIT:** Aflac will pay \$10,000 (ten thousand dollars) when a Covered Person receives and incurs a charge for a peripheral Stem Cell Transplantation for the treatment of Internal Cancer or an Associated Cancerous Condition. This benefit is payable once per Covered Person. Lifetime maximum of \$10,000 (ten thousand dollars) per Covered Person.
- d. **BONE MARROW TRANSPLANTATION BENEFIT:** (1) Aflac will pay \$10,000 (ten thousand dollars) when a Covered Person receives and incurs a charge for a Bone Marrow Transplantation for the treatment of Internal Cancer or an Associated Cancerous Condition. (2) Aflac will pay the Covered Person's bone marrow donor an indemnity of \$1,000 (one thousand dollars) for his or her expenses incurred as a result of the transplantation procedure. Lifetime maximum of \$10,000 (ten thousand dollars) per Covered Person.
- e. **BLOOD AND PLASMA BENEFIT:** Aflac will pay \$150 (one hundred fifty dollars) times the number of days paid under the Hospital Confinement Benefit when a Covered Person receives and incurs a charge for blood and/or plasma transfusions during a covered Hospital confinement. Aflac will pay \$250 (two hundred fifty dollars) for each day a Covered Person receives and incurs a charge for blood and/or plasma transfusions for the treatment of Internal Cancer or an Associated Cancerous Condition as an outpatient in a Physician's office, clinic, Hospital, or Ambulatory Surgical Center. This benefit does not pay for immunoglobulins, Immunotherapy, anti-hemophilia factors, or colony-stimulating factors. No lifetime maximum.

Exhibit B: Plans

**3. SURGICAL TREATMENT BENEFITS:**

- a. **SURGICAL/ANESTHESIA BENEFIT:** When a surgical operation is performed on a Covered Person for a diagnosed Internal Cancer or Associated Cancerous Condition, Aflac will pay the indemnity listed in the following Schedule of Operations for the specific procedure when a charge is incurred. If any operation for the treatment of Internal Cancer or Associated Cancerous Condition is performed other than those listed, Aflac will pay an amount comparable to the amount shown in the Schedule of Operations for the operation most nearly similar in severity and gravity.

**EXCEPTIONS: Surgery for Skin Cancer will be payable under Benefit A3b. Reconstructive Surgery will be payable under Benefit C7.**

Two or more surgical procedures performed through the same incision will be considered one operation, and benefits will be paid based upon the highest eligible benefit.

Aflac will pay an indemnity benefit equal to 25% of the amount shown in the Schedule of Operations for the administration of anesthesia during a covered surgical operation.

The maximum daily benefit will not exceed \$6,250 (six thousand two hundred fifty dollars). No lifetime maximum on the number of operations.

**SCHEDULE OF OPERATIONS**

<b>ABDOMEN</b>		(simple) .....	650
Paracentesis .....	\$ 140	(radical) .....	1,000
Exploratory laparotomy.....	525	Physical complications of mastectomy .....	50
<b>BLADDER</b>		<b>CERVIX</b>	
Cystoscopy.....	140	D & C .....	175
TUR bladder tumors .....	525	Colposcopy .....	175
Cystectomy		Vaginal hysterectomy/ uterus only.....	525
(partial) .....	900	Oophorectomy .....	525
(complete) .....	1,800	Abdominal hysterectomy/ uterus only.....	900
(with ureteroileal conduit)....	3,600	uterus, tubes & ovaries.....	1,750
<b>BRAIN</b>		with partial exenteration.....	3,000
Burr holes not		with complete exenteration..	5,000
followed by surgery .....	700	<b>CHEST</b>	
Ventriculoperitoneal shunt .....	700	Thoracentesis .....	140
Exploratory craniotomy.....	1,500	Bronchoscopy .....	300
Excision brain tumor .....	3,500	Mediastinoscopy .....	300
Hemispherectomy .....	5,000	Thoracostomy .....	300
<b>BREAST</b>		Thoracotomy .....	700
Needle biopsy.....	140	Wedge resection .....	1,200
Cutting operation biopsy.....	280	Lobectomy .....	1,500
Lumpectomy.....	350	Pneumonectomy .....	2,100
Mastectomy			
(partial) .....	475		

## Exhibit B: Plans

### ESOPHAGUS

Esophagoscopy.....	280
Esophagogastrectomy.....	1,500
Resection of esophagus.....	2,000

### EYE

P32 uptake.....	250
Enucleation.....	500

### INTESTINES

Sigmoidoscopy.....	140
Proctosigmoidoscopy.....	140
Colonoscopy (does not include virtual).....	280
Cutting operation on rectum for biopsy.....	280
Colostomy/or revision of.....	350
ERCP.....	350
Ileostomy.....	350
Colectomy.....	900
Resection of small intestine.....	2,100
Abdominal-perineal approach for removal of Cancer of sigmoid colon or rectum.....	2,500

### KIDNEY

Nephrectomy (simple).....	2,100
(radical).....	3,600

### LIVER

Needle biopsy.....	140
Wedge biopsy.....	350
Resection of liver (partial).....	1,000
(complete).....	2,500

### LYMPHATIC

Excision of lymph nodes.....	175
Splenectomy.....	700
Axillary node dissection.....	700
Lymphadenectomy (unilateral).....	700
(bilateral).....	900

### MANDIBLE

Mandibulectomy.....	1,400
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### MISCELLANEOUS

Peripherally inserted central catheter (PICC).....	140
Bone marrow biopsy or aspiration.....	140
Venous-catheters/venous port for chemotherapy.....	140
Pathological fracture.....	400
Cholecystectomy.....	700
Pathological hip fracture.....	875

### MOUTH

Hemiglossectomy.....	350
Tonsil/mucous membrane.....	525
Glossectomy.....	700
Resection of palate.....	700

### PANCREAS

Jejunostomy.....	900
Pancreatectomy.....	2,100
Whipple procedure.....	3,600

### PENIS

Amputation (partial).....	350
(complete).....	700
(radical).....	900

### PROSTATE

Needle biopsy.....	140
Cystoscopy.....	140
TUR prostate.....	525
Radical prostatectomy.....	1,400

### RADIUM IMPLANTS

Insertion.....	1,000
Removal.....	500

### SALIVARY GLANDS

Biopsy.....	350
Parotidectomy.....	700
Radical neck dissection.....	1,800

### SPINE

Cordotomy.....	525
Laminectomy.....	900

Exhibit B: Plans

**STOMACH**

Gastroscopy .....	300
Gastrojejunostomy .....	900
Gastrectomy	
(partial) .....	900
(complete) .....	1,400

**TESTIS**

Orchiectomy	
(unilateral) .....	350
(bilateral) .....	490

**THROAT**

Laryngoscopy .....	300
Tracheostomy .....	300
Laryngectomy	
(without neck dissection) ....	900
(with neck dissection) .....	1,800

**THYROID**

Thyroidectomy	
(partial: one lobe).....	525
(total: both lobes).....	700

**VULVA**

Vulvectomy	
(partial).....	525
(complete) .....	1,050
(radical) .....	1,400

- b. **SKIN CANCER SURGERY BENEFIT:** When a surgical operation is performed on a Covered Person for a diagnosed skin cancer, including melanoma or Nonmelanoma Skin Cancer, Aflac will pay the indemnity listed below when a charge is incurred for the specific procedure. The indemnity amount listed below includes anesthesia services. The maximum daily benefit will not exceed \$600 (six hundred dollars). No lifetime maximum on the number of operations.

Laser or Cryosurgery	\$ 50
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**Surgeries OTHER THAN Laser or Cryosurgery:**

Biopsy	100
Excision of lesion of skin without flap or graft	250
Flap or graft without excision	375
Excision of lesion of skin with flap or graft	600

**B. HOSPITALIZATION BENEFITS:**

1. **HOSPITAL CONFINEMENT BENEFITS (includes confinement in a U.S. government Hospital):**

- a. **HOSPITALIZATION FOR 30 DAYS OR LESS:** When a Covered Person is confined to a Hospital for treatment of Cancer or an Associated Cancerous Condition for 30 days or less, Aflac will pay the amount listed below per day for each day a Covered Person is charged for a room as an inpatient. No lifetime maximum.

Named Insured or Spouse	\$300
Dependent Child	\$375

- b. **HOSPITALIZATION FOR 31 DAYS OR MORE:** During any continuous period of Hospital confinement of a Covered Person for treatment of Cancer or an Associated Cancerous Condition for 31 days or more, Aflac will pay benefits as described in Benefit B1a above for the first 30 days. Beginning with the 31st day of such continuous Hospital confinement, Aflac will pay the amount listed below per day for

## Exhibit B: Plans

each day a Covered Person is charged for a room as an inpatient. No lifetime maximum.

Named Insured or Spouse	\$600
Dependent Child	\$750

**EXCEPTION: A person confined to a U.S. government Hospital does not need to be charged for the Hospital Confinement Benefit to be payable.**

- 2. OUTPATIENT HOSPITAL SURGICAL ROOM CHARGE BENEFIT:** When a surgical operation is performed on a Covered Person for treatment of a diagnosed Internal Cancer or Associated Cancerous Condition, and a surgical room charge is incurred, Aflac will pay \$300 (three hundred dollars). For this benefit to be paid, surgeries must be performed on an outpatient basis in a Hospital, to include an Ambulatory Surgical Center. This benefit is payable once per day and is not payable on the same day as the Hospital Confinement Benefit. This benefit is payable in addition to the Surgical/Anesthesia Benefit. The maximum daily benefit will not exceed \$300 (three hundred dollars). No lifetime maximum on number of operations.

**This benefit is also payable for Nonmelanoma Skin Cancer surgery involving a flap or graft. It is not payable for any surgery performed in a Physician's office.**

### **C. CONTINUING CARE BENEFITS:**

- 1. EXTENDED-CARE FACILITY BENEFIT:** When a Covered Person is hospitalized and receives benefits under Benefit B1 and is later confined, within 30 days of the covered Hospital confinement, to an extended-care facility, a skilled nursing facility, a rehabilitation unit or facility, a transitional care unit or any bed designated as a swing bed, or to a section of the Hospital used as such, (collectively referred to as "Extended-Care Facility"), Aflac will pay \$150 (one hundred fifty dollars) per day when a charge is incurred for such continued confinement. For each day this benefit is payable, benefits under Benefit B1 are NOT payable. Benefits are limited to 30 days in each Calendar Year per Covered Person.

If more than 30 days separates confinements in an Extended-Care Facility, benefits are not payable for the second confinement unless the Covered Person again receives benefits under Benefit B1 and is confined as an inpatient to the Extended Care Facility within 30 days of that confinement.

- 2. HOME HEALTH CARE BENEFIT:** When a Covered Person is hospitalized for the treatment of Internal Cancer or an Associated Cancerous Condition and then has either home health care or health supportive services provided on his or her behalf, Aflac will pay \$150 (one hundred fifty dollars) when a charge is incurred for each such visit, subject to the following conditions:
- The home health care or health supportive services must begin within seven days of release from the Hospital.
  - This benefit is limited to ten visits per hospitalization for each Covered Person.
  - This benefit is limited to 30 visits in any Calendar Year for each Covered Person.
  - This benefit will not be payable unless the attending Physician prescribes such services to be performed in the home of the Covered Person and certifies that if

## Exhibit B: Plans

these services were not available, the Covered Person would have to be hospitalized to receive the necessary care, treatment, and services.

- e. Home health care and health supportive services must be performed by a person, other than a member of your Immediate Family, who is licensed, certified, or otherwise duly qualified to perform such services on the same basis as if the services had been performed in a health care facility.

**This benefit is not payable the same day the Hospice Care Benefit is payable.**

3. **HOSPICE CARE BENEFIT:** When a Covered Person is diagnosed with Internal Cancer or an Associated Cancerous Condition and therapeutic intervention directed toward the cure of the disease is medically determined to be no longer appropriate, and if the Covered Person's medical prognosis is one in which there is a life expectancy of six months or less as the direct result of Internal Cancer or an Associated Cancerous Condition, (hereinafter referred to as "Terminally Ill") Aflac will pay a one-time benefit of \$1,000 (one thousand dollars) for the first day the Covered Person receives Hospice care and \$50 (fifty dollars) per day thereafter for Hospice care. For this benefit to be payable, Aflac must be furnished: (1) a written statement from the attending Physician that the Covered Person is Terminally Ill, and (2) a written statement from the Hospice certifying the days services were provided. This benefit is not payable the same day the Home Health Care Benefit is payable. Lifetime maximum for each Covered Person is \$12,000 (twelve thousand dollars).
4. **NURSING SERVICES BENEFIT:** While confined in a Hospital for the treatment of Cancer or an Associated Cancerous Condition, if a Covered Person requires and is charged for private nurses and their services other than those regularly furnished by the Hospital, Aflac will pay \$150 (one hundred fifty dollars) per day for full-time private care and attendance provided by such nurses (registered graduate nurses, licensed practical nurses, or licensed vocational nurses). These services must be required and authorized by the attending Physician. This benefit is not payable for private nurses who are members of your Immediate Family. This benefit is payable for only the number of days the Hospital Confinement Benefit is payable. No lifetime maximum.
5. **SURGICAL PROSTHESIS BENEFIT:** Aflac will pay \$3,000 (three thousand dollars) when a charge is incurred for surgically implanted prosthetic devices that are prescribed as a direct result of surgery for Internal Cancer or Associated Cancerous Condition treatment. Lifetime maximum of \$6,000 (six thousand dollars) per Covered Person.  
**The Surgical Prosthesis Benefit does not include coverage for tissue expanders or a Breast Transverse Rectus Abdominis Myocutaneous (TRAM) Flap.**
6. **PROSTHESIS NONSURGICAL BENEFIT:** Aflac will pay \$250 (two hundred fifty dollars) per occurrence, per Covered Person when a charge is incurred for up to two postoperative prosthetic devices that are nonsurgically implanted. Examples of nonsurgically implanted prosthetic devices include voice boxes, hair pieces, and removable breast prostheses. Lifetime maximum of \$500 (five hundred dollars) per Covered Person.
7. **RECONSTRUCTIVE SURGERY BENEFIT:** Aflac will pay the specified indemnity listed below when a charge is incurred for a reconstructive surgical operation that is performed on a Covered Person as a result of treatment of Cancer or treatment of an Associated Cancerous Condition. The maximum daily benefit will not exceed \$3,000 (three thousand dollars). No lifetime maximum on number of operations.

## Exhibit B: Plans

Breast Transverse Rectus Abdominis Myocutaneous (TRAM) Flap	\$3,000
Breast Reconstruction	700
Breast Symmetry (on the nondiseased breast occurring within five years of breast reconstruction)	350
Facial Reconstruction	700

Aflac will pay an indemnity benefit equal to 25% of the amount shown above for the administration of anesthesia during a covered reconstructive surgical operation.

If any reconstructive surgery is performed other than those listed, Aflac will pay an amount comparable to the amount shown above for the operation most nearly similar in severity and gravity.

### **D. AMBULANCE, TRANSPORTATION, AND LODGING BENEFITS:**

- 1. AMBULANCE BENEFIT:** Aflac will pay \$250 (two hundred fifty dollars) when a charge is incurred for ambulance transportation of a Covered Person to or from a Hospital where the Covered Person is confined overnight for treatment of Cancer or an Associated Cancerous Condition. Aflac will pay \$2,000 (two thousand dollars) when a charge is incurred for air ambulance transportation of a Covered Person to or from a Hospital where the Covered Person is confined overnight for Cancer or Associated Cancerous Condition treatment. This benefit is limited to two trips per confinement. The ambulance service must be performed by a licensed professional ambulance company. No lifetime maximum.
- 2. TRANSPORTATION BENEFIT:** If a Covered Person requires treatment for Cancer or an Associated Cancerous Condition that has been prescribed by the attending Physician, Aflac will pay 50 cents per mile, up to a maximum of \$1,500 (one thousand five hundred dollars) for transportation of the Covered Person and a companion, limited to the distance of miles between the Hospital or medical facility and the residence of the Covered Person. If commercial travel (coach-class plane, train, or bus fare) is necessary, we will pay for one additional person to accompany the Covered Person. If the treatment is for a covered Dependent Child and commercial travel is necessary, Aflac will pay for up to two adults to accompany the covered Dependent Child.

**THIS BENEFIT IS NOT PAYABLE FOR TRANSPORTATION TO ANY HOSPITAL/FACILITY LOCATED WITHIN A 50-MILE RADIUS OF THE RESIDENCE OF THE COVERED PERSON OR FOR TRANSPORTATION BY AMBULANCE TO OR FROM ANY HOSPITAL.**

- 3. LODGING BENEFIT:** Aflac will pay \$80 (eighty dollars) per day when a charge is incurred for lodging, in a room in a motel, hotel, or other commercial accommodation, for you or any one adult family member when a Covered Person receives treatment for Cancer or an Associated Cancerous Condition at a Hospital or medical facility more than 50 miles from the Covered Person's residence. This benefit is not payable for lodging occurring more than 24 hours prior to treatment or for lodging occurring more than 24 hours following treatment. This benefit is limited to 90 days per Calendar Year.

**E. PREMIUM WAIVER AND RELATED BENEFITS:**

- 1. WAIVER OF PREMIUM BENEFIT:** If you, due to having Cancer or an Associated Cancerous Condition, are completely unable to perform all of the usual and customary duties of your occupation [if you are not employed: are completely unable to perform two or more Activities of Daily Living (ADLs) without the assistance of another person] for a period of 90 continuous days, Aflac will waive, from month to month, any premiums falling due during your continued inability. For premiums to be waived, Aflac will require an employer's statement (if applicable) and a Physician's statement of your inability to perform said duties or activities, and may each month thereafter require a Physician's statement that total inability continues.

If you die and your spouse becomes the new Named Insured, premiums will resume and be payable on the first premium due date after the change. The new Named Insured will then be eligible for this benefit if the need arises.

Aflac may ask for and use an independent consultant to determine whether you can perform an ADL when this benefit is in force.

Aflac will also waive, from month to month, any premiums falling due while you are receiving Hospice Benefits.

- 2. CONTINUATION OF COVERAGE BENEFIT:** Aflac will waive all monthly premiums due for the policy and riders for two months if you meet all of the following conditions:
- a. Your policy has been in force for at least six months;
  - b. We have received premiums for at least six consecutive months;
  - c. Your premiums have been paid through payroll deduction;
  - d. You or your employer has notified us in writing within 30 days of the date your premium payments ceased due to your leaving employment; and
  - e. You re-establish premium payments through:
    - (1) your new employer's payroll deduction process, or
    - (2) direct payment to Aflac.

You will again become eligible to receive this benefit after:

- a. You re-establish your premium payments through payroll deduction for a period of at least six months, and
- b. We receive premiums for at least six consecutive months.

**"Payroll deduction" means your premium is remitted to Aflac for you by your employer through a payroll deduction process.**

**IMPORTANT: This is a limited benefit, specified-disease policy. It pays benefits for Cancer and Associated Cancerous Condition treatment only.**

*Optional*

# Cancer Screening and Annual Care Benefit Rider

## Summary Page - Policy Rider Series A76000

Riders become a part of the policy and are subject to all policy provisions unless otherwise stated.

### What We Will Pay

#### Cancer Vaccine Benefit

Aflac will pay \$40 if a Covered Person incurs a charge for receiving any Cancer vaccine that is approved by the Food and Drug Administration for the prevention of Cancer. The vaccine must be administered by licensed medical personnel. This benefit is limited to one payment per Covered Person, per calendar year.

#### Cancer Wellness Benefit

\$50      \$75      \$100      \$125

Aflac will pay the amount shown in the Policy Schedule per calendar year when a Covered Person incurs a charge for one of the following:

- Mammogram
- Breast ultrasound
- Breast MRI
- CA 15-3 (tumor marker for breast cancer)
- Pap smear
- ThinPrep
- Biopsy
- Chest X-ray
- CEA (blood test for colon Cancer)
- CA 125 (blood test for ovarian Cancer)
- PSA (blood test for prostate Cancer)
- Testicular ultrasound
- Thermography
- Flexible sigmoidoscopy
- Colonoscopy
- Virtual colonoscopy
- Hemocult stool specimen (lab confirmed)

This benefit is limited to one payment per calendar year, per Covered Person. Tests must be performed to determine whether Cancer or an Associated Cancerous Condition exists in a Covered Person and must be administered by licensed medical personnel. No lifetime maximum.

#### Bone Marrow Donor Screening Benefit

Aflac will pay \$40 when a Covered Person provides documentation of participation in a screening test as a potential bone marrow donor. This benefit is limited to one benefit per Covered Person, per lifetime.

#### Annual Care Benefit

Aflac will pay \$500 on the anniversary date of a Covered Person's Internal Cancer diagnosis upon proof that the Covered Person is still under the active care of a Physician. This benefit is not payable for Associated Cancerous Conditions or nonmelanoma skin Cancers. Lifetime maximum of five annual payments per Covered Person.

### Terms You Need to Know

**Termination:** The rider will terminate if the policy to which it is attached terminates or if the premium for the rider is not paid.

**Effective Date** The Effective Date of the rider is the Effective Date listed on the Policy Schedule.

The rider to which this sales material pertains is written only in English; the rider prevails if interpretation of this material varies.

**Refer to the policy and rider for complete details, definitions, limitations, and exclusions.**



**FOR ILLUSTRATION ONLY**

This **CANCER SCREENING AND ANNUAL CARE BENEFIT RIDER** is a part of the policy and is subject to all policy provisions unless modified herein.

**EFFECTIVE DATE**

The Effective Date of this rider is the Effective Date listed on the Policy Schedule.

**ELIGIBILITY FOR BENEFITS**

This rider is issued on the basis that the information shown on the application is correct and complete. If any answers on your application for this rider are incorrect or incomplete, the benefits under this rider will be the lesser of the benefits that you would have been eligible to purchase if a correct or complete answer had been given or your original rider benefit amount. Any overpayment of premium will be refunded to you, less any claims paid.

**BENEFITS**

No diagnosis of either Cancer or an Associated Cancerous Condition is required for benefits A or B to be payable.

**A. CANCER VACCINE BENEFIT:** Aflac will pay \$40 (forty dollars) if a Covered Person incurs a charge for receiving any Cancer vaccine that is FDA approved for the prevention of Cancer. The vaccine must be administered by licensed medical personnel. This benefit is limited to one payment per Covered Person, per Calendar Year.

**B. CANCER WELLNESS BENEFITS:**

1. **CANCER WELLNESS:** Aflac will pay the amount shown in the Policy Schedule, per Calendar Year, when a Covered Person incurs a charge for one of the following:

- mammogram
- breast ultrasound
- breast MRI
- CA15-3
- Pap smear
- ThinPrep
- biopsy
- flexible sigmoidoscopy
- hemocult stool specimen (lab confirmed)
- chest X-ray
- CEA (blood test for colon cancer)
- CA 125 (blood test for ovarian Cancer)
- PSA (blood test for prostate Cancer)
- testicular ultrasound
- thermography
- colonoscopy
- virtual colonoscopy

This benefit is limited to one payment per Calendar Year, per Covered Person. These tests must be performed to determine whether Cancer or Associated Cancerous Condition exists in a Covered Person and must be administered by licensed medical personnel. No lifetime maximum.

2. **BONE MARROW DONOR SCREENING:** Aflac will pay \$40 (forty dollars) when a Covered Person provides documentation of participation in a screening test as a potential bone marrow donor. This benefit is limited to one benefit per Covered Person per lifetime.

**C. ANNUAL CARE BENEFIT:** Aflac will pay \$500 (five hundred dollars) on the anniversary date of a Covered Person's Internal Cancer diagnosis upon proof that the Covered Person is still under the active care of a Physician. **This benefit is not payable for Associated Cancerous Conditions or Nonmelanoma Skin Cancers.** Lifetime maximum of five annual payments per Covered Person.

Exhibit B: Plans

**TERMINATION**

This rider will terminate if the policy to which it is attached terminates or if the premium for this rider is not paid.

Form A76051

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Form A76051

2

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# Optional Specified-Disease Benefit Rider

Summary Page - Policy Rider Series A76000

Riders become a part of the policy and are subject to all policy provisions unless otherwise stated.

## What We Will Pay

### Specified-Disease Initial Benefit

Aflac will pay \$1,000 while coverage is in force if a Covered Person is first diagnosed with any of the covered Specified Diseases after the Effective Date of the rider. This benefit is payable only once per covered disease, per Covered Person. No other benefits are payable for any covered Specified Disease not provided for in the rider.

### Hospital Confinement Benefits

Aflac will pay \$200 per day when a Covered Person is confined to a Hospital for 30 days or less for a covered Specified Disease. During any continuous period of Hospital confinement of 31 days or more for a covered Specified Disease, Aflac will pay \$500 per day, beginning on the 31st day of confinement.

### Definition of Covered Diseases

Specified Disease means one or more of the diseases listed below:

- Adrenal hypofunction (Addison's disease)
- Amyotrophic lateral sclerosis (ALS or Lou Gehrig's disease)
- Botulism
- Bubonic plague
- Cerebral palsy
- Cholera
- Cystic fibrosis
- Diphtheria
- Encephalitis (including encephalitis contracted from West Nile virus)
- Huntington's chorea
- Malaria
- Meningitis (bacterial)
- Multiple sclerosis
- Muscular dystrophy
- Myasthenia gravis
- Necrotizing fasciitis
- Osteomyelitis
- Polio
- Rabies
- Reye's syndrome
- Scleroderma
- Sickle cell anemia
- Systemic lupus
- Tetanus
- Toxic shock syndrome
- Tuberculosis
- Tularemia
- Typhoid fever
- Variant Creutzfeldt-Jakob disease (mad cow disease)
- Yellow fever

For benefits to be paid, these diseases must be first diagnosed by a Physician on or after the Effective Date of the rider. The diagnosis must be made by and upon a tissue specimen, culture, and/or titer.

## Terms You Need to Know

**Effective Date:** The Effective Date of the rider is the Effective Date listed on the Policy Schedule.

**Termination:** The rider will terminate if the policy to which it is attached terminates or if the premium for the rider is not paid.

The rider to which this sales material pertains is written only in English; the rider prevails if interpretation of this material varies.

**Refer to the policy and rider for complete details, definitions, limitations, and exclusions.**



Amusement and Recreation Insurance Company of America, Member of Aflac

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## Exhibit B: Plans

### FOR ILLUSTRATION ONLY

#### AMERICAN FAMILY LIFE ASSURANCE COMPANY OF COLUMBUS (AFLAC)

Worldwide Headquarters • Columbus, Georgia 31999

A Stock Company

This **SPECIFIED-DISEASE BENEFIT RIDER** is a part of the policy and is subject to all policy provisions unless modified herein.

#### **Part 1** **EFFECTIVE DATE**

The Effective Date of this rider is the Effective Date listed on the Policy Schedule.

#### **Part 2** **ELIGIBILITY FOR BENEFITS**

This rider is issued on the basis that the information shown on the application is correct and complete. If answers on your application for this rider are incorrect or incomplete, then this rider may be voided or claims may be denied. If voided, any premiums for this rider, less any claims paid, will be refunded to you.

#### **Part 3** **BENEFITS**

**SPECIFIED-DISEASE INITIAL BENEFIT:** While coverage is in force, if a Covered Person is first diagnosed, after the Effective Date of this rider, with any of the covered Specified Diseases, Aflac will pay a benefit of \$1,000. This benefit is payable only once per covered disease per Covered Person. **NO OTHER BENEFITS ARE PAYABLE FOR ANY COVERED SPECIFIED DISEASE NOT PROVIDED FOR IN THIS RIDER.**

#### **A. HOSPITAL CONFINEMENT BENEFITS:**

- 1. HOSPITALIZATION FOR 30 DAYS OR LESS:** When a Covered Person is confined to a Hospital for 30 days or less, for a covered Specified Disease, Aflac will pay \$200 (two hundred dollars) per day.
- 2. HOSPITALIZATION FOR 31 DAYS OR MORE:** During any continuous period of Hospital confinement of 31 days or more for a covered Specified Disease, Aflac will pay benefits as described in Section A1 above for the first 30 days, and beginning with the 31st day of such continuous Hospital confinement, Aflac will pay \$500 (five hundred dollars) per day.

#### **Part 4** **DEFINITION OF COVERED DISEASES**

"Specified Disease" as used under this benefit means one or more of the diseases listed below. These diseases must be first diagnosed by a Physician on or after the Effective Date of the rider for benefits to be paid. The diagnosis must be made by and upon a tissue specimen, culture(s) and/or titer(s).

## Exhibit B: Plans

- adrenal hypofunction (Addison's disease)
- amyotrophic lateral sclerosis (ALS or Lou Gehrig's disease)
- botulism
- bubonic plague
- cerebral palsy
- cholera
- cystic fibrosis
- diphtheria
- encephalitis (including encephalitis contracted from West Nile virus)
- Huntington's chorea
- malaria
- meningitis (bacterial)
- multiple sclerosis
- muscular dystrophy
- myasthenia gravis
- necrotizing fasciitis
- osteomyelitis
- polio
- rabies
- Reye's syndrome
- scleroderma
- sickle cell anemia
- systemic lupus
- tetanus
- toxic shock syndrome
- tuberculosis
- tularemia
- typhoid fever
- variant Creutzfeldt-Jakob disease (mad cow disease)
- yellow fever

### **Part 5** **TERMINATION**

This rider will terminate if the policy to which it is attached terminates or if the premium for this rider is not paid.

In witness whereof, Aflac's president and secretary signed this rider in Columbus, Georgia, as of the Effective Date shown in the Policy Schedule.



Paul S. Amos II, President



Joey M. Loudermilk, Secretary

OPTIONAL COVERAGE INCLUDING A HEALTH CARE PLAN WITH THE FOLLOWING

**FOR ILLUSTRATION ONLY  
Bi-Weekly Rates**

COVERAGE TYPE	AGES	\$75 WELLNESS BENEFIT
<b>Individual/One-Parent Family</b>	18-35	\$3.06
	36-45	\$3.72
	46-55	\$4.32
	56-70	\$4.74
<b>Insured/Spouse &amp; Two-Parent Family</b>	18-35	\$4.86
	36-45	\$5.70
	46-55	\$6.78
	56-70	\$7.62

**FOR ILLUSTRATION ONLY  
Bi-Weekly Rates**

COVERAGE TYPE	AGES	RATE
<b>Individual/One-Parent Family</b>	18-70	\$0.60
<b>Insured/Spouse &amp; Two-Parent Family</b>	18-70	\$0.90

Exhibit B: Plans

**FOR ILLUSTRATION ONLY**

**Payroll**

**Application for Limited Benefit Cancer Indemnity Insurance  
(A76000 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 \_\_\_\_\_ - \_\_\_\_\_ (optional)  
 Month/Day/Year

Are you applying for Dependent Child(ren) coverage?  Yes  No  
 If yes, Dependent Children must be under age 25 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

Address \_\_\_\_\_  
 Street or Post Office Box Apt. No.

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Home Telephone ( ) \_\_\_\_\_ E-Mail Address (optional) \_\_\_\_\_

Billing Name (if different from Proposed Insured/Employee): \_\_\_\_\_

Payroll Account Name \_\_\_\_\_ Payroll Account No. \_\_\_\_\_

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 associate/agent, if applicable.

Do you currently have an active Aflac Cancer Policy Form Series A76100?  Yes  No

If yes, then you may not use this application. **Please use Application Form Series A76004.**

**You may be eligible to apply for additional coverage.**

If no, do you currently have an active Aflac cancer policy that has been in force for 12 months or more?  Yes  No

**TO BE COMPLETED BY AFLAC ASSOCIATE/AGENT**

<b>Check Coverage Desired:</b>	<input type="checkbox"/> Individual	<input type="checkbox"/> Named Insured/Spouse Only	<input type="checkbox"/> One-Parent Family	<input type="checkbox"/> Two-Parent Family
<input type="checkbox"/> Policy (Series A76100)	<input type="checkbox"/> Policy (Series A761ES)			<input type="checkbox"/> Pre-Tax <input type="checkbox"/> After-Tax
<b>Optional Riders:</b>				
Initial Diagnosis Benefit Rider (Series A76050)				
Options: <input type="checkbox"/> No rider <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$7,500 <input type="checkbox"/> \$10,000				
Cancer Screening and Annual Care Benefit Rider (Series A76051)				
Options: <input type="checkbox"/> No rider <input type="checkbox"/> \$50 <input type="checkbox"/> \$75 <input type="checkbox"/> \$100 <input type="checkbox"/> \$125				
Specified-Disease Benefit Rider (Series A76052)				
Options: <input type="checkbox"/> No rider <input type="checkbox"/> New rider <input type="checkbox"/> Retain current rider				
<input type="checkbox"/> After-Tax Only				
Return of Premium Benefit Rider (Series A76053)				
Options: <input type="checkbox"/> No rider <input type="checkbox"/> New rider <input type="checkbox"/> Retain current rider (Factor amt. _____)				

Exhibit B: Plans

<b>Billing Method:</b>	<b>Mode:</b>	
<input type="checkbox"/> Payroll Deduction	<input type="checkbox"/> 01 Semimonthly	<input type="checkbox"/> 01 Monthly
<input type="checkbox"/> Bank Draft (B/D, ACH)	<input type="checkbox"/> 01 Weekly	<input type="checkbox"/> 03 Quarterly
	<input type="checkbox"/> 01 14-Day Biweekly	<input type="checkbox"/> 06 Semiannual
	<input type="checkbox"/> 01 28-Day Biweekly	<input type="checkbox"/> 12 Annual
Employee No. _____	Dept. No. _____	Assoc./Agent's No. _____
Billable Premium \$ _____	Premium Collected \$ _____	Sit. Code _____

**ASSOCIATED CANCEROUS CONDITION:** a myelodysplastic blood disorder, myeloproliferative blood disorder, or carcinoma in situ (in the natural or normal place, confined to the site of origin without having invaded neighboring tissue). An Associated Cancerous Condition is limited to only the conditions listed above.

**CANCER:** a disease manifested by the presence of a malignant tumor characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue. "Cancer" also includes, but is not limited to, leukemia, Hodgkin's disease, and melanoma.

**INTERNAL CANCER** means all Cancers other than Nonmelanoma Skin Cancer.

**PLEASE COMPLETE THE FOLLOWING QUESTIONS**

1. Have you or has anyone to be covered had Internal Cancer or an Associated Cancerous Condition that was diagnosed or last treated **within the last five years** or received preventive hormonal therapy within the last 12 months?  Yes  No

If yes, was it the  Named Insured  Spouse  Child? Name of the child(ren):

**Any person(s) so designated will not be covered under the policy. If the named person is the Proposed Insured/Employee, a policy will not be issued.**

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

2. Have you or has anyone to be covered had Internal Cancer or an Associated Cancerous Condition that was diagnosed or last treated **over five years ago**?  Yes  No

If yes, was it the  Named Insured  Spouse  Child? Name of the child(ren):

**If yes, please complete a Cancer History Form provided by your associate/agent on any individual(s) listed. You are eligible for a maximum of \$5,000 of the Initial Diagnosis Benefit Rider and you are eligible for a maximum of \$75 of the Cancer Screening and Annual Care Benefit Rider. No additional amounts will be issued.**

3. Have you or has anyone to be covered had Nonmelanoma Skin Cancer that was diagnosed or last treated within the last five years?  Yes  No

If yes, was it the  Named Insured  Spouse  Child? Name of the child(ren)

**Any person(s) so designated will be issued a Skin Cancer Exclusion Rider. Benefits will not be payable under this policy for the Indicated individual for the treatment of Skin Cancer.**

**If yes, and this is a conversion, the person(s) so designated is not eligible for coverage under the converted policy.**

Proposed Insured's/Employee's Initials \_\_\_\_\_

Exhibit B: Plans

**ANSWER THE FOLLOWING QUESTIONS ONLY IF YOU WISH TO PURCHASE MORE THAN \$5,000 OF THE INITIAL DIAGNOSIS BENEFIT RIDER OR MORE THAN \$75 OF THE CANCER SCREENING AND ANNUAL CARE BENEFIT RIDER.**

- 4. Have you or has anyone to be covered received abnormal test results from a Cancer or Associated Cancerous Condition screening within the past 90 days, or are you or anyone to be covered waiting on the results of medical tests for an undiagnosed condition?  Yes  No
- 5. Have you or has anyone to be covered used tobacco products or products containing nicotine of any type in the last 12 months?  Yes  No

**If the answer to either Question 2, 4, or 5 is yes, you are eligible for a maximum of \$5,000 of the Initial Diagnosis Benefit Rider and you are eligible for a maximum of \$75 of the Cancer Screening and Annual Care Benefit Rider. No additional amounts will be issued.**

**PLEASE READ NUMBER 6 IF THIS IS A CONVERSION AND YOU DID NOT SELECT ANY OF THE OPTIONAL RIDERS.**

- 6. I acknowledge that I was offered the Optional Riders and declined one or more of them.

**Proposed Insured's/Employee's Initials \_\_\_\_\_**

**PLEASE ANSWER THE FOLLOWING QUESTION IF APPLYING FOR THE SPECIFIED-DISEASE RIDER**

- 7. Have you or has anyone to be covered under this policy ever had adrenal hypofunction (Addison's disease), ALS (amyotrophic lateral sclerosis) or Lou Gehrig's disease, botulism, bubonic plague, cerebral palsy, cholera, cystic fibrosis, diphtheria, encephalitis (including encephalitis contracted from West Nile virus), Huntington's chorea, malaria, meningitis (bacterial), multiple sclerosis, muscular dystrophy, myasthenia gravis, necrotizing fasciitis, osteomyelitis, polio, rabies, Reye's syndrome, scleroderma, sickle-cell anemia, systemic lupus, tetanus, toxic shock syndrome, tuberculosis, tularemia, typhoid fever, variant Creutzfeldt-Jakob disease (mad cow disease), or yellow fever in any form?  Yes  No

If yes, was it the  Named Insured  Spouse  Child? Name of the child(ren): \_\_\_\_\_

**Any person(s) so designated above will not be covered under Specified-Disease Rider Form Series A76052.**

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

**APPLICANT'S STATEMENTS AND AGREEMENTS**

- 8. I understand that the Effective Date of this policy will be the date recorded on the Policy Schedule by Aflac. **It is not the date the application is signed.**
- 9. I acknowledge receipt of, if applicable:
  - Guide to Health Insurance for People with Medicare*
  - Replacement Notice
  - Outline of Coverage
- 10. I understand that: (a) the policy of insurance I am now applying for will be issued based upon the written answers to questions and information asked for in this application and any other pertinent information Aflac may require for proper underwriting; (b) the associate/agent cannot change the provisions of the policy or waive any of its provisions either orally or in writing; (c) the policy, together with this application, endorsements, benefit agreements, riders, and attached papers, if any, constitutes the entire contract of insurance; and (d) no change to the policy will be valid until approved by Aflac's secretary and president and noted in or attached to the policy.
- 11. If this is an application for a conversion, the following condition applies: (a) If Cancer or Associated Cancerous Condition is diagnosed between the date this application is signed and the Effective Date of the policy shown in the Policy Schedule, the policy for which this application is made will be void, and coverage will continue under the terms of the previous policy, which may remain in force. Any benefits that may be due will be paid under the previous 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.

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 by my associate/agent.

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

If I am applying to convert my current policy to another Aflac policy, I acknowledge that I have been advised that the policies have different benefits and that I should compare them to determine which is best for me. I understand and agree that I am giving up my current policy and its benefits for the benefits provided in the new 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 realize that any fraudulent material misrepresentation therein may result in loss of coverage under the policy.

Proposed Insured's/Employee's Signature \_\_\_\_\_ Date \_\_\_\_\_

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.**

For policies that pay fixed dollar amounts for specified diseases or other specified impairments. This includes cancer, specified disease, and other health insurance policies that pay a scheduled benefit or specific payment based on diagnosis of the conditions named in the policy.

**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 pays a fixed amount, regardless of your expenses, if you meet the policy conditions, for one of the specific diseases or health conditions named in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

**Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:**

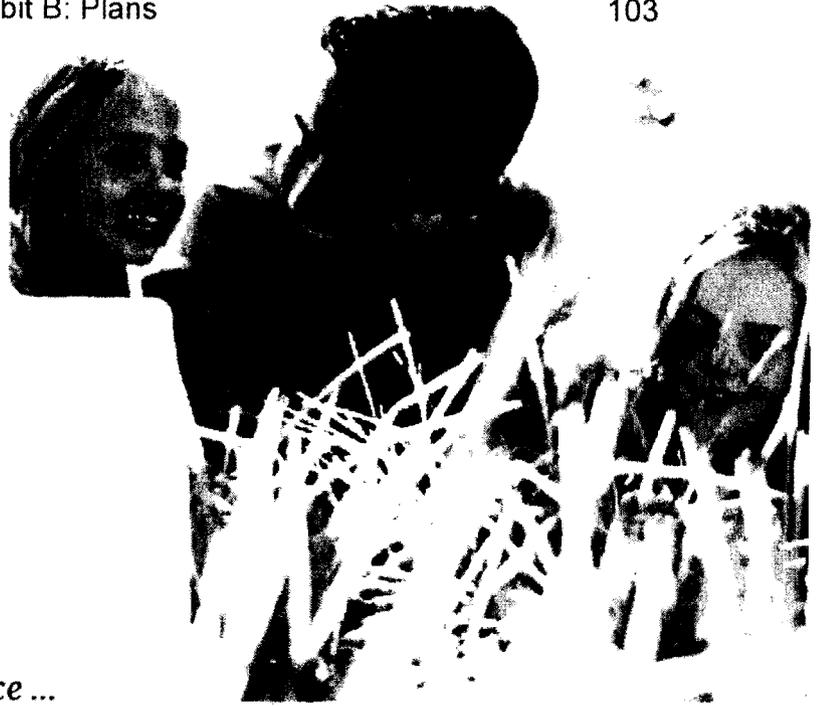
- \* hospitalization
- \* physician services
- \* hospice
- \* outpatient prescription drugs if you are enrolled in Medicare Part D
- \* other approved items and services

**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).

- 
- 
- 
1. Aflac is offering our individual hospital plan guarantee-issue during the County's next open enrollment. The following guidelines apply:
    - Guarantee-issue is valid for the current enrollment/plan year only, July 1, 2011, through June 30, 2012. Guarantee-issue simply means that medical underwriting has been waived. We will not ask about a person's health history to determine eligibility for coverage. However, the applicant must fall within the required age limits for a policy. Additionally, all policy provisions and definitions—such as waiting periods, pre-existing conditions language, and limitations and exclusions—still apply.
    - Existing employees will be eligible, for the guarantee-issue offer, during their initial open enrollment period only.
    - New employees will be eligible, for the guarantee-issue offer, during their new employee benefit enrollment period only.
  2. The hospital rates are guaranteed for five years. While the rates are guaranteed, we cannot guarantee the availability of this plan.
  3. We have expanded coverage for dependent children on new and existing policies to age 26 regardless of marital, IRS, or education status.

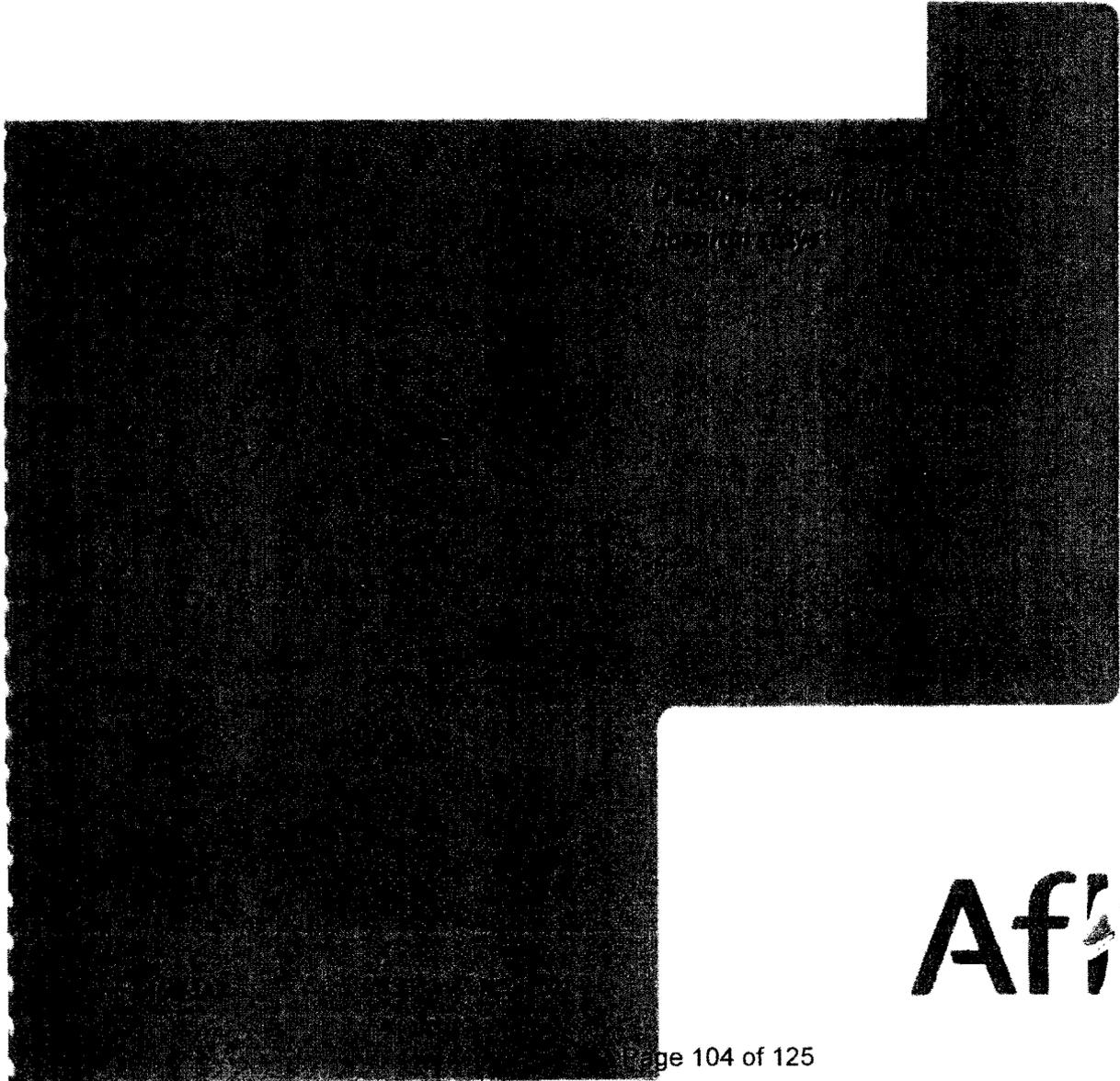


Plan 1

# Hospital Protection

*Hospital Confinement Indemnity Insurance ...*

*what you need, when you need it.*



**Aflac**™

**Annual Hospitalization Confinement Benefit**

Aflac will pay the amount listed below for the first five days of hospitalization when a covered person requires hospital confinement\* for a covered sickness or injury and a charge is incurred.

Benefits for the Annual Hospitalization Confinement Benefit are limited to a total benefit payment of five days per calendar year, per policy. Confinements not separated by 30 days or more, or hospitalization that begins prior to the end of one calendar year and continues into the next calendar year, will be considered one confinement.

**Daily Hospital Confinement Benefit**

Aflac will pay the amount listed below for the period of hospital confinement\* when a covered person requires hospital confinement for a covered sickness or injury. This benefit is payable in addition to the Annual Hospitalization Confinement Benefit. The maximum benefit period for any one period of hospital confinement is 365 days. No lifetime maximum.

\*Hospital confinement does not include emergency rooms. Treatment or confinement in a U.S. government hospital does not require a charge for benefits to be payable.

**Rehabilitation Unit Benefit**

Aflac will pay the amount listed below for each day you are charged when a covered person is confined in a hospital and is transferred to a bed in a rehabilitation unit of a hospital for a covered sickness or injury. This benefit is limited to 15 days for each covered person per period of hospital confinement and is limited to a calendar year maximum of 30 days per covered person. No lifetime maximum.

**Waiver of Premium Benefit**

Aflac will waive from month to month, for the named insured only, any premium(s) falling due during the named insured's continued hospital confinement. This benefit will begin after the named insured has received Daily Hospital Confinement Benefits from the policy for 30 consecutive days. When Daily Hospital Confinement Benefits are no longer being paid, premium payments must be resumed. Once premium payments are resumed, any new confinements must again satisfy the 30-day continued confinement for premiums to be waived. If you die and your spouse becomes the new named insured, premiums will start again at the appropriate rate and will be due on the first premium due date after the change. The new named insured will then be eligible for this benefit if the need arises.

**Guaranteed-Renewable**

The policy is guaranteed-renewable for your lifetime, subject to Aflac's right to change premiums by class upon any renewal date.

**Family Coverage**

Family coverage includes the insured; spouse; and dependent, unmarried children to age 19 (or 23 if they are full-time students). Newborn children are automatically insured from the moment of birth. One-parent family coverage includes the insured and dependent, unmarried children to age 19 (or 23 if they are full-time students). A dependent child must be under age 19 at the time of application to be eligible for coverage.

**Effective Date**

The effective date is the date shown in the Policy Schedule, not the date the application is signed. Payroll rates may be retained after one month's premium payment on payroll deduction.

**Limitations and Exclusions**

Any illness, disease, or disorder diagnosed by a physician or medically treated during the 12 months prior to the effective date of the policy will not be covered, unless the loss begins more than six months after the effective date of the policy.

The policy does not cover losses caused by or resulting from intentionally self-inflicting bodily injury or attempting suicide; participating in or attempting to participate in any illegal activity that is classified as a felony (the term felony is as defined by the law of the jurisdiction in which the activity takes place); being exposed to war or any act of war, declared or undeclared, or actively serving in any of the armed forces or units auxiliary thereto, including the National Guard or Reserve; having treatment for a mental or nervous disorder or disease; alcoholism or drug dependency; any loss sustained or contracted due to a covered person's being intoxicated or under the influence of alcohol, drugs, or any narcotic unless administered on the advice of a physician and taken according to the physician's instructions (the term intoxicated refers to that condition as defined by the law of the jurisdiction in which the injury or cause of the loss occurred); having cosmetic surgery that is not medically necessary; having elective surgery that is not medically necessary within the first 12 months of the effective date of the policy; pregnancy or childbirth within the first ten months of the effective date of the policy (complications of pregnancy, including nonelective cesarean, will be covered to the same extent as a sickness); routine nursing or well-baby care for a newborn child; being hospitalized before the effective date of coverage; or donating an organ within the first 12 months of the effective date of the policy.

If the period of hospital confinement follows a previously covered confinement, it will be deemed a continuation of the first confinement unless the later confinement is the result of an entirely unrelated sickness or injury.

A physician does not include a member of your immediate family

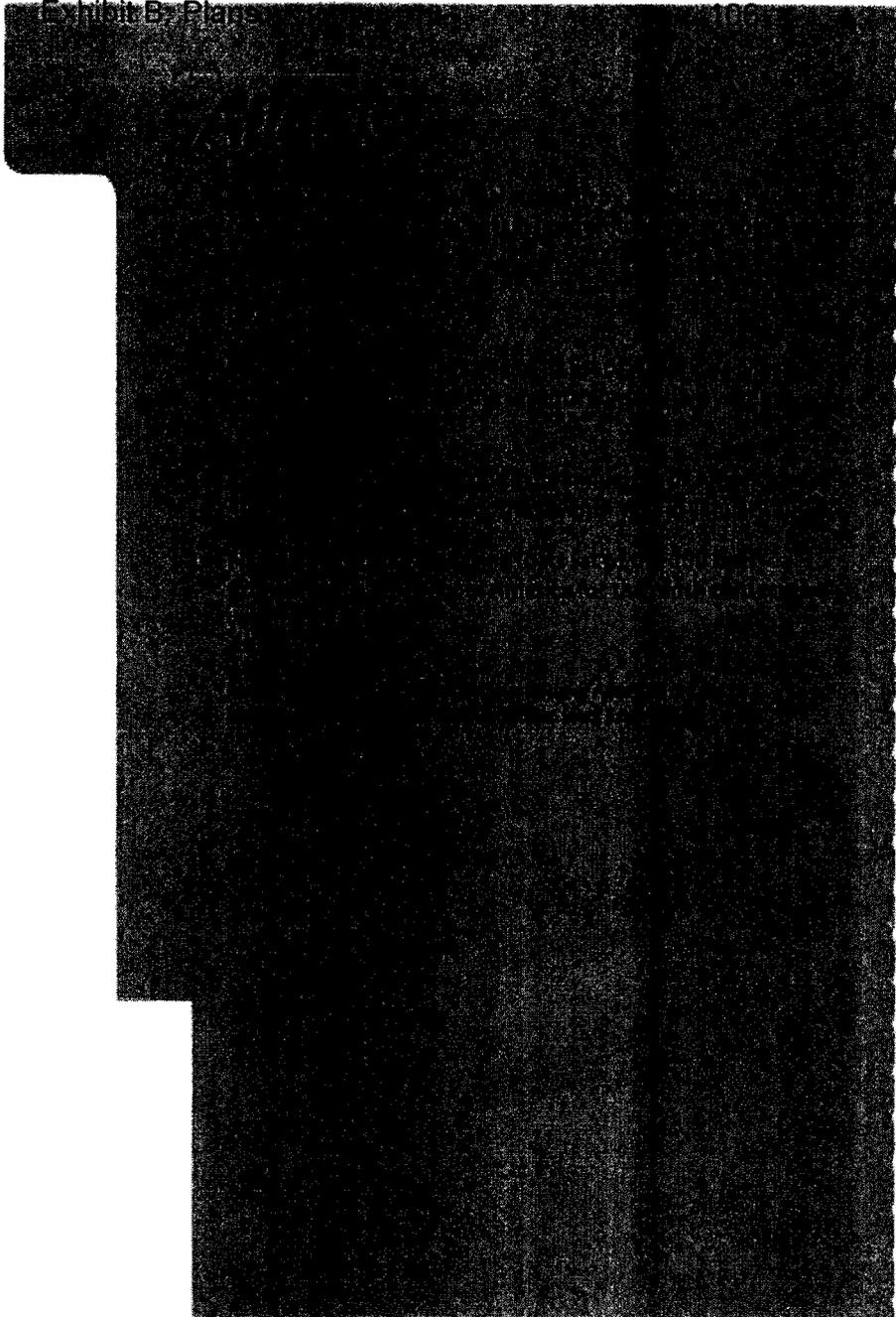
Hospital does not include any institution or part thereof used as an emergency room; a rehabilitation unit; a hospice unit, including any bed designated as a hospice or a swing bed; a convalescent home; a rest or nursing facility; a psychiatric unit; an extended-care facility; a skilled nursing facility; or a facility primarily affording custodial or educational care, care or treatment for persons suffering from mental disease or disorders, care for the aged, or care for persons addicted to drugs or alcohol. Benefits for confinement in a rehabilitation unit are payable under the Rehabilitation Unit Benefit.

Complications of pregnancy do not include premature delivery without incidence, false labor, occasional spotting, prescribed rest during pregnancy, morning sickness, and similar conditions associated with the management of a difficult pregnancy not constituting a classifiably distinct complication of pregnancy. Cesarean deliveries are not considered complications of pregnancy.

**Pre-Existing Conditions**

A pre-existing condition is an illness, disease, or disorder 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. Care or treatment caused by a pre-existing condition will not be covered unless it begins more than six months after the effective date of coverage. A sickness is an illness, disease, or disorder, independent of injury, diagnosed or treated after the effective date of coverage and while coverage is in force.

This is a brief summary of coverage. Refer to the policy for complete details, limitations, and exclusions.



1 800.99.AFLAC (1.800.992.3522)

En español:  
1.800.SI.AFLAC (1.800.742.3522)

Visit our Web site at [aflac.com](http://aflac.com).

## FOR ILLUSTRATION ONLY

PLAN ONE

## HOSPITAL CONFINEMENT INDEMNITY POLICY

**THIS IS A LIMITED POLICY. READ IT CAREFULLY.**

**THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY.** If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide furnished by Aflac.

The Named Insured as shown in the Policy Schedule will be referred to as "you," "your", or "yours." **American Family Life Assurance Company of Columbus (Aflac)**, a stock company, will be referred to as "we," "our," "us", or "Aflac."

**CONSIDERATION**

This policy is issued in consideration of statements made in your application and the payment of the premium shown in the Policy Schedule. A copy of your application is attached and is a part of this policy. The following paragraphs set forth the definition of terms, the limitations and exclusions, the insurance benefits, and other provisions.

**YOUR RIGHT TO EXAMINE THIS POLICY**

It is important to us that you are satisfied with this policy and that it meets your insurance goals. If you are not satisfied, you may return it within 30 days after you receive it. Send it to your associate (duly licensed agent) or to Aflac Worldwide Headquarters, 1932 Wynnton Road, Columbus, Georgia 31999. You will receive a full refund of all premiums paid, and your policy will be void from its Effective Date. If you return the policy, please note in writing: "This policy is returned for cancellation and refund of premium."

**IMPORTANT NOTICE**

**Please read your application attached to this policy. This policy is issued on the basis that the information shown on the application is correct and complete. I realize that statements made in the application are deemed representations and not warranties. Carefully check the application. Write to us within 30 days of the date you receive this policy if any information shown on it is not correct or complete. Incorrect information may result in the denial of a claim or termination of the policy. No associate (duly licensed agent) may change this policy or waive any of its provisions.**

**THIS POLICY IS GUARANTEED-RENEWABLE FOR YOUR LIFETIME, SUBJECT TO AFLAC'S RIGHT TO CHANGE PREMIUMS BY CLASS UPON ANY RENEWAL DATE.**

We agree that this policy will never be restricted by the addition of any rider without your consent, nor will continuation of coverage be refused because of any change in any covered person's health or physical condition. You are guaranteed the right to continue this policy in force for your lifetime by the timely payment of premiums at the rate in effect at the beginning of each term.

Aflac may change the established premium rate, but only if the rate is changed for all policies of this class. While this policy is in force, no change will be made in your class because of the age, sex, or physical condition of any covered person. "Class" means all policies of this form number and premium classification in your state that are then in force. If the established premium rate changes, Aflac will notify you in writing at your last known address at least 30 days before the change becomes effective.

**PRE-EXISTING CONDITIONS**

A "Pre-existing Condition" is an illness, disease, or disorder 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. Care or treatment caused by a Pre-existing Condition will not be covered unless it begins more than six months after the Effective Date of coverage.

**American Family Life Assurance Company of Columbus (Aflac)  
Worldwide Headquarters: 1932 Wynnton Road, Columbus, Georgia 31999  
For assistance or information about this policy, call 1-800-99-AFLAC (1-800-992-3522).  
For claim forms, visit our Web site at aflac.com.**

PLAN ONE

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Limitations and Exclusions.....Part 2

Right of Conversion .....Part 3

Uniform Provisions.....Part 4

Benefits.....Part 5

Policy Schedule
-----------------

**NAMED INSURED:** John A. Doe

**POLICY NUMBER:** 111-2222

**TYPE OF COVERAGE:** Individual

**COVERAGE:** XXXXXX  
AAABBB

**MODE OF PAYMENT:** Monthly

**PREMIUMS:**

Policy:	\$XX.xx
Rider:	\$XX.xx

**EFFECTIVE DATES:**

Policy:	XX/XX/XX
Rider:	XX/XX/XX

In witness whereof, Aflac's president and secretary signed this policy in Columbus, Georgia, as of the Effective Date shown in the Policy Schedule.

Joey M. Loudermilk, Secretary

Daniel P. Amos, President

PLAN ONE

This is a legal contract between you and Aflac.  
**READ YOUR POLICY CAREFULLY.**

**Part 1**  
**DEFINITIONS**

- A. AMBULATORY SURGICAL CENTER:** a facility, licensed as such, that provides surgical services on an outpatient basis. This does not include a doctor's or dentist's office or clinic or other such location.
- B. CALENDAR YEAR:** January 1st through December 31st of the same year.
- C. COMPLICATIONS OF PREGNANCY:** (a) conditions requiring medical treatment prior to or subsequent to the termination of a pregnancy whose diagnoses are distinct from pregnancy but that are adversely affected by pregnancy or caused by pregnancy, such as acute nephritis; nephrosis; cardiac decompensation; missed abortion; disease of the vascular, hemopoietic, nervous, or endocrine systems; and similar medical and surgical conditions of comparable severity; (b) hyperemesis gravidarum and pre-eclampsia requiring Hospital Confinement, ectopic pregnancy that is terminated, and spontaneous termination of pregnancy that occurs during a period of gestation in which a viable birth is not possible.

Complications of Pregnancy do not include premature delivery without incidence, false labor, occasional spotting, prescribed rest during pregnancy, morning sickness and similar conditions associated with the management of a difficult pregnancy not constituting a classifiably distinct complication of pregnancy. Cesarean deliveries are not considered Complications of Pregnancy.

- D. DEPENDENT CHILDREN:** your natural children, stepchildren, or legally adopted children who are unmarried, who are under age 19, and who are your dependent. **A Dependent Child must be under age 19 at the time of application to be eligible for coverage.** Coverage of a Dependent Child will be extended to the anniversary date of this policy following the child's 19<sup>th</sup> birthday or 23<sup>rd</sup> birthday if he or she is enrolled as a full-time student in a postsecondary institution of higher learning for five calendar months in that Calendar Year or if not enrolled, would have been eligible to enroll and was prevented from enrolling due to Sickness or Injury. Coverage provided under any One-Parent or Two-Parent Family contract will include any other unmarried Dependent Child, regardless of age, who is incapable of self-sustaining employment by reason of mental retardation or physical handicap and who became so incapacitated prior to age 19 (23 if a full-time student) and while covered hereunder. You must furnish proof of such incapacity and dependency to Aflac within 31 days of the Dependent Child's 19<sup>th</sup> birthday (23<sup>rd</sup> if a full-time student). You must furnish proof of continued incapacity and dependency at Aflac's request, but not more often than annually, after the two-year period following the child's 19<sup>th</sup> birthday (23<sup>rd</sup> if a full-time student).
- E. EFFECTIVE DATE:** the date(s) shown in the Policy Schedule. The Effective Date of this policy is **not** the date you signed the application for coverage.

## PLAN ONE

- F. HOSPITAL:** a legally operated institution licensed by the state in which it is located that maintains and uses a laboratory, X-ray equipment, and an operating room on its premises or in facilities available to it on a prearranged, written, contractual basis. The institution must also have permanent and full-time facilities for the care of overnight-resident bed patients under the supervision of one or more licensed Physicians, provide 24-hour-a-day nursing service by or under the supervision of a registered professional nurse, and maintain the patients' written histories and medical records on the premises. The term "Hospital" also includes Ambulatory Surgical Centers. The term "Hospital" does not include any institution or part thereof used as an emergency room; a Rehabilitation Unit; a hospice unit, including any bed designated as a hospice or a swing bed; a convalescent home; a rest or nursing facility; a psychiatric unit; an extended-care facility; a skilled nursing facility; or a facility primarily affording custodial or educational care, care or treatment for persons suffering from mental disease or disorders, care for the aged, or care for persons addicted to drugs or alcohol. **Benefits for confinement in a Rehabilitation Unit are payable under the Rehabilitation Unit Benefit C in Part 5.**
- G. HOSPITAL CONFINEMENT:** confined and charged as an inpatient, or assigned to a bed for 23 hours or more as an outpatient, in a Hospital for which a charge is made. The assignment must be on the advice of a Physician. The confinement must be Medically Necessary and as a result of Sickness or Injury. Treatment or confinement in a U.S. government Hospital does not require a charge for benefits to be payable.
- H. IMMEDIATE FAMILY:** anyone related to you in the following manner: spouse; brother or sister (includes stepbrother and stepsister); children (includes stepchildren); parent(s) (includes stepparents); grandchildren; father- or mother-in-law; and spouses, as applicable, of any of these.
- I. INJURY:** a bodily injury caused directly by an accident, independent of Sickness, bodily infirmity, or any other cause, occurring on or after the Effective Date of coverage and while coverage is in force. See the Limitations and Exclusions section for Injuries not covered by this policy.
- J. MEDICALLY NECESSARY:** treatment, services, or supplies necessary and appropriate for the diagnosis or treatment of Sickness or Injury based upon generally accepted medical practice.
- K. PERIOD OF HOSPITAL CONFINEMENT:** the time period of Hospital Confinement that starts while this policy is in force. If confinement follows a previously covered confinement, it will be deemed a continuation of the first confinement unless the later confinement is the result of an entirely unrelated Sickness or Injury. Hospitalization that begins prior to the end of one Calendar Year and continues into the next Calendar Year will be considered one confinement.
- L. PHYSICIAN:** a person legally qualified to practice medicine, other than a member of your Immediate Family, who is licensed by the state to treat the type of condition for which a claim is made.

## PLAN ONE

- M. REHABILITATION UNIT:** a unit of a Hospital providing coordinated multidisciplinary physical restorative services to inpatients under the direction of a Physician knowledgeable and experienced in rehabilitative medicine. Beds must be set up and staffed in a unit specifically designated for this service.
- N. SICKNESS:** an illness, disease, or disorder, independent of Injury, diagnosed or treated after the Effective Date of coverage and while coverage is in force.
- O. TYPE OF COVERAGE:** Individual, Named Insured/Spouse Only, One-Parent Family, or Two-Parent Family. (See your Policy Schedule to determine the Type of Coverage in force.)
1. **Individual:** coverage for only the Named Insured listed in the Policy Schedule.
  2. **Named Insured/Spouse Only:** coverage for you and your spouse. Your spouse is defined as the person to whom you are legally married and who is listed on your application.
  3. **One-Parent Family:** coverage for the Named Insured and all of your Dependent Children.
  4. **Two-Parent Family:** coverage for the Named Insured, your spouse, and all of your Dependent Children (or those of your spouse).

Newborn children are automatically covered under the terms of the policy from the moment of birth. Adopted children are covered from the date of adoption or date of placement for adoption, whichever is earliest. Children born to your Dependent Children or children born to Dependent Children of your spouse are not covered under this policy. If Individual or Named Insured/Spouse Only coverage is in force and you desire uninterrupted coverage for a newborn or adopted child, you must notify Aflac within 31 days of the child's birth or the date of adoption or date of placement for adoption, whichever is earliest. Upon notification, Aflac will convert this policy to One-Parent Family or Two-Parent Family coverage and advise you of the additional premium due. If One-Parent Family or Two-Parent Family coverage is in force, it is not necessary for you to notify Aflac of the birth of your child or the date of adoption or date of placement for adoption, and an additional premium payment will not be required. **Newborn children will not be covered for routine nursing or well-baby care. We will pay policy benefits for their Sickness or Injury, including congenital anomaly.** Any other person(s) who wishes to become insured after the Effective Date of the policy must be added by endorsement. The added person(s) will be subject to a Pre-existing Conditions provision, which will begin on the Effective Date of the endorsement. If Two-Parent Family coverage is already in force, an additional premium will not be required. Insurance for persons added by endorsement becomes effective on the date specified on the endorsement.

The insurance on any Dependent Child will terminate on the anniversary date of this policy following the child's 19<sup>th</sup> birthday (23<sup>rd</sup> if a full-time student) or at the child's marriage, whichever occurs first. Termination will be without prejudice to any claim originating prior thereto. Aflac's acceptance of premium after such date will be considered as premium for only the remaining persons who qualify for coverage under this policy. When coverage on all Dependent Children terminates, you must notify us, in writing, and elect whether to

## PLAN ONE

continue the policy on an Individual or Named Insured/Spouse Only basis. Coverage provided under any One-Parent or Two-Parent Family contract will include any other unmarried Dependent Child, regardless of age, who is incapable of self-sustaining employment by reason of mental retardation or physical handicap and who became so incapacitated prior to age 19 (23 if a full-time student) and while covered hereunder. You must furnish proof of such incapacity and dependency to Aflac within 31 days of the Dependent Child's 19<sup>th</sup> birthday (23<sup>rd</sup> if a full-time student). You must furnish proof of continued incapacity and dependency at Aflac's request, but not more often than annually, after the two-year period following the child's 19<sup>th</sup> birthday (23<sup>rd</sup> if a full-time student).

**Part 2****LIMITATIONS AND EXCLUSIONS**

- A.** Any illness, disease, or disorder diagnosed by a Physician or medically treated during the 12 months prior to the Effective Date of this policy will not be covered, unless the loss begins more than six months after the Effective Date of this policy.
- B. This policy does not cover losses caused by or resulting from:**
1. Intentionally self-inflicting bodily injury or attempting suicide.
  2. Participating in or attempting to participate in any illegal activity that is classified as a felony (the term "felony" is as defined by the law of the jurisdiction in which the activity takes place).
  3. Being exposed to war or any act of war, declared or undeclared, or actively serving in any of the armed forces or units auxiliary thereto, including the National Guard or Reserve.
  4. Having treatment for a mental or nervous disorder or disease; alcoholism or drug dependency; any loss sustained or contracted due to a covered person's being intoxicated or under the influence of alcohol, drugs, or any narcotic unless administered on the advice of a Physician and taken according to the Physician's instructions (the term "intoxicated" refers to that condition as defined by the law of the jurisdiction in which the Injury or cause of the loss occurred).
  5. Having cosmetic surgery that is not Medically Necessary.
  6. Having elective surgery that is not Medically Necessary within the first 12 months of the Effective Date of this policy.
  7. Pregnancy or childbirth within the first ten months of the Effective Date of this policy. Complications of Pregnancy, including nonelective cesarean, will be covered to the same extent as a Sickness.
  8. Routine nursing or well-baby care for a newborn child.
  9. Being hospitalized before the Effective Date of coverage.
  10. Donating an organ within the first 12 months of the Effective Date of this policy.

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**Part 3**  
**RIGHT OF CONVERSION**

- A. DISSOLUTION OF MARRIAGE:** If you and your spouse dissolve your marriage by a valid decree of dissolution of marriage and your spouse was covered under a Named Insured/Spouse Only policy or a Two-Parent Family policy, coverage on the ex-spouse will terminate. Your ex-spouse may then apply for and receive, without evidence of insurability, a policy providing coverage not greater than the terminated coverage. To obtain a policy, your ex-spouse must apply to Aflac within 60 days following the entry of the decree of dissolution of marriage and pay the appropriate premium for the policy. No waiting period is required except to the extent that such period has not been satisfied by that person under this policy. If such dissolution of marriage occurs, the Named Insured under this policy at the time of the dissolution will retain that status. Any covered dependents may be covered under either policy, but not both. If neither you nor your ex-spouse wish to continue the coverage but wish to have coverage for the dependent children, your dependent children are eligible for a conversion policy.
- B. DEATH:** In the event of your death, your spouse, if alive and covered under this policy, will become the Named Insured. All benefits accrued prior to your death will be paid to your estate. No waiting period is required except to the extent that such period has not been satisfied by that person under this policy.
- C. TERMINATION OF DEPENDENCY:** A covered person whose dependency has terminated and who desires to continue coverage as a Named Insured under a separate policy may do so by notifying Aflac of the request in writing. The dependent will have the right to apply for an equivalent policy without evidence of insurability and without interruption in coverage, provided Aflac receives written notification of the request prior to 31 days after the anniversary date of this policy following the date he or she is no longer considered a dependent. No waiting period is required except to the extent that such period has not been satisfied by that person under this policy.

**Part 4**  
**UNIFORM PROVISIONS**

- A. ENTIRE CONTRACT; CHANGES:** This policy, together with the application, endorsements, benefit agreements, riders, and attached papers, if any, constitutes the entire contract of insurance. No change in this policy is valid until approved in writing by the secretary and president of Aflac at our worldwide headquarters. Any such change must be noted on or attached hereto. No associate (duly licensed agent) has the authority to change this policy or to waive any of its provisions.
- B. TIME LIMIT ON CERTAIN DEFENSES:** (1) After two years from the Effective Date of this policy, any misstatements, except fraudulent misstatements, made by you in the application shall not be used to void this policy or to deny a claim for care commencing after the expiration of such two-year period. (2) No claim for loss commencing after six months from the Effective Date of this policy will be reduced or denied on the grounds that a disease or physical condition, not excluded from coverage by name or specific description, had existed prior to such Effective Date.

## PLAN ONE

- C. TERM:** The term of this policy begins at midnight, standard time, at the place where you reside on the Effective Date shown in the Policy Schedule. It ends at midnight, at the same standard time, on the first premium due date. Each succeeding term ends at midnight, at the same standard time, on the next following premium due date. Premium due dates are determined by the mode of payment. The mode of payment for the original term of this policy is shown in the Policy Schedule. An annual premium will maintain this policy in force for 12 months, semiannual for six months, quarterly for three months, and monthly for one month. Premium for a term is due on the first day of that term. **If you fail to pay your premium by the end of the grace period, coverage under this policy will terminate.**
- D. GRACE PERIOD:** A grace period of 31 days will be granted for the payment of each premium falling due after the first premium. During the grace period, this policy shall continue in force.
- E. REINSTATEMENT:** You may request reinstatement of your policy from our associate (duly licensed agent) or Aflac. If your policy has lapsed for nonpayment of premium and we accept a later payment without requiring an application, your policy will be reinstated. If we require a written application and provide you with a conditional receipt, your policy shall be reinstated upon our approval of the application. If we do not notify you of our disapproval in writing within 45 days of the date of your application, your policy shall be deemed reinstated. The reinstated policy shall cover loss resulting from Injury that takes place after the date of reinstatement and loss resulting from Sickness that is diagnosed or treated more than 10 days after the date of reinstatement. In all other respects you and Aflac shall have the same rights as provided under the policy immediately before the due date of the defaulted premium, subject to any provisions added in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period prior to the date of reinstatement.
- F. NOTICE OF CLAIM:** Written notice of claim must be given within 60 days after a covered loss starts or as soon as reasonably possible. The notice can be given to Aflac at our worldwide headquarters or to our associate (duly licensed agent). Notice of claim should include the name of the covered person and the policy number.
- G. CLAIM FORMS:** When we receive a notice of claim, we will send you forms for filing proof of loss. If the forms are not given to you within ten working days, you will meet the proof-of-loss requirements by giving us a written statement of the nature and extent of the loss within the time limit stated in the Proof of Loss provision.
- H. PROOF OF LOSS:** Written proof of loss must be furnished to Aflac at our worldwide headquarters within 90 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate or reduce any claim if it was not reasonably possible to give proof within such time. However, such proof must be furnished as soon as reasonably possible and in no event (except in the absence of legal capacity) later than 15 months from the time proof is otherwise required.
- I. TIME OF PAYMENT OF CLAIMS:** All benefits payable under this policy will be paid immediately upon receipt of due written proof of loss.

## PLAN ONE

- J. PAYMENT OF CLAIMS:** All benefits will be payable to you unless assigned by you or by operation of law. Any accrued benefits unpaid at your death will be paid to your estate.
- K. LEGAL ACTIONS:** No legal action may be brought to recover on this policy within 60 days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action may be brought after six years from the time written proof of loss is required to be furnished.
- L. CONFORMITY WITH STATE AND FEDERAL STATUTES:** Any provision of this policy that, on its Effective Date, is in conflict with the statutes of the state in which it was issued or with any federal statute is hereby amended to conform to the minimum requirements of such statutes.
- M. OTHER INSURANCE WITH AFLAC:** If any person is covered under more than one hospital confinement indemnity policy or rider with us, only the one Aflac policy chosen by you, your beneficiary or estate, as the case may be, will be effective. We will pay benefits under the policies for claims that may have been incurred since their respective Effective Dates. We will also return all premiums paid for the canceled policies from the date of duplication, less any benefits paid under these policies from such date.

**Part 5**  
**BENEFITS**

We will pay the following benefits, as applicable, while coverage is in force. Hospital Confinement does not include emergency rooms. Treatment or confinement in a U.S. government Hospital does not require a charge for benefits to be payable.

- A. ANNUAL HOSPITALIZATION CONFINEMENT BENEFIT:** Aflac will pay the amount listed below for the first five days of hospitalization when a covered person requires Hospital Confinement for a covered Sickness or Injury and a charge is incurred.

Sickness	\$400 per day
Injury	\$500 per day

**IMPORTANT: Benefits for the Annual Hospitalization Confinement Benefit are limited to a total benefit payment of five days per Calendar Year, per policy.** Confinements not separated by 30 days or more, or hospitalization that begins prior to the end of one Calendar Year and continues into the next Calendar Year will be considered one confinement.

- B. DAILY HOSPITAL CONFINEMENT BENEFIT:** Aflac will pay \$100 (one hundred dollars) per day for the Period of Hospital Confinement when a covered person requires Hospital Confinement for a covered Sickness or Injury. This benefit is payable in addition to the Annual Hospitalization Confinement Benefit. The maximum benefit period for any one Period of Hospital Confinement is 365 days. No lifetime maximum.

## PLAN ONE

- C. REHABILITATION UNIT BENEFIT:** Aflac will pay \$100 (one hundred dollars) per day for each day you are charged when a covered person is confined in a Hospital and is transferred to a bed in a Rehabilitation Unit of a Hospital for a covered Sickness or Injury. This benefit is limited to 15 days for each covered person per Period of Hospital Confinement and is limited to a Calendar Year maximum of 30 days, per covered person. No lifetime maximum.
- D. WAIVER OF PREMIUM BENEFIT:** Aflac will waive from month to month, for the Named Insured only, any premium(s) falling due during the Named Insured's continued Hospital Confinement. This benefit will begin after the Named Insured has received Daily Hospital Confinement Benefits for 30 consecutive days from this policy. When Daily Hospital Confinement Benefits are no longer being paid, premium payments must be resumed. Once premium payments are resumed, any new confinements must again satisfy the 30-day continued confinement for premiums to be waived.

If you die and your spouse becomes the new Named Insured, premiums will start again at the appropriate rate and will be due on the first premium due date after the change. The new Named Insured will then be eligible for this benefit if the need arises.

**FOR ILLUSTRATION ONLY**

**Payroll**

**HOSPITAL CONFINEMENT INDEMNITY INSURANCE POLICY  
(A46000 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 Name \_\_\_\_\_ Last First MI DOB \_\_\_\_\_ Sex \_\_\_\_\_  
Month/Day/Year

SSN \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Are you applying for dependent child(ren) coverage?  Yes  No  
If yes, dependent children must be under age 19 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 \_\_\_\_\_ Last First MI DOB \_\_\_\_\_ Sex \_\_\_\_\_  
Month/Day/Year

Address \_\_\_\_\_ Street or Post Office Box Apt. No. \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Home Telephone ( ) \_\_\_\_\_

Employee's Name \_\_\_\_\_ Relationship \_\_\_\_\_  
(If Other Than Proposed Insured)

Payroll Account Name \_\_\_\_\_ Payroll Account No. \_\_\_\_\_ (Optional)

Do you have any other hospital indemnity coverage other than a hospital confinement sickness indemnity policy with Aflac?  Yes  No  
If yes, this must be a conversion of that coverage. Provide current policy number and see Item 17.  
Policy Number \_\_\_\_\_

Is this insurance intended to replace any other hospital indemnity 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**

<b>Check Coverage Desired:</b>	<input type="checkbox"/> Individual	<input type="checkbox"/> Named Insured/Spouse Only	<input type="checkbox"/> One-Parent Family	<input type="checkbox"/> Two-Parent Family
<input type="checkbox"/> Plan 1: (Policy Series A46100)	<b>Optional Rider</b>		<input type="checkbox"/> Pre-Tax or	
<input type="checkbox"/> Plan 2: (Policy Series A46200)	<input type="checkbox"/> Initial Hospitalization Benefit Rider (Rider Series A46050)			
<input type="checkbox"/> Plan 3: (Policy Series A46300)	\$250 per unit:	UNITS: _____	<input type="checkbox"/> After-Tax	

<b>Billing Method:</b> <input checked="" type="checkbox"/> Payroll Deduction	<b>Mode:</b> <input type="checkbox"/> 01 Weekly <input type="checkbox"/> 01 14-Day Biweekly <input type="checkbox"/> 01 28-Day Biweekly	<input type="checkbox"/> 01 Semimonthly <input type="checkbox"/> 01 Monthly <input type="checkbox"/> 03 Quarterly	<input type="checkbox"/> 06 Semiannual <input type="checkbox"/> 12 Annual
Employee ID No. _____	Dept. No. _____	Assoc./Agent's No. _____	
Billable Premium \$ _____	Premium Collected \$ _____	Sit. Code _____	

**ALL OF THE FOLLOWING MUST BE COMPLETED:**

1. Is anyone to be covered the mother or father of a child currently conceived but as yet unborn?  
**If yes, this policy will not be issued.**  Yes  No
  
2. 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
  
3. 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
  
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)?  Yes  No
  
5. 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
  
6. 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
  
7. 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
  
8. Has anyone to be covered been confined in a Hospital within the last 12 months for treatment of asthma?  Yes  No

9. **If any one of Questions 2 through 8 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.**

10. Has anyone to be covered ever tested positive for human immunodeficiency virus (HIV)?  Yes  No  
 If yes, has the result been substantiated by one ELISA test and one Western Blot Blood Test?  Yes  No  
 Please complete Supplemental Questionnaire A-14394-AZ and if applicable, Consent Notice A-14393AZR.
11. List all hospital indemnity policies you currently have in force, other than Aflac hospital indemnity policies, and provide the daily benefit amount. \_\_\_\_\_

**APPLICANT'S STATEMENTS AND AGREEMENTS:**

12. I understand that the Effective Date of the policy will be the date recorded in the Policy Schedule by Aflac Worldwide Headquarters.
13. 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.
14. I understand that dependent children, if any, must be under age 19 at the time of application. Once covered, coverage will be extended until the anniversary date of the policy following their 19<sup>th</sup> birthday (23<sup>rd</sup> if a full-time student).
15. I acknowledge receipt of, if applicable:  
 Replacement Notice  Outline of Coverage  Guide to Health Insurance for People with Medicare
16. 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.
17. If this is an application for a conversion of coverage, the following conditions will apply: (a) If any one of Questions 2 through 8 are answered yes, the policy for which this application is made for the person(s) identified in Item 9 will be void, and coverage will continue under the terms of the previous policy, which may remain in force. Benefits that may be due any person(s) listed in Item 9 will be paid under the previous policy. (b) Any person(s) not listed in Item 9, if eligible, will be covered under the new policy. (c) The Time Limit on Certain Defenses provision will run from the Effective Date of the original policy, and the original policy will be terminated as of the Effective Date of the new policy. (d) The Pre-existing Conditions provision in the new policy will run from the original policy's Effective Date for the benefits provided under the original policy. For the increased benefit amount, the Pre-existing Conditions provision in the new policy will run from the new policy's Effective Date.

**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.

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 by my associate/agent.

**I understand that the purchase of this policy is intended to supplement my existing comprehensive health care coverage. It is not intended to replace or be issued in lieu of that coverage.**

If I am applying to replace existing Aflac hospital indemnity 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. 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 fraudulent material misrepresentation therein may result in loss of coverage under the policy.

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**

For indemnity policies and other policies that pay a fixed dollar amount per day, excluding long-term care policies.

**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 pays a fixed dollar amount, regardless of your expenses, for each day you meet the policy conditions. 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).

**EXHIBIT C: VOLUNTARY EMPLOYEE BENEFITS PREMIUM SCHEDULE (3 Pages)**

**COST:**

Rates are firm, fixed, fully-loaded, and include all direct, indirect costs, overhead and profit margin, as well as subcontractors' costs if appropriate, and all costs required to provide all services for the items as defined by Exhibit A: Scope of Services. The contractor shall not add nor delete any item description.

**PLAN A: SHORT TERM DISABILITY**

**Option 1: 3 month Benefit Duration – 0/7 Elimination Period**

Item #	Age Bands	Rate per \$100 of monthly benefit/ Minimum Monthly benefit is \$500, subject to income requirements
1	18-49	\$6.90
2	50-64	\$7.20

**Option 2: 6 month Benefit Duration – 0/7 Elimination Period**

Item #	Age Bands	Rate per \$100 of monthly benefit/ Minimum Monthly benefit is \$500, subject to income requirements
1	18-49	\$8.70
2	50-64	\$9.30

**Option 3: 12 month Benefit Duration- 0/7 Elimination Period (Class Specific)**

Item #	Age Bands	Rate per \$100 of monthly benefit/ Minimum Monthly benefit is \$500, subject to income requirements
1	18-49	\$11.10
2	50-64	\$12.90

**Option 4: 3 month Benefit Duration - 0/14 Elimination Period**

Item #	Age Bands	Rate per \$100 of monthly benefit/ Minimum Monthly benefit is \$500, subject to income requirements
1	18-49	\$4.80
2	50-64	\$5.10

**Option 5: 6 month Benefit Duration - 0/14 Elimination Period**

Item #	Age Bands	Rate per \$100 of monthly benefit/ Minimum Monthly benefit is \$500, subject to income requirements
1	18-49	\$5.70
2	50-64	\$6.60

**Option 6: 12 month Benefit Duration-- 0/14 Elimination Period (Class Specific)**

Item #	Age Bands	Rate per \$100 of monthly benefit/ Minimum Monthly benefit is \$500, subject to income requirements
1	18-49	\$8.40
2	50-64	\$9.90

**Option 7: 6 month Benefit Duration-- 14/14 Elimination Period (Class Specific)**

Item #	Age Bands	Rate per \$100 of monthly benefit/ Minimum Monthly benefit is \$500, subject to income requirements
1	18-49	\$4.80
2	50-64	\$5.70

1. Are discounts available for multiple lines of insurance? No ----
2. Do you have a minimum participation requirement? No.
3. Are rates guaranteed? Yes For how long? Five years; however, the plan availability is not guaranteed.
4. Guarantee Issue is \$2,000 maximum benefit amount ( applicants must qualify by income). Elimination period is 14/14 (accident/sickness) and the benefit period is six months.

**EXHIBIT C: VOLUNTARY EMPLOYEE BENEFITS PREMIUM SCHEDULE (3 Pages)**

**PLAN B: ACCIDENT INDEMNITY**

Item #	Description: Plan B – Accident Protection	Bi-Weekly Premium
1	<i>Employee Only</i>	\$9.96
2	<i>Employee + Spouse</i>	\$14.10
3	<i>Employee + Child(ren)</i>	\$16.14
4	<i>Employee + Family</i>	\$21.00

1. Are discounts available for multiple lines of insurance? No
2. Do you have a minimum participation requirement? No.
3. Are rates guaranteed? Yes For how long? Five years; however, the plan availability is not guaranteed.
4. Guaranteed Issue is available. No underwriting is required for the base plan.

**PLAN C: CANCER CARE**

Item #	Description: Plan C – Cancer Care	Bi-Weekly Premium
1	<i>Employee Only</i>	Ages 18-35 - \$ 7.44 Ages 36-45 - \$10.80 Ages 46-55 - \$15.24 Ages 56-70 - \$20.10
2	<i>Employee + Spouse</i>	Ages 18-35 - \$13.80 Ages 36-45 - \$19.44 Ages 46-55 - \$28.50 Ages 56-70 - \$39.54
3	<i>Employee + Child(ren)</i>	Ages 18-35 - \$ 7.44 Ages 36-45 - \$10.80 Ages 46-55 - \$15.24 Ages 56-70 - \$20.10
4	<i>Employee + Family</i>	Ages 18-35 - \$ 13.80 Ages 36-45 - \$19.44 Ages 46-55 - \$28.50 Ages 56-70 - \$39.54

Item #	Cancer Care Screening and Annual Care Benefit Rider	Bi-Weekly Premium
5	<i>Employee Only/ One-Parent Family</i>	Ages 18-35 - \$ 3.06 Ages 36-45 - \$ 3.72 Ages 46-55 - \$ 4.32 Ages 56-70 - \$ 4.74
6	<i>Insured/Spouse &amp; Two Parent Family</i>	Ages 18-35 - \$ 4.86 Ages 36-45 - \$ 5.70 Ages 46-55 - \$ 6.78 Ages 56-70 - \$ 7.62
Item #	Description: Plan C – Specified Disease Rider	Bi-Weekly Premium
7	<i>Employee Only/ One-Parent Family</i>	Ages 18-70 - \$ 0.60
8	<i>Insured/Spouse &amp; Two Parent Family</i>	Ages 18 -70- \$ 0.90

1. Are discounts available for multiple lines of insurance? No
2. Do you have a minimum participation requirement? No.
3. Are rates guaranteed? Yes For how long? Five years; however, the plan availability is not guaranteed.
4. Guarantee Issue is not available with this plan.

**EXHIBIT C: VOLUNTARY EMPLOYEE BENEFITS PREMIUM SCHEDULE (3 Pages)**

**PLAN D: HOSPITALIZATION**

Item #	Description: Plan D – Hospitalization	Bi-Weekly Premium
1	<i>Employee Only</i>	Ages 18-39 - \$14.17 Ages 40-49 - \$16.35 Ages 50-59 - \$21.32 Ages 60-70 - \$26.82
2	<i>Employee + Spouse</i>	Ages 18-39 - \$20.10 Ages 40-49 - \$21.19 Ages 50-59 - \$25.20 Ages 60-70 - \$34.12
3	<i>Employee + Child(ren)</i>	Ages 18-39 - \$25.77 Ages 40-49 - \$27.27 Ages 50-59 - \$36.18 Ages 60-70 - \$44.64
4	<i>Employee + Family</i>	Ages 18-39 - \$29.20 Ages 40-49 - \$29.59 Ages 50-59 - \$39.54 Ages 60-70 - \$49.49

1. Are discounts available for multiple lines of insurance? No
2. Do you have a minimum participation requirement? No.
3. Are rates guaranteed? Yes For how long? Five years; however, the plan availability is not guaranteed.
4. Guarantee Issue is available with this plan.

**End of Exhibit C**