Payroll

APPLICATION FOR HOSPITAL CONFINEMENT SICKNESS INDEMNITY LIMITED BENEFIT INSURANCE (NY-45000 Series)

Application to: American Family Life Assurance Company of New York (AFLAC New York) 22 Corporate Woods Boulevard, Albany, New York 12211

❑ New
❑ Conversion

Policy Number

Please Print in Black Ink - To Be Completed by Applicant

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

Applicant's SSN _____ - _____ - _____ Dependent Children ❑ Yes ❑ No

(Write spouse's name below if you are applying for family coverage; if no spouse or spouse is not to be covered, put N/A in space below.)

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

Address _____
Street or Post Office Box Apt. No.

City _____ State _____ ZIP _____

Home Telephone ( ) _____

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

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

City _____ State _____ ZIP _____

Name of Employer _____

Do you have any other hospital confinement **sickness** indemnity coverage with AFLAC New York? ❑ Yes ❑ No
If yes, this must be a conversion of that coverage. Provide current policy number and see Item 13.
Policy Number _____

Do you have any hospital confinement indemnity coverage with AFLAC New York? ❑ Yes ❑ No
If yes, do you intend to terminate this existing coverage? ❑Yes ❑ No
If yes, please provide current policy number and complete the Supplemental Notification section at the end of this application. Policy Number _____

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 agent, if applicable.

TO BE COMPLETED BY AFLAC NEW YORK AGENT

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

Level 1: Policy Series NY-45100	❑ DHIPSA	❑ DHIPSB	❑ DHIPSC	❑ Pre-tax
Level 2: Policy Series NY-45200	❑ DHIPSD	❑ DHIPSE	❑ DHIPSF	❑ After-tax
Level 3: Policy Series NY-45300	❑ DHIPSG	❑ DHIPSH	❑ DHIPSI	

Billing Method:
❑ Payroll Deduction
❑ Payroll ACH

Mode:
❑ 01 Weekly
❑ 01 Biweekly
❑ 01 28-day
❑ 01 Semimonthly
❑ 01 Monthly
❑ 03 Quarterly
❑ 06 Semiannual
❑ 12 Annual

Employee No. _____ Dept. No. _____ Agent's No. _____

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

ALL OF THE FOLLOWING MUST BE COMPLETED:

1. Is anyone to be covered currently confined in a hospital or nursing home, or has a physician recommended hospitalization? ❑ Yes ❑ No

2. Has anyone to be covered been confined in a hospital for 14 or more hours within the last 36 months because of any of the following? (Check all that apply.) ❑ Yes ❑ No
   - ❑ angina (heart-related chest pain)
   - ❑ congestive heart failure
   - ❑ heart attack
   - ❑ Crohn's disease
   - ❑ ulcerative colitis
   - ❑ cerebral vascular insufficiency
   - ❑ heart surgery
   - ❑ stroke
   - ❑ cancer (other than nonmelanoma skin cancers)
   - ❑ transient ischemic attack (TIA) (ministroke)
   - ❑ peripheral vascular disease (circulatory problems)

3. Has anyone to be covered been confined in a hospital for 14 or more hours within the last 12 months because of any of the following? (Check all that apply.) ❑ Yes ❑ No
   - ❑ emphysema
   - ❑ sickle-cell anemia
   - ❑ asthma
   - ❑ Parkinson's disease
   - ❑ liver disease or disorder (excluding Hepatitis A)
   - ❑ chronic obstructive pulmonary disease

4. Has anyone to be covered ever been medically treated or medically diagnosed by a member of the medical profession as having any of the following? (Check all that apply.) ❑ 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

5. Has anyone to be covered ever been treated or diagnosed by a member of the medical profession as having AIDS? ❑ Yes ❑ No

6. If Question 1, 2, 3, 4 or 5 is answered yes, the name and the relationship of the person(s) must be shown in the following space. Any person(s) so named will not be covered under the policy. _____

   _____

7. List all hospital indemnity policies you currently have in force and provide the daily benefit amount. _____

   _____

   _____

APPLICANT'S STATEMENTS AND AGREEMENTS:

8. I understand that the Effective Date of the policy will be the date recorded in the Policy Schedule by AFLAC New York.
9. I understand that the policy I am applying for will not cover any person who has attained age 71 prior to the Effective Date of the policy.
10. I acknowledge receipt of, if applicable:
    - ❑ Replacement Notice
    - ❑ Disclosure Statement
    - ❑ *Guide To Health Insurance for People with Medicare*
11. **I understand that coverage is not provided for health conditions for which symptoms existed that would ordinarily cause a prudent person to seek diagnosis, care or treatment or for which medical advice or treatment was recommended by a Physician or received from a Physician within the 12-month period before the Effective Date of coverage unless the loss begins six months or more after the Effective Date of coverage.**
12. I understand that: (a) the insurance I am applying for will be issued based solely upon the written answers to questions and information asked for in this application; (b) AFLAC New York is not bound by any statement made by me, the applicant, or any agent of AFLAC New York unless written herein; (c) the 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, is the entire contract of insurance; and (e) no change to the policy will be valid until approved by AFLAC New York's secretary and president, and noted in or attached to the policy.

13. If this is an application for a conversion of coverage, the following conditions will apply: (a) If Question 1, 2, 3, 4 or 5 is answered yes, the policy for which this application is made for the person(s) identified in Item 6 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 6 will be paid under the previous policy. (b) Any person(s) not listed in Item 6, 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.
14. **OTHER INSURANCE WITH AFLAC NEW YORK:** Insurance effective at any one time on a covered person under a like policy or policies with AFLAC New York is limited to the one such policy elected by the insured, his beneficiary or his estate, as the case may be, and AFLAC New York will return all premiums paid for all other such policies.

SUPPLEMENTAL NOTIFICATION
COMPLETE THIS SECTION IF YOU ARE REPLACING/TERMINATING EXISTING COVERAGE.

I, _____ , am applying for AFLAC New York's Hospital Confinement Sickness Indemnity Limited Benefit Policy that pays benefits for a covered Sickness only. I currently have hospital confinement benefits under AFLAC New York Hospital Confinement Indemnity Policy number _____.

_____ **Please cancel my existing hospital confinement indemnity policy and issue this new policy.**
(Please Initial)

I understand that this new policy pays benefits for a covered Sickness only. Other than the Physician Visits Benefit, this policy does not pay for Injuries.

I understand that the premium amount listed on this application represents the premium amount that my employer will remit to AFLAC New York on my behalf, and 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 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 New York 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 also understand that the new policy only pays benefits for a covered Sickness. Other than the Physician Visits Benefit, this policy does not pay for Injuries. I have read, or had read to me, the completed application, and I realize policy issuance is based upon statements and answers provided herein, and they are complete and true to the best of my knowledge and belief.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

This policy provides limited benefits health insurance ONLY. This policy does NOT provide basic hospital, basic medical or major medical insurance, as defined by the New York State Insurance Department. This policy does NOT provide Medicare supplement insurance, long term care insurance, nursing home insurance only, home care insurance only, or nursing home and home care insurance as defined by the New York State Insurance Department. Purchase of this coverage may be unnecessary if you already have or intend to purchase Medicare supplement insurance or long term care insurance. For information concerning Medicare supplement insurance contact the New York State Insurance Department. You may also contact your local social security office or this company and request a copy of the Medicare supplement buyers' guide.

Signed and Dated at _____ on _____
City and State Date

Applicant's Signature _____

Agent's Signature _____ Date _____
Licensed Resident Agent

FOR INFORMATION, CALL TOLL-FREE 1-800-366-3436.

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).

American Family Life Assurance Company of New York (AFLAC New York)
22 Corporate Woods Boulevard, Albany, New York 12211
For information, call toll-free 1-800-366-3436.

Additional Information Supplement Form

This is part of the application and will become part of the policy.

Insured _____

Policy Number _____

The following information must be completed on each dependent child to be covered.

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

Signature of Applicant/Named Insured _____ Date _____