Payroll

**SPECIFIED HEALTH EVENT INSURANCE POLICY**
**(Series A74000)**
**Supplemental Health Insurance Coverage**
Application to: American Family Life Assurance Company of Columbus
(herein referred to as Aflac)
Worldwide Headquarters • Columbus, Georgia 31999

☒ New
☐ Conversion

Policy Number:

**Please Print in Black Ink – To Be Completed by Proposed Insured**

* Proposed Insured's Name _____
Last First MI

* DOB _____ * Sex _____ * SSN _____ - _____ - _____
Month/Day/Year

* Address _____
Street or Post Office Box Apt. No.

* City _____ * State _____ *ZIP _____

* Telephone ( ) _____
☐ Home ☐ Work ☐ Cell

Email Address (optional) _____

* Are you applying for Dependent Child(ren) coverage? ☐ Yes ☐ No
If yes, Dependent Children must be under age 26 as of the Effective Date of coverage.

**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

Account Name Mississippi State University Account No. R9474

Name of Employer Mississippi State University

**PLEASE COMPLETE THE FOLLOWING ELIGIBILITY QUESTIONS**

* 1. Are you, the Proposed Insured, actively at work with the employer listed above? ☐ Yes ☐ No
If no, a policy will not be issued; therefore, do not submit this application.

* 2. (a) Is your Spouse, if applying for coverage, actively at work? ☐ Yes ☐ No ☐ N/A
(b) If no, is your Spouse now hospitalized or unable to perform his or her normal duties and activities? *If yes to 2(b), your Spouse is not eligible for coverage.* ☐ Yes ☐ No ☐ N/A

* 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 have any other critical illness coverage (Specified Health Event, Critical Care and Recovery, or Lump Sum Critical Illness) with Aflac (not including a critical illness rider)? ☐ Yes ☐ No

If yes, this must be a conversion of that coverage. Please give current policy number and see Applicant's Statements and Agreements concerning conversions.

Policy Number: _____

* Do you have a hospital intensive care policy or rider with Aflac? ❑ Yes ❑ No

If yes, and you are applying for Option 2 or Option 3, and you have both a hospital intensive care policy and a critical illness policy, the oldest policy will be converted. The newest policy will be cancelled.
If yes, and you are applying for Option 2 or Option 3, and you only have a hospital intensive care policy, it will be converted.
If yes, and you are applying for Option 2 or Option 3, and you only have either a hospital intensive care rider or specified health event rider, it will be cancelled.

Please give current policy number and see Applicant's Statements and Agreements concerning conversions and replacement of coverage.
Policy Number: _____

**PLEASE NOTE: If anyone other than the Proposed Insured is to be covered and has any other Specified Health Event, Critical Care and Recovery, or Lump Sum Critical Illness coverage with Aflac, or if applying for policy Option 2 or Option 3, any other hospital intensive care policy or rider with Aflac, the existing coverage must be cancelled in order to be covered under this policy. Please submit a request to cancel the existing coverage.**

| * **Check Coverage Desired:** | ❑ Individual | ❑ Named Insured/ Spouse Only | ❑ One-Parent Family | ❑ Two-Parent Family |
|---|---|---|---|---|

**Policy (Select one):**
☒ **Option 1: Specified Health Event (Policy Series A74100)**
❑ **Option 2: Specified Health Event with Intensive Care Unit Benefits (Policy Series A74200)**
❑ **Option 3: Specified Health Event with ICU and Heart Surgery Benefits (Policy Series A74300)**

☒ Pre-Tax
or
❑ After-Tax

**Optional Riders:**
❑ **First-Occurrence Building Benefit Rider (Rider Series A74050)**
**Options:** ☒ **No rider** ❑ **New rider** ❑ **Retain current rider**
❑ **Specified Health Event Recovery Benefit Rider (Rider Series A74051)**
**Options:** ☒ **No rider** ❑ **New rider** ❑ **Retain current rider**

| **Billing Method:** | **Mode:** | | |
|---|---|---|---|
| ☒ Payroll Deduction | ❑ 01 Semimonthly | ❑ 01 28-Day Biweekly | ❑ 06 Semiannual |
| ❑ Bank Draft (B/D, ACH) | ❑ 01 Weekly | ☒ 01 Monthly | ❑ 12 Annual |
| ❑ Credit Card (C/C) | ❑ 01 14-Day Biweekly | ❑ 03 Quarterly | |

**PLEASE NOTE: If the B/D or C/C billing method is checked, only the following modes of payment are available: Monthly, Quarterly, Semiannual, or Annual.**

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

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

**IF YOU ARE APPLYING FOR OPTION 1, OPTION 2, OR OPTION 3, PLEASE COMPLETE QUESTIONS 1 THROUGH 3.**

* 1. Within the last five years, has anyone to be covered been diagnosed with or treated by a member of the medical profession at a health facility for any of the following? ❑ Yes ❑ No

Heart Attack
Stroke or transient ischemic attack (TIA)
Kidney disease or disorder (excluding stones)

* 2. Within the last five years, has anyone to be covered had or been advised by a member of the medical profession of the need to have any of the following? ❑ Yes ❑ No

Major organ transplant
Coronary artery bypass surgery
Angioplasty or stent placement

3. **If either of Questions 1 or 2 is answered yes, was it the:**

❑ Proposed Insured? ❑ Spouse? ❑ Child? If "Child," please list the name(s) of the child(ren).

_____

**Any person(s) indicated above will not be covered under the policy. If the named person is the Proposed Insured, a policy will not be issued; therefore, do not submit this application.**

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

**IF YOU ARE APPLYING FOR OPTION 2 OR OPTION 3, PLEASE ALSO COMPLETE QUESTIONS 4 THROUGH 10.**

4. Is anyone to be covered the mother or father of a child currently conceived but as yet unborn, or within the last 12 months, has anyone to be covered been diagnosed with or treated by a member of the medical profession for infertility? ❑ Yes ❑ No

5. Has anyone to be covered ever been diagnosed with or received medical treatment for any of the following by a member of the medical profession? ❑ Yes ❑ No

Cerebral vascular insufficiency
Congenital heart disease (excluding surgically corrected atrial septal defect)
Acquired immune deficiency syndrome (AIDS)
Angina
Congestive heart failure
Cystic fibrosis
Systemic lupus

6. Has anyone to be covered ever been diagnosed with or received medical treatment by a member of the medical profession for diabetes:

requiring the use of insulin within the last five years;
with complications to include retinopathy, neuropathy, or nephropathy;
with continued tobacco use; or
diagnosed prior to age 30 (excluding gestational)? ❑ Yes ❑ No

7. Is anyone to be covered currently confined in a hospital or nursing home, or within the last 12 months, has hospitalization been recommended by a Physician? ❑ Yes ❑ No

8. Has anyone to be covered ever been diagnosed with or medically treated by a member of the medical profession for sickle cell anemia or emphysema, or has anyone to be covered required the use of oxygen for a chronic respiratory disease/disorder, excluding the use of a CPAP machine for the treatment of sleep apnea? ❑ Yes ❑ No

9. In the last 12 months, has anyone to be covered received treatment for more than 24 hours in a Hospital Intensive Care Unit (not including treatment as a result of an accident)? ❑ Yes ❑ No

10. **If any one of Questions 4 through 9 is answered yes, was it the:**

❑ Proposed Insured? ❑ Spouse? ❑ Child? If "Child," please list the name(s) of the child(ren).

_____

**Any person(s) indicated above will not be covered under the policy. If the named person is the Proposed Insured, a policy will not be issued; therefore, do not submit this application.**

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

**IF YOU ARE APPLYING FOR OPTION 3, PLEASE ALSO COMPLETE QUESTIONS 11 – 14.**

11. Has anyone to be covered had or been advised to have, or consulted with or been evaluated by a member of the medical profession of the need to have, any of the following? ❑ Yes ❑ No

Defibrillator placement
Pacemaker placement
Heart valve surgery

12. Within the last 12 months, has anyone to be covered been prescribed medication for irregular heartbeat, heart palpitation, or tachycardia (not including preventive treatment with antibiotics prior to dental appointment); received medical treatment in an emergency room or hospital for hypertension/high blood pressure (not related to pregnancy); or had a medication change to improve blood pressure readings, by a member of the medical profession? ❑ Yes ❑ No

13. Has anyone to be covered ever been diagnosed with or received medical treatment for any of the following by a member of the medical profession? ❑ Yes ❑ No

| | |
|---|---|
| Heart Attack (two or more) | Cardiomyopathy |
| Coronary artery disease | Arterial blockage |
| Bypass surgery | Peripheral vascular disease |
| Atrial fibrillation | Stroke or TIA (two or more) |

14. **If any one of Questions 11 through 13 is answered yes, was it the:**

❑ Proposed Insured? ❑ Spouse? ❑ Child? If "Child," please list the name(s) of the child(ren).

_____

**Any person(s) indicated above will not be covered under the policy. If the named person is the Proposed Insured, a policy will not be issued; therefore, do not submit this application.**

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

**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 I signed this application.
- I understand that the policy I am applying for will not cover any person who has reached his or her 71st birthday before the Effective Date of coverage. **The Benefits for Hospital Intensive Care Unit Confinements in the Option 2 (Series A74200) and Option 3 (Series A74300) policies reduce to half at age 70.**

- 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, prescription medication was taken or medical testing, 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. Benefits will not be payable for any Loss that is caused by a Pre-existing Condition unless the Loss occurs more than 12 months after the Effective Date of coverage.

* **Proposed Insured's Initials** _____

- If applicable, I understand that Dependent Children, if any, must be under age 26 as of the Effective Date of coverage. Once covered, Dependent Children will continue to be covered until their 26th birthday. When coverage on all Dependent Children terminates, you must notify Aflac, in writing, and elect whether to continue the coverage on an 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.
- I acknowledge receipt of, if applicable:
  - ☐ Replacement Notice
  - ☒ Outline of Coverage
  - ☐ *Guide to Health Insurance for People with Medicare*
- I understand that (1) the policy, together with the applications, endorsements, benefit agreements, riders, and attached papers, if any, constitutes the entire contract of insurance, and (2) 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 (1) Aflac is not bound by any statement made by me, or any associate/agent of Aflac, unless written herein and (2) 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.
- I have read, or had read to me, the statements and answers I have provided on this application. I understand that the policy is to be issued based upon these statements and answers, and any other pertinent information Aflac may require for proper underwriting. The answers are complete and true. I understand that all statements made in this application are deemed representations and not warranties, but that material misrepresentations herein may result in loss of coverage under the policy.
- I understand that the purchase of the 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 coverage with this policy, I acknowledge that the policies and/or rider may have different benefits and that I should compare them to determine which is best for me. I understand and agree that I am terminating my current Aflac policy and/or rider and its/their benefits for the benefits provided in this Aflac policy.

* **Proposed Insured's Initials** _____

- If this is an application for a conversion of coverage, the following conditions will apply: (1) If any one of Questions 1 or 2, 4 through 9, or 11 through 13 is answered yes, the policy for which this application is made for the person(s) identified in Item 3, Item 10, or Item 14 will be void, and coverage will continue for such person(s) only under the terms of the previous policy, if such policy remains in force; (2) The Time Limit on Certain Defenses provision will run from the Effective Date of the new policy, and the original policy will be terminated as of the Effective Date of the new policy; and (3) The Pre-existing Condition Limitations provision in the new policy will run from the original policy's Effective Date for the benefits provided under the original policy. For any increased benefit amount, the Pre-existing Condition Limitations provision in the new policy will run from the new policy's Effective Date.

* **Proposed Insured's Initials** _____

**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, Montana, Nevada, New Jersey, North Carolina, Ohio, Oregon, and Virginia.

* I prefer to receive an electronic copy of my policy instead of a paper copy. ☐ Yes ☐ No
If yes, please enter your email address on Page 1.

* Signed and Dated at _____ on _____
City and State Date

* Proposed Insured's Signature _____

**I certify that I personally saw the Proposed Insured when the application was written, and each question was asked of the Proposed Insured and answered as recorded. All answers above are correct to the best of my knowledge.**

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

**ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO AFLAC.**
**DO NOT MAKE CHECK PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK.**
**FOR INFORMATION, CALL TOLL-FREE 1.800.99.AFLAC (1.800.992.3522).**
**VISIT OUR WEBSITE 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).

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 • 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: _____

# * AUTHORIZATION TO DISCLOSE 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 American Family Life Assurance Company of Columbus, American Family Life Assurance Company of New York, and Continental American Insurance Company (collectively, "Aflac") to make a brief report of my personal health information to MIB, Inc. (formerly known as the Medical Information Bureau).

I understand that this information will be used by MIB, Inc. for the purpose of assisting the insurance industry in the accurate underwriting of insurance products as well as assisting the insurance industry in facilitating the fair pricing of insurance products through more accurate risk assessment.

"Information" includes information in Aflac's possession relating to my physical or mental health or condition (excluding psychotherapy notes, but including, for example, medical diagnosis/treatment information related to underwriting), and nonmedical financial information (including, for example, policy status).

I understand that any disclosure of health information to MIB, Inc. 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 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 Aflac has taken action in reliance on this authorization. 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)*

**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

# AFLAC Critical Care 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
- Enter your address including City, State and Zip
- Enter your telephone number
- Email address is optional
- Check Yes or No when asked if you are applying for Dependent child(ren) coverage
- 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 plan, write "N/A" in the spouse's name blank
- There are a couple of eligibility questions at the bottom of page 1. Check yes to question 1 stating that you are actively at work and the insured.
- Answer yes or no to question 2 which asks if your spouse is applying for coverage and answer if he/she is now hospitalized.
- Answer yes or no to the question asking if this policy is intended to replace another policy still in force.
- Answer yes or no to the question asking if you have another critical illness policy.

- If the answer to this question is “Yes”, please write the policy number in the blank.
- 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 the question asking if you have a hospital intensive care policy or a rider with AFLAC.
- If you do, please give the policy number in the space provided.
- About ½ way down the page, you will check the coverage desired: Individual, Named insured/spouse only, one-parent family, or two-parent family.
- **You will also notice in this section that Option 1 with no riders is already marked for you.**
- **Options 2 and 3 are not available to you currently.**
- The billable premium will be populated by the AFLAC agent
- Answer yes or no to question number 1 at the bottom of page 2 asking if anyone to be covered has been diagnosed or treated by a medical professional for heart attack, stroke, or kidney disease.

*Page 3*

- Answer yes or no to question number 2 asking if anyone to be covered has been treated by a medical professional in the last 5 years for organ transplant, coronary artery bypass surgery, or angioplasty/stent placement.
- If the answer was yes to either of the above questions, check who it was and enter the name(s) of spouse and/or children.

- Answer yes or no to the question asking if any other children will be covered under this plan.
- The last part of this page pertains to if you are applying for Option 2 or 3 of this coverage and you are not.
- Again, Option 1 is the only option you have.
- Skip questions 4-10.

*Page 4*

- Skip question 10 -14.

*Page 5*

- Initial in the 3 places indicated.

*Page 6*

- This is asking if you would like to receive an electronic copy of your new policy instead of a paper copy. You will check Yes or No.

*Page 7*

- This page is for Informational purposes only.

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.

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 Critical Care 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 print your name, address, and sign with date of signature.
- You can leave the policy number blank as this will be populated by an AFLAC agent.

Authorization to Obtain Information.

- 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.

Suitability Notice.

- Enter your name as the “Proposed Insured’s Name”.
- 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 how to send secure email.  To find your benefit specialist, view the home page, about us, our staff.
- Campus mailstop 9603