Payroll

Application for Cancer Indemnity Insurance (A-75000 Series)
Application to: American Family Life Assurance Company of Columbus (AFLAC)
Worldwide Headquarters: Columbus, Georgia 31999

☒ New
☐ Conversion
Policy Number:

To Be Completed by Applicant: Please Print in Black Ink

* Applicant's Name _____ (Last / First / MI) * DOB _____ (Month/Day/Year) * Sex _____

* Applicant's SSN _____ - _____ - _____ * Dependent Children ☐ Yes ☐ No

(Write spouse's name below if you are applying for Two-Parent Family coverage; if no spouse or spouse is not to be covered, write "N/A" or "None" in the space below.)

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

* Address _____ (Street or Post Office Box / Apt. No.)

* City _____ * State _____ * ZIP Code _____

* Home Telephone ( ) _____

Policyowner's Name _____ (if other than applicant) Relationship to Applicant _____

Address _____ (Street or Post Office Box / Apt. No.) Owner's SSN _____ - _____ - _____

City _____ State _____ ZIP Code _____

Payroll Account Name Mississippi State University Payroll Account Number R9474

* 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.

TO BE COMPLETED BY AFLAC ASSOCIATE/AGENT

Check Coverage Desired: *	☐ Individual ☐ Two-Parent Family	☐ One-Parent Family	
Level 1: Policy (Series A-75100)	☐ CCAIPA	☐ CCAIPD	☒ Pre-tax
Level 2: Policy (Series A-75200)	☐ CCAIPB	☐ CCAIPE	☐ After-tax
* Level 3: Policy (Series A-75300)	☐ CCAIPC	☐ CCAIPF	

Optional Rider:

* Building Benefit Rider (Series A-75050) Units ____ ☐ No rider ☐ New rider ☐ Retain current rider	☐ CCAIPG	☐ CCAIPK
Return of Premium Rider (Series A-75051) ☒ No rider ☐ New rider ☐ Retain current rider	☐ CCAIPH	☐ CCAIPL
Specified-Disease Rider (Series A-75052) ☒ No rider ☐ New rider ☐ Retain current rider	☐ CCAIPJ	☐ CCAIPM

Billing Method: ☒ Payroll Deduction

Mode: ☐ 01 Weekly ☐ 01 14-Day Biweekly ☐ 01 28-Day Biweekly ☐ 01 Semimonthly ☒ 01 Monthly ☐ 03 Quarterly ☐ 06 Semiannual ☐ 12 Annual

Employee No. _____ Dept. No. _____ * Assoc./Agent's No. _____

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

PLEASE COMPLETE THE FOLLOWING QUESTIONS:

* 1. Have you or has anyone to be covered under this policy ever been diagnosed with or treated for Cancer of any type or form? ☐ Yes ☐ No
If no, skip to number 7 or number 5 if this is a conversion. If yes, please complete numbers 2 and 3.

2. Was any Cancer referred to in number 1 an internal Cancer (which includes melanoma of Clark's Level III or higher, or a Breslow level greater than 1.5 mm):
   (a) diagnosed or treated within the last five years or for which preventive Hormonal Therapy has been received within the last 12 months? ☐ Yes ☐ No
   If yes, was it the ☐ Named Insured ☐ Spouse ☐ Child? Name of the child(ren):

   _____

   Any individual(s) indicated above will not be covered under the policy.

   (b) last diagnosed or treated over five years ago? ☐ Yes ☐ No
   If yes, was it the ☐ Named Insured ☐ Spouse ☐ Child? Name of the child(ren):

   _____

   Please complete a Cancer History Form provided by your associate/agent on any individual(s) listed.

3. Was any Cancer referred to in number 1 a Skin Cancer (which includes melanoma of Clark's Level I or II, or a Breslow level less than or equal to 1.5 mm):
   (a) diagnosed or treated within the last five years? ☐ Yes ☐ No
   If yes, was it the ☐ Named Insured ☐ Spouse ☐ Child? Name of the child(ren):

   _____

   Any individual(s) indicated above 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.

   (b) last diagnosed or treated over five years ago? ☐ Yes ☐ No
   If yes, was it the ☐ Named Insured ☐ Spouse ☐ Child? Name of the child(ren):

   _____

   Any individual(s) indicated above will not be issued a Skin Cancer Exclusion Rider.
   Benefits will be payable under this policy for the indicated individual for the treatment of Skin Cancer.

If you answered yes to number 1 and this is a conversion, please complete the conversion section below.

YOU MUST COMPLETE THIS SECTION IF THIS IS A CONVERSION.

IF your answer to number 1 above was "yes," complete number 4 below. If no, skip to number 5.

4. Have you or any person to be covered under this policy received benefits, other than Wellness Benefits, under your existing AFLAC Cancer policy in the last five years? ☐ Yes ☐ No
   If yes, was it ☐ Named Insured ☐ Spouse ☐ Child? Name of the child(ren):

   _____

   Any individual(s) indicated above will not be covered under the policy.

5. If this is an application for a conversion, the following conditions apply: (a) If Cancer 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. (b) The waiting period 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. Any premium paid on the original policy that is unearned as of the Effective Date of the new policy will be applied to the new policy.

6. I acknowledge that I was offered the Building Benefit Rider and declined it. I understand that by not applying for the Building Benefit Rider that I will lose the building benefit amount accrued in my previous policy, if any.
   ☐ Yes
   Applicant's Initials _____
   ☐ N/A

7. 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.** This policy contains a 30-day waiting period. If a covered person has Cancer diagnosed before coverage has been in force 30 days from the Effective Date of coverage shown in the Policy Schedule, benefits for treatment of that Cancer will apply only to treatment occurring after two years from the Effective Date of the policy or, at your option, you may elect to void the policy from its beginning and receive a full refund of premium.
8. I acknowledge receipt of, if applicable:
   - ☐ Fair Credit Reporting Notice
   - ☐ Replacement Notice
   - ☐ *Guide to Health Insurance for People with Medicare*
   - ☒ Outline of Coverage
9. 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) AFLAC is not bound by any statement made by me, or any associate/agent of AFLAC, unless written herein; (c) the associate/agent cannot change the provisions of the policy or waive any of its provisions either orally or in writing; (d) the policy, together with this application, endorsements, benefit agreements, riders, and attached papers, if any, constitutes the entire contract of insurance; and (e) no change to the policy will be valid until approved by AFLAC's secretary and president and noted in or attached to the policy.

NOTICE OF INFORMATION PRACTICES

To issue an insurance policy, AFLAC may need to obtain additional information about you and any other persons proposed for insurance. Some information will come from you and some may come from other sources. That information and any other subsequent information collected by AFLAC may in some circumstances be disclosed to third parties without your specific consent. You have the right to access and correct the information collected about you except information that relates to a claim or to a civil or criminal proceeding. If you wish to have a more detailed explanation of our information practices, please submit a written request to our worldwide headquarters. This notice applies only in Arizona, California, Connecticut, Georgia, Illinois, Maine, Massachusetts, Minnesota, Nevada, New Jersey, North Carolina, Ohio, Oregon, and Virginia.

Complete this section if applicant is applying for Specified-Disease Rider Series A-75052.

American Family Life Assurance Company of Columbus (AFLAC)
Worldwide Headquarters: 1932 Wynnton Road, Columbus, Georgia 31999

SUPPLEMENTAL MEDICAL INFORMATION QUESTIONNAIRE FOR SPECIFIED-DISEASE RIDER

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, Legionnaires' disease, malaria, meningitis (bacterial), multiple sclerosis, muscular dystrophy, myasthenia gravis, necrotizing fasciitis, osteomyelitis, polio, rabies, Reye's syndrome, scarlet fever, 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?

If "child," please list the name of the child(ren) _____.

Any person(s) named will not be covered under Specified-Disease Rider Form Series A-75052.

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.

*Applicant's Signature _____ * Date _____

*Associate's/Agent's Signature _____ *Date _____
Licensed Resident Associate/Agent

ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO AFLAC:
DO NOT MAKE CHECK PAYABLE TO THE ASSOCIATE/AGENT OR LEAVE THE PAYEE BLANK.
FOR INFORMATION, CALL TOLL-FREE 1-800-99-AFLAC (1-800-992-3522).

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).

American Family Life Assurance Company of Columbus
(herein referred to as Aflac)
Worldwide Headquarters • 1932 Wynnton Road • Columbus, Georgia 31999

STATEMENT OF UNDERSTANDING AND AGREEMENT

I, the undersigned, understand and agree that the: (check all that apply)

- ☒ Cancer/Specified Disease
- ☐ Hospital Intensive Care
- ☐ Hospital Indemnity
- ☐ Accident
- ☐ Short Term Disability
- ☐ Life
- ☐ Specified Health Event
- ☐ Dental
- ☐ Payroll Long-Term Care
- ☐ Hospital Confinement Sickness Indemnity
- ☐ Vision

policy (policies) that I am applying for or if already issued, will not be effective until _____ _____. No benefits will be due to me or any family members, if applicable, and Aflac will not be liable for any claims for loss incurred prior to the effective date of the policy (policies) listed above.

Reissues only
_____(policyholder's initials) I certify my medical condition has not changed from the time I originally applied for coverage and I understand that any pre-existing condition clauses and applicable waiting periods will begin as of the newly selected effective date above.

* Applicant's/Policyholder's Printed Name: _____

* Address: _____

Policy Number: _____

* Signature of Applicant/Policyholder: _____

* Date Signed: _____

* Signature of Associate: _____

AMERICAN FAMILY LIFE ASSURANCE COMPANY OF COLUMBUS (AFLAC)
WORLDWIDE HEADQUARTERS: COLUMBUS, GEORGIA 31999
A STOCK COMPANY

IMPORTANT NOTICE ABOUT THE POLICY OF INSURANCE FOR WHICH YOU HAVE APPLIED

THIS DOCUMENT AFFECTS YOUR LEGAL RIGHTS

READ THE FOLLOWING INFORMATION CAREFULLY.

1. **THE POLICY FOR WHICH YOU HAVE APPLIED INCLUDES A BINDING ARBITRATION AGREEMENT.**

2. **THE ARBITRATION AGREEMENT REQUIRES THAT ANY DISPUTE RELATED TO THIS POLICY MUST BE RESOLVED BY ARBITRATION AND NOT IN A COURT OF LAW.**

3. **THE RESULTS OF THE ARBITRATION ARE FINAL AND BINDING ON YOU AND THE INSURANCE COMPANY.**

4. **IN AN ARBITRATION, ONE OR MORE ARBITRATORS, WHO ARE INDEPENDENT, NEUTRAL DECISION MAKERS, RENDER A DECISION AFTER HEARING THE POSITIONS OF THE PARTIES.**

5. **WHEN YOU ACCEPT THIS INSURANCE POLICY YOU AGREE TO RESOLVE ANY DISPUTE RELATED TO THE POLICY BY BINDING ARBITRATION INSTEAD OF A TRIAL IN COURT, INCLUDING A TRIAL BY JURY.**

6. **BINDING ARBITRATION GENERALLY TAKES THE PLACE OF RESOLVING DISPUTES BY A JUDGE AND JURY.**

7. **SHOULD YOU NEED ADDITIONAL INFORMATION REGARDING THE BINDING ARBITRATION PROVISION IN THE POLICY, YOU MAY CONTACT OUR TOLL FREE ASSISTANCE LINE AT 1-800-99-AFLAC (1-800-992-3522).**

ACKNOWLEDGEMENT OF ARBITRATION AGREEMENT

I HAVE READ THIS STATEMENT. I UNDERSTAND THAT I AM VOLUNTARILY SURRENDERING MY RIGHT TO HAVE ANY DISPUTE BETWEEN THE INSURANCE COMPANY AND MYSELF RESOLVED IN COURT. THIS MEANS I AM WAIVING MY RIGHT TO A TRIAL BY JURY.

I UNDERSTAND THAT UPON RECEIPT OF THE POLICY, I SHOULD READ THE ARBITRATION CLAUSE CONTAINED IN THE POLICY AND THAT I HAVE THE RIGHT TO REJECT THIS POLICY WITHIN FIVE (5) DAYS OF THE DATE OF DELIVERY IF I DO NOT WANT TO ACCEPT THE REQUIREMENT FOR ARBITRATION.

I UNDERSTAND THAT THIS SAME TYPE OF INSURANCE MAY BE AVAILABLE THROUGH AN INSURANCE COMPANY THAT DOES NOT REQUIRE THAT POLICY RELATED DISPUTES BE RESOLVED BY BINDING ARBITRATION.

* _____	* _____	* _____
APPLICANT/INSURED	**DATE**	**TIME**
* _____	* _____	* _____
AGENT	**DATE**	**TIME**

American Family Life Assurance Company of Columbus
(herein referred to as Aflac)
Worldwide Headquarters • Columbus, GA 31999
For information, call toll-free 1.800.99.AFLAC (1.800.992.3522).

Suitability Notice

I, _____, have reviewed the benefits and premium of the insurance
Proposed Insured's Name

policy(ies) and/or riders that I am applying for and agree to the following.

- I understand the impact that the premium for this coverage has on my paycheck/income;
- I understand the impact that the total Aflac premium for this coverage and any other Aflac coverage has on my paycheck/income and believe it to be appropriate for me; and
- I have considered all of my existing health insurance coverage, with Aflac and/or with other carriers, and believe this additional coverage is appropriate for my insurance needs. I further understand that I can contact Aflac and/or other insurance carriers to assist in evaluating the suitability of insurance coverage for me.

* Proposed Insured's Signature _____ Date _____

I certify that I have advised the applicant to consider the impact that this Aflac coverage has on his or her paycheck/income, and I agree with the applicant's decision that it is appropriate for purchase.

Associate's/Agent's Signature _____ Date _____
Licensed Associate/Agent

AUTHORIZATION TO OBTAIN INFORMATION

MAIL TO: American Family Life Assurance Company of Columbus
1932 Wynnton Road
Columbus, Georgia 31999-0001

Primary Policyholder's Name:	**SSN**(optional):	**Date of Birth:**
Policy Number(s):		
Address:		
Name of Individual Subject to Disclosure (if not the primary policyholder):		**Date of Birth:**
Relationship to Primary Policyholder: ☐ Self ☐ Spouse ☐ Domestic Partner		

I authorize the following to give information (as defined below) to American Family Life Assurance Company of Columbus, American Family Life Assurance Company of New York, and Continental American Insurance Company (collectively, "Aflac"): any medical professional, medical care institution, pharmacy-related service organizations, 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" includes 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 are required as part of the underwriting process in order to determine eligibility for insurance or to evaluate a claim for benefits during the time this authorization is valid.

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, Policy Service, 1932 Wynnton Road, Columbus, Georgia 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 date this authorization is signed.

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.

_____ _____

Signature of Individual Subject to Disclosure | Date Signed

If this authorization has been signed by a personal representative on behalf of an individual, his/her authority to act on behalf of the individual must be set forth here:

_____ _____

Printed Name of Legal/Personal Representative | Legal Relationship *(e.g. Power of Attorney)*

AFLAC Cancer Forms Instructions

This policy is subject to underwriting by AFLAC. You will receive notification from AFLAC whether you were approved or denied coverage.

Everything with a star (*) on AFLAC forms is a required field.

Page 1

- Enter your last name, first name and middle initial
- Enter your date of birth
- Enter M or F for sex
- Enter your social security number
- Check whether you have dependent children
- For spouse's name: ***ONLY write in Spouse name and information if you are covering your spouse!** If no spouse will be covered on your cancer plan, write "N/A" in the spouse's name blank.
- If a child is being insured, you will write their name in the Policyowner's name blank and enter their relationship to you.
- Enter address, social, city, state, and zip.
- Check NO for the question "Is this insurance intended to replace any other health insurance now in force?"
- In the section that reads: To Be Completed by AFLAC Associate/Agent, please check whether want individual coverage, coverage for two-parent family or one parent family.
- If you are a two-parent family or individual policy, you will check CCAIPC beside Level 3
- If you are a one-parent family coverage, you will check CCAIPF beside Level 3

- In the Optional Rider Section, if you would like to include riders on your cancer policy, enter 1,2,3,4, or 5 beside “Units”. Leave blank if you want no rider.
- At the bottom of the page, the billable premium and Associate /Agent number will be populated by AFLAC.

Page 2

- Answer Yes or No to question 1.
- If no, skip to question 7 on page 3.
- If yes, answer questions 2 and 3 below.
- If you are answering 2, check whether it was yourself, spouse, or child with cancer and enter the person’s name.
- Question 3 refers to skin cancer. Check whether it was yourself, spouse, or child with cancer and enter the person’s name.

Page 3

- At the bottom of this page, you will sign and date under Applicants signature section.
- The agent will sign in the Associate/Agent’s signature section.

Page 4 This is for informational purposes only

Statement of Understanding and Agreement.

- The middle of the page is where you will enter the date this policy will start or become effective (for new hire enrollment). This date will not be your hire date but typically will be the same date that your other optional coverages begin. For instance, if your hire date is July 15th, your effective date for Cancer coverage will be September 1. If you sign up during open enrollment, your effective date will be January 1 of the new year; your premiums will start deducting December 15 of the current year.
- If this is a Reissued policy, you will place your initials in the blank.
- Otherwise, you will enter your name and address
- Sign with date of signature.
- You can leave the policy number blank as this will be populated by an AFLAC agent.

Important Notice about the Policy of Insurance for which you have Applied

- This is strictly for informational use only.

Sign and date the Acknowledgement of Arbitration Agreement.

- The agent will sign in their section.

Suitability Notice.

- You will enter your name as the “Proposed Insured’s Name”.
- Sign and date at the bottom.

Authorization to Obtain Information.

- You will enter your name as the Primary Policyholder's Name,
- Enter your social security number
- Enter your date of birth.
- Since the Policy number is not yet assigned, you will leave this blank.
- Enter your address
- Check relationship to Primary Policy holder.
- Sign and date at the bottom.

Please send completed form to the Human Resource Department via:

- In person: 245 Barr Ave, 150 McArthur Hall
- U. S. Mail: PO Box 9603, Mississippi State, MS 39762
- Fax: 662 325-0753
- Secure e-mail: contact your benefit specialist listed on the website: www.hrm.msstate.edu for information on how to send secure email. To find your benefit specialist, view the home page, about us, our staff.
- Campus mailstop 9603