Payroll

Application for Specified Disease Coverage (NY-75000 Series)
Application to: American Family Life Assurance Company of New York
(Aflac New York)
22 Corporate Woods Boulevard, Ste. 2
Albany, New York 12211

❑ New
❑ Conversion
Policy Number:

To Be Completed by Applicant: Please Print in Black Ink

Proposed Insured's/Employee's Name _____
Last First MI

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

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 coverage; if no spouse or spouse is not to be covered, write "N/A" or "None" in the space below.)

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

Address _____
Street or Post Office Box Apt. No.

City _____ State _____ ZIP Code _____

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 Code _____

Payroll Account Name _____ Payroll Account Number _____

1. Are you (and, if family coverage is applied for, everyone to be insured) currently covered by at least major medical insurance or at least basic hospital and basic medical insurance? ☐ Yes ☐ No
   If yes, please proceed to the next section.

   (a) If you do not have such coverage, a policy will not be issued. If you do have such coverage, but your spouse and/or dependent children do not, please list their names in the space provided:

   _____

   Any person(s) listed will not be covered by this policy.

2. Are you (or, if family coverage is applied for, anyone to be insured) currently covered by (or have an application(s) pending as of the date of application) specified disease insurance either with us or another insurer? ☐ Yes ☐ No
   If yes, please answer the questions below.

   (a) Does the other specified disease insurance provide coverage for Cancer? ☐ Yes ☐ No
   If yes: (1) how many policies are in force? _____; (2) how many policies are pending? _____
   If you answered yes and do not replace your other coverage (or rescind your application(s) pending as of the date of application), then a policy will not be issued. If your spouse and/or dependent children have (or have an application(s) pending as of the date of application) such coverage and are not replacing it (or rescinding their application(s) pending as of the date of application), please list their names here:

   _____

   Any person(s) listed will not be covered by this policy.

(b) Does the other specified disease insurance cover more than 6 diseases? ☐ Yes ☐ No

How many specified diseases are covered? _____ How many specified diseases are included for the coverage to which you have an application pending? _____
If you answered yes and do not replace your other coverage (or rescind your application(s) pending as of the date of application) such that you are no longer covered for more than 6 specified diseases, then a policy will not be issued. If your spouse and/or dependent children have (or have an application(s) pending as of the date of application) such coverage covering more than 6 specified diseases and are not replacing it (or rescinding their application(s) pending as of the date of application), please list their names here:

_____

Any person(s) listed will not be covered by this policy.

IF YOU ARE APPLYING FOR ANY SPECIFIED HEALTH EVENT RIDER PLEASE ANSWER THE FOLLOWING QUESTION:
Does anyone to be covered have any other Specified Health Event coverage with Aflac New York? ❑ Yes ❑ No
If yes, this must be a conversion of that coverage. If yes, give current policy number and see Item 24.
Policy Number: _____

TO BE COMPLETED BY AFLAC NEW YORK AGENT

Check Coverage Desired:	❑ Individual	❑ One-Parent Family
	❑ Two-Parent Family	

❑ Level 1: Policy (Series NY-75100)	CCAIPA	CCAIPD	❑ Pre-tax
❑ Level 2: Policy (Series NY-75200)	CCAIPB	CCAIPE	❑ After-tax
❑ Level 3: Policy (Series NY-75300)	CCAIPC	CCAIPF	

Optional Riders:

❑ Cancer Policy Building Benefit Rider (Series NY75050) Units _____	CCAIPG	CCAIPK	
PLEASE CHOOSE ONLY ONE SPECIFIED HEALTH EVENT RIDER: ❑ Specified Health Event with First Occurrence Building Benefit Rider (Series NY75055)	CCAIP7	CCAIQ3	
❑ Specified Health Event with First Occurrence Building Benefit and Recovery Benefit Rider (Series NY75056)	CCAIP8	CCAIQ4	

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. _____ Agent's No. ___

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

PLEASE COMPLETE THE FOLLOWING QUESTIONS:

3. 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 9 or 19, as applicable, or skip to number 6 if this is a conversion.
   If yes, please complete numbers 4 and 5.

4. Was any Cancer referred to in number 3 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 ❑ Proposed Insured/Employee? ❑ Spouse? ❑ Child? Name of the child(ren):

   _____

   Any individual(s) indicated above will not be covered under the policy or any riders. If the person named is the Proposed Insured/Employee named on the front of this application, a policy will not be issued.

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

   _____

   Please complete a Specified Disease History Form provided by your agent on any individual(s) listed.

5. Have you or anyone to be covered had three or more Skin Cancers, of any type or form, diagnosed or removed in the last 12 months? ❑ Yes ❑ No
   If yes, was it the ❑ Proposed Insured/Employee? ❑ Spouse? ❑ Child? Name of the child(ren):

   _____

   Any individual(s) indicated above will not be covered under the policy or any riders. If the person named is the Proposed Insured/Employee named on the front of this application, a policy will not be issued.

If you answered yes to number 3 and this is a conversion, please complete the conversion section below.

YOU MUST COMPLETE THIS SECTION IF THIS IS A CONVERSION.

6. Have you or any person to be covered under this policy received benefits, other than Wellness or Skin Cancer Benefits, under your existing Aflac New York Specified Disease policy in the last five years? ❑ Yes ❑ No
   If yes, was it the ❑ Proposed Insured/Employee? ❑ Spouse? ❑ Child? Name of the child(ren):

   _____

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

7. 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.
8. I acknowledge that I was offered the Cancer Building Benefit Rider and declined it. I understand that by not applying for the Cancer Building Benefit Rider that I will lose the building benefit amount accrued in my previous Cancer policy, if any.
   ❑ Yes
   Applicant's Initials _____
   ❑ N/A

PLEASE COMPLETE THE FOLLOWING QUESTIONS IF APPLYING FOR ANY SPECIFIED HEALTH EVENT RIDER

9. 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

Impaired kidney function (not including stones or acute infection)
Cerebral vascular insufficiency
Congenital heart disease (excluding surgically corrected atrial septal defect)
Heart Attack (two or more)
Cardiomyopathy
Stroke or TIA (two or more)
Liver disease or disorder (excluding Hepatitis A)
Cystic fibrosis
Systemic lupus

10. Has anyone to be covered ever been diagnosed with or received medical treatment by a member of the medical profession for diabetes (1) requiring the use of insulin within the last five years, or (2) with complications to include retinopathy, neuropathy, or nephropathy, or (3) with continued tobacco use, or (4) diagnosed prior to age 30 (excluding gestational)? ❑ Yes ❑ No

11. Has anyone to be covered ever had or been advised to have a major organ transplant or consulted with or been evaluated by a member of the medical profession of the need to have a major organ transplant? ❑ Yes ❑ No

12. Has anyone to be covered ever been diagnosed with or medically treated for acquired immune deficiency syndrome (AIDS) by a member of the medical profession? ❑ Yes ❑ No

13. In the last five years, has anyone to be covered been diagnosed with or received medical treatment for any of the following by a member of the medical profession? ❑ Yes ❑ No

Angina
Stroke or TIA (single event)
Coronary artery disease
Angioplasty, stent placement or bypass surgery
Chronic obstructive pulmonary disease (COPD)
Atrial fibrillation
Arterial blockage
Heart Attack (single event)
Peripheral vascular disease

14. Within the last two years, has anyone to be covered received chemotherapy treatment by a member of the medical profession for any medical condition, not to include hormonal treatment for cancer? ❑ Yes ❑ No

15. Within the last 12 months, has anyone to be covered been prescribed or received treatment with blood thinners, not including aspirin, by a member of the medical profession? ❑ Yes ❑ No

16. Within the last 12 months, has anyone to be covered received medical treatment by a member of the medical profession 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? ❑ Yes ❑ No

17. 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), or has anyone to be covered ever required treatment by a member of the medical profession with a pacemaker or defibrillator? ❑ Yes ❑ No

18. Within the last six months, has anyone to be covered had or been advised by a member of the medical profession of the need to have diagnostic tests performed to evaluate symptoms of chest pain, shortness of breath, blackouts, fainting, or dizziness? ❑ Yes ❑ No

IF ANY ONE OF QUESTIONS 9 THROUGH 18 IS ANSWERED YES, A SPECIFIED HEALTH EVENT RIDER WILL NOT BE ISSUED.

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	

APPLICANT'S STATEMENTS AND AGREEMENTS

The Effective Date of this policy will be the date recorded on the Policy Schedule by Aflac New York. **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 one year 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.

19. I understand that coverage is not provided for Specified Health Events for which medical advice or treatment was recommended or received from a Physician within the six-month period before the Effective Date of coverage unless the Specified Health Event occurs more than 30 days after the Effective Date of coverage.
20. I understand that unmarried Dependent Children, if any, must be under age 25 at the time of application. Once covered, Dependent Children will continue to be covered until the anniversary date of the policy following their 25th birthday.
21. I acknowledge receipt of, if applicable:
    - ❑ Fair Credit Reporting Notice
    - ❑ *Guide to Health Insurance for People with Medicare*
    - ❑ Conditional Receipt
    - ❑ Disclosure Statement
22. 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 New York may require for proper underwriting; (b) Aflac New York is not bound by any statement made by me, 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, constitutes 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.
23. If this is an application for a conversion of Specified Health Event coverage, the following conditions will apply: (a) If any one of Questions 9 through 18 are answered yes, the policy for which this application is made will be void, and coverage will continue under the terms of the previous policy(ies), which may remain in force. (b) The waiting period and 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. (c) The Pre-existing Conditions provision in the rider(s) will run from the original policy's Effective Date for the similar benefits provided under the original policy, if any.
24. **I understand that the policy for which I am applying is designed to supplement my basic health coverage and should not be viewed as a substitute for such coverage. Applicant's Initials: _____**

OTHER INSURANCE WITH AFLAC NEW YORK: If a person is covered under more than one Cancer policy or rider, only one Aflac New York policy chosen by you, your beneficiary, or your estate, as the case may be, will be effective. We will pay benefits under the policies for claims that may have been incurred since their respective Effective Dates. We will also return all premiums paid for all other such policies.

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 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 make a comparison to personally 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.

The coverage applied for provides specified disease coverage only. If applied for and issued, coverage will be provided for Specified Health Events under optional riders. This coverage does not meet the minimum requirements for basic hospital, basic medical, major medical, Medicare supplement, long term care insurance, nursing home insurance only, home care insurance only, or nursing home and home care insurance in the state of New York. Purchase of this coverage may be unnecessary if you already have or intend to purchase Medicare supplement insurance or long term care insurance.

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 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.

Proposed Insured's/Employee's Signature _____ Date _____

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.

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).