Union

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
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 (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

Account Name _____ 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 ❑ Not applicable

If Yes, please read and sign the Replacement Notice provided by our agent, if 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: _____

TO BE COMPLETED BY AFLAC NEW YORK AGENT

Billing Method:
- ❑ Direct
- ❑ List Bill
- ❑ Bank Draft (B/D, ACH)
- ❑ Credit Card (C/C)

Mode:
- ❑ 01 Monthly
- ❑ 03 Quarterly
- ❑ 06 Semiannual
- ❑ 12 Annual

Agent No. _____ Sit. Code _____ Billable Premium $ _____ Premium Collected $ _____

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

Class: ☐ A ☐ B ☐ C ☐ D ☐ E			
Select Only One Policy Series		**Premium**	
❑ Accident Essentials Policy Series NY35B24			☒ After -Tax Only
❑ Plan 1 Accident Policy Series NYR35100			
❑ Plan 2 Accident Policy Series NYR35200			

❑ Additional Accidental-Death Benefit Rider Series NY35054			☒ After -Tax Only
	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

1. Are you currently working at your primary job with the employer listed on the front of this application? ❑ Yes ❑ No

If you answered No to Question 1 above, a policy will not be issued; therefore, do not submit this application.

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
- 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.

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 NYR35UAPP

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

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.

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 NYR35UAPP

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 _____