Payroll

Application for Accident Insurance (NYR35000 Series)
Application to American Family Life Assurance Company of New York
(Aflac New York)
22 Corporate Woods Boulevard • Suite 2 • Albany New York 12211

❑ 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 _____ Sex _____ SSN _____ - _____ - _____
Month/Day/Year (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 _____ DOB _____ Sex _____
Last First MI Month/Day/Year

Payroll Account Name _____ Payroll Account No. _____

Name of Employer _____ Type of Business _____

Job Duties _____

Job Title _____

Occupation Class _____ Industry Code _____
(Completed by agent) (Completed by 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 agent, if applicable, ❑ Not applicable
and provide the policy number here: _____

Does anyone to be covered have any other Accident coverage with Aflac New York? ❑ 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 New York? ❑ 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 New York.

Are you covered under New York's Disability Benefits Law or an equivalent state-mandated disability insurance plan? ❑ Yes ❑ No ❑ Not applicable

TO BE COMPLETED BY AFLAC NEW YORK AGENT

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

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

Disability Benefit Period:
- ❑ 6 Months
- ❑ 12 Months

Accident Disability Elimination Period:
- ❑ 0 Days
- ❑ 7 Days

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. _____ Agent No. _____

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

CHECK COVERAGE DESIRED: ❑ Individual ❑ One-Parent Family ❑ Two-Parent Family ❑ Named Insured/Spouse Only

Class: ☐ A ☐ B ☐ C ☐ D ☐ E			
SELECT ONLY ONE POLICY SERIES		**Premium**	
24-Hour Accident			
❑ Accident Essentials Policy Series NY35B24			❑ Pre-Tax or ❑ After-Tax
❑ Plan 1 Accident Policy Series NYR35100			
❑ Plan 2 Accident Policy Series NYR35200			
Off-the-Job Accident ONLY			
❑ Off-the-Job Accident Essentials Policy Series NY35BOF			
❑ Plan 1 Off-the-Job Accident Policy Series NYR35300			
❑ Plan 2 Off-the-Job Accident Policy Series NYR35400			

❑ Additional Accidental-Death Benefit Rider Series NY35054			☒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 NY35050 Options: ❑ No rider ❑ New rider ❑Retain current NYR35000 series rider			❑ Pre-Tax
On-the-Job Accident Disability Benefit Rider Series NY35051 **Only available with Policy Series NY35B24, NYR35100, or NYR35200** Options: ❑ No rider ❑ New rider ❑Retain current NYR35000 series rider			or ❑ After-Tax
Sickness Disability Benefit Rider Series NY35052 14-Day Elimination Period Options: ❑ No rider ❑ New rider ❑Retain current NYR35000 series rider			

The disability rider shown below applies only to your spouse.

Spouse Off-the-Job Accident Disability Benefit Rider Series NY35053 0-Day Elimination Period/6-Month Benefit Period Options: ❑ No rider ❑ New rider ❑Retain current NYR35000 series rider			☒ After-Tax Only
	Total Premium		

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**	
❑ Off-the-Job Accident Disability Benefit Rider **Current Units:**_____			❑ Pre-Tax or ❑ After-Tax
❑ Sickness Disability Benefit Rider 14-Day Elimination Period **Current Units:**_____			
	Total Premium		

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 New York 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

1. 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

2. 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

3. 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

4. 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.

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 NYR35PAPP

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. To the best of your knowledge and belief, 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. To the best of your knowledge and belief, 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. To the best of your knowledge and belief, 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

2. To the best of your knowledge and belief, 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. To the best of your knowledge and belief, 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. To the best of your knowledge and belief, 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
   Systemic lupus
   muscular dystrophy
   Parkinson's Disease
   cystic fibrosis
   pulmonary hypertension
   renal hypertension
   Crohn's disease
   ileitis
   regional enteritis
   ulcerative colitis
   ulcerative proctitis
   vascular insufficiency (circulatory problems)
   diabetes (Type II) diagnosed prior to age 30

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

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.

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.

Form NYACCPUW

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 New York. It is not the date this application was signed by me.
- I acknowledge receipt of, if applicable:
  - ❑ Replacement Notice
  - ❑ Disclosure Statement
  - ❑ *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 or treatment was recommended by a Physician or received from a Physician, 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, condition, or disorder for which, within the 12-month period before the Effective Date of coverage, medical advice or treatment was recommended by a Physician or received from a Physician, 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, 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 New York 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 New York's president and secretary, and noted in or attached to the policy.
- I understand that (1) Aflac New York is not bound by any statement made by me, or any agent of Aflac New York, unless written herein and (2) the 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 New York 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 New York 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 New York policy and its benefits for the benefits provided in this Aflac New York 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 New York may require for proper underwriting. The answers are complete and true. I understand that all statements made in this application are deemed representations and not warranties but that material misrepresentations herein may result in loss of coverage under this policy. 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.

- **OTHER INSURANCE WITH AFLAC NEW YORK:** If a person is covered under more than one Aflac New York accident-only policy, only the one policy chosen by you, your beneficiary, or your estate, as the case may be, will be effective. Aflac New York will pay benefits under the policies for claims that may have been incurred since their respective Effective Dates. Aflac New York 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.

SUPPLEMENTAL NOTIFICATION
COMPLETE IF YOU ARE REPLACING/TERMINATING EXISTING AFLAC NEW YORK DISABILITY COVERAGE.

I, _____ , am applying for Aflac New York's policy with disability benefits. I currently have disability benefits under Aflac New York short-term disability policy number _____. I understand that I must cancel my existing Aflac New York 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.

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

I authorize the following to give information (as defined below) to American Family Life Assurance Company of New York (Aflac New York) or any person or entity acting on its part: any medical professional, medical care institution, insurer (including Aflac New York, with respect to other Aflac New York 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 New York 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 New York to give information to MIB, Inc.

I understand that any disclosure of health information to Aflac New York 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 New York 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 New York 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 New York has taken action in reliance on this authorization or (2) other law provides Aflac New York with the right to contest a claim under the policy or the policy itself. My revocation must be submitted in writing to Aflac New York, Attn: Policy Service, 22 Corporate Woods Boulevard, Suite 2, Albany, New York 12211.

Unless otherwise revoked, I agree that this authorization will expire on the earlier of the date Aflac New York 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.

Form NYR35PAPP

I, the undersigned Proposed Insured/Employee, agree that by signing below I am submitting an application to Aflac New York for the following insurance policy(ies).

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

I would prefer to receive an electronic copy of my policy(ies) instead of paper. ❑ Yes ❑ No

Signed and Dated at _____ on _____
City and State Date

Proposed Insured's/Employee's Signature _____

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

Agent's Signature _____ Date _____
Licensed Resident Agent

MAKE CHECK OR MONEY ORDER PAYABLE TO AFLAC NEW YORK.
FOR INFORMATION, CALL TOLL-FREE 1-800-366-3436.
VISIT OUR WEB SITE AT AFLACNY.COM.

Form NYsignc

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 NYR35PAPP

American Family Life Assurance Company of New York (Aflac New York)
22 Corporate Woods Boulevard, Suite 2, 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
		❑ M ❑ F	
		❑ M ❑ F	
		❑ M ❑ F	
		❑ M ❑ F	
		❑ M ❑ F	
		❑ M ❑ F	
		❑ M ❑ F	
		❑ M ❑ F	

Signature of Applicant/Named Insured _____ Date _____