

Peace of Mind *and*  
Real Cash Benefits



PERSONAL CANCER INDEMNITY/  
HOSPITAL INTENSIVE CARE  
PROTECTION INSURANCE

PCI

Prepared for:  
*State of Florida Employees*



Capital Insurance Agency, Inc.  
1.800.780.3100

*Proof approved  
8/16/10  
Bonnie P. Cook*

**Aflac**®

We've got you under our wing.®

Underwritten by:  
American Family Life Assurance Company of Columbus

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## If you're uncertain about your need for cancer expense protection ... take a look at these facts!

**About \$93 billion is spent each year to treat cancer.\***

**There are many different types of major medical coverages.**

**Think about yours and ask yourself ...**

***Will I need help with:***

### **DEDUCTIBLES?**

Most standard health insurance plans have hefty deductibles—some as high as \$300, \$500, or \$1,000—that must be paid before your coverage kicks in.

### **COST-SHARING EXPENSES?**

Once your deductible is satisfied, you may still be responsible for 10 percent or 20 percent of the bills as part of your copayment arrangement.

### **OUT-OF-POCKET EXPENSES?**

Normal, everyday living costs and incidental costs still have to be paid, such as:

- Car payments
- Utility bills
- Mortgage or rent payments
- Grocery bills
- Travel expenses
- Phone bills
- Food
- Household help
- Lodging

### **LOSS OF EARNING POWER?**

If you're seriously injured or ill, the paychecks will eventually stop. And if your spouse has to leave work to care for you, your family may face a double loss of income.

\*Cancer Facts & Figures 2009, American Cancer Society.

## **CANCER'S SEVEN WARNING SIGNALS:**

- C** hange in bowel or bladder habits
- A** sore that does not heal
- U** nusual bleeding or discharge
- T** hickening or lump in breast or elsewhere
- I** ndigestion or difficulty in swallowing
- O** bvious change in a wart or mole
- N** agging cough or hoarseness

**IF YOU HAVE A WARNING SIGNAL,  
SEE YOUR DOCTOR!**

American Cancer Society, 2008.

## **TAKE A LOOK AT THE PROTECTION OFFERED BY AFLAC ...**

### **CANCER PLAN:**

**POLICY A-75100-FL (LEVEL 1)**  
(PEOPLE FIRST PLAN CODE NO. 6500)

**POLICY A-75300-FL (LEVEL 3)**  
(PEOPLE FIRST PLAN CODE NO. 6510)

**OPTIONAL RIDERS TO THE  
CANCER PLAN:  
BUILDING BENEFIT RIDER  
SPECIFIED-DISEASE RIDER**

**HOSPITAL INTENSIVE  
CARE PLAN**

## AFLAC'S PERSONAL CANCER INDEMNITY PLAN POLICY SUMMARIES

<b>BENEFIT</b>	<b>(People First Plan Code No. 6500)</b>	<b>(People First Plan Code No. 6510)</b>
<b>Wellness</b>	<b>A-75100-FL (LEVEL 1)</b> \$40/calendar year per person	<b>A-75300-FL (LEVEL 3)</b> \$75/calendar year per person
<b>First-Occurrence</b>	\$1,500 Primary & Spouse \$2,250 (child)	\$5,000 Primary & Spouse \$7,500 (child)
<b>Hospital Confinement</b>	\$200/day (Days 1–30) \$400/day (Days 31+)	\$300/day \$600/day
<b>Medical Imaging</b>	\$100 1x per year/per person	\$200 1x per year/per person
<b>Radiation/Chemotherapy</b>	\$200/daily treatment Monthly Max = \$1,600 self-injected Max = \$800 pump & oral	\$300/daily treatment Monthly Max = \$2,400 self-injected Max = \$1,200 pump & oral
<b>Experimental Treatment</b>	\$200/daily treatment Monthly Max = \$1,600 self-injected Max = \$800 pump & oral	\$300/daily treatment Monthly Max = \$2,400 self-injected Max = \$1,200 pump & oral
<b>Immunotherapy</b>	\$300/month Lifetime Max \$1,500	\$500/month Lifetime Max \$2,500
<b>Antinausea</b>	\$100/month	\$150/month
<b>Nursing Services – Inpatient</b>	\$100/day	\$150/day
<b>Skin Cancer Surgery</b>	\$100–\$600	\$100–\$600
<b>Surgical/Anesthesia</b>	\$95–\$3,000 25 percent of Surgical Benefit	\$100–\$5,000 25 percent of Surgical Benefit
<b>Outpatient Hospital Surgical</b>	\$200 (in addition to Surgical Benefit)	\$300 (in addition to Surgical Benefit)
<b>Prosthesis</b>		
• Surgical	\$2,500 Lifetime Maximum \$5,000 per covered person	\$3,000 Lifetime Maximum \$6,000 per covered person
• Nonsurgical	\$200 per occurrence Lifetime Maximum \$400 per covered person	\$250 per occurrence Lifetime Maximum \$500 per covered person
<b>Reconstructive Surgery</b>	\$325–\$2,500/procedure, Anesthesia = 25 percent of surgical benefit payable No max on number of operations	\$350–\$3,000/procedure, Anesthesia = 25 percent of surgical benefit payable No max on number of operations
<b>Blood &amp; Plasma</b>		
• In-Hospital	\$50 times the number of days confined	\$150 times the number of days confined
• Outpatient	\$200/day	\$250/day
<b>Second Surgical Opinion</b>	\$200	\$300
<b>NCI Evaluation/ Consultation</b>	Consultation \$500 (once per person) Travel & Lodging \$250 (over 50 miles)	Consultation \$500 (once per person) Travel & Lodging \$250 (over 50 miles)
<b>Ambulance</b>	\$200 Ground \$1,000 Air	\$200 Ground \$1,000 Air
<b>Transportation</b>	(Over 50 miles) \$.40/mile Limit \$1,200/round trip Pays benefit for up to two adults to accompany dependent child if commercial travel is necessary	(Over 50 miles) \$.50/mile Limit \$1,500/round trip Pays benefit for up to two adults to accompany dependent child if commercial travel is necessary
• <b>Dependent Child</b>		
<b>Lodging</b>	\$50/day Limit 90 days/calendar year	\$60/day Limit 90 days/calendar year
<b>Bone Marrow Transplantation</b>	\$10,000 Inpatient or Outpatient Lifetime Maximum \$10,000 per covered person	\$10,000 Inpatient or Outpatient Lifetime Maximum \$10,000 per covered person
<b>Bone Marrow Donor</b>	\$1,000	\$1,000
<b>Stem Cell Transplantation</b>	\$2,500 Lifetime Maximum \$2,500 per covered person	\$5,000 Lifetime Maximum \$5,000 per covered person
<b>Extended-Care Facility</b>	\$100/day Lifetime Maximum 365 days per covered person	\$100/day Lifetime Maximum 365 days per covered person
<b>Hospice</b>	\$500 for first day \$50/day thereafter Lifetime Maximum \$12,000 per covered person	\$1,000 for first day \$50/day thereafter Lifetime Maximum \$12,000 per covered person
<b>Home Health Care</b>	\$50/day (10/confinement/30 per year)	\$50/day (10/confinement/30 per year)
<b>Waiver of Premium</b>	Yes	Yes
<b>Specified-Disease</b>	Covers 32 diseases (Rider)	Covers 32 diseases (Rider)
<b>Building Benefit</b>	\$300/year build (Rider)	\$500/year build (Rider)

# AFLAC'S PERSONAL CANCER INDEMNITY PLAN

Policies A-75100-FL and A-75300-FL

# CI



*This is a preventive benefit; a diagnosis of cancer is not required for this benefit to be payable.*

**CANCER SCREENING WELLNESS BENEFIT:** *Aflac will pay \$40 (A-75100-FL) or \$75 (A-75300-FL) per calendar year when a charge is incurred for one of the following: mammogram, breast ultrasound, Pap smear, ThinPrep, biopsy, flexible sigmoidoscopy, hemocult stool specimen, chest X-ray, CEA (blood test for colon cancer), CA 125 (blood test for ovarian cancer), PSA (blood test for prostate cancer), thermography, colonoscopy, or virtual colonoscopy. These tests must be performed to determine whether cancer exists in a covered person. This benefit is limited to one payment per calendar year, per covered person.*

**FIRST-OCCURRENCE BENEFIT:** *Aflac will pay \$1,500 (A-75100-FL) or \$5,000 (A-75300-FL) for the insured, \$1,500 (A-75100-FL) or \$5,000 (A-75300-FL) for the spouse, or \$2,250 (A-75100-FL) or \$7,500 (A-75300-FL) for children when a covered person is diagnosed with internal cancer. This benefit is payable only once for each covered person and will be paid in addition to any other benefit in the policy. Internal cancer includes melanomas classified as Clark's Level III and higher, or a Breslow level greater than 1.5 mm. In addition to the pathological or clinical diagnosis required by the policy, we may require additional information from the attending physician and hospital. Any covered person who has had a previous diagnosis of cancer will not be eligible for a First-Occurrence Benefit under the policy for a recurrence, extension, or metastatic spread of that same cancer.*

## PEACE of MIND. CASH BENEFITS.

OUR INSURANCE POLICIES HELP PROVIDE BOTH.



**HOSPITAL CONFINEMENT BENEFIT:** *Aflac will pay \$200 (A-75100-FL) or \$300 (A-75300-FL) per day when a covered person is confined to a hospital for treatment of cancer and is charged for a room as an inpatient. Benefits increase to \$400 (A-75100-FL) or \$600 (A-75300-FL) per day beginning with the 31st day of continuous confinement.*

A person confined to a U.S. government hospital does not need to be charged for the Hospital Confinement Benefit to be payable.

When cancer treatment is received in a U.S. government hospital, the remaining benefits (except the Cancer Screening Wellness Benefit) are not payable unless the covered person is actually charged and is legally required to pay for such services.

**MEDICAL IMAGING BENEFIT:** *Aflac will pay \$100 (A-75100-FL) or \$200 (A-75300-FL) per calendar year when a charge is incurred for each covered person who receives an initial diagnosis or follow-up evaluation of internal cancer using one of the following medical imaging exams: CT scans, MRIs, bone scans, multiple gated acquisition (MUGA) scans, positron emission tomography (PET) scans, or transrectal ultrasounds. These exams must be performed in a hospital, an ambulatory surgical center, or a physician's office. This benefit is payable once per calendar year, per covered person.*

**RADIATION AND CHEMOTHERAPY BENEFIT:** *Aflac will pay \$200 (A-75100-FL) or \$300 (A-75300-FL) per day as follows when a charge is incurred for a covered person who receives one or more of the following cancer*

treatments for the purpose of modification or destruction of abnormal tissue:

1. Cytotoxic chemical substances and their administration in the treatment of cancer:
  - a. Injection by medical personnel in a physician's office, clinic, or hospital.
  - b. Self-injected medications [limited to \$200 (A-75100-FL) or \$300 (A-75300-FL) per daily treatment, subject to a monthly maximum of \$1,600 (A-75100-FL) or \$2,400 (A-75300-FL) for all medications].
  - c. Medications dispensed by a pump or implant [limited to \$200 (A-75100-FL) or \$300 (A-75300-FL) for the initial prescription and \$200 (A-75100-FL) or \$300 (A-75300-FL) for each pump refill, subject to a monthly maximum of \$800 (A-75100-FL) or \$1,200 (A-75300-FL) for all medications].
  - d. Oral chemotherapy, regardless of where administered [limited to \$200 (A-75100-FL) or \$300 (A-75300-FL) per prescription, subject to a monthly maximum of \$800 (A-75100-FL) or \$1,200 (A-75300-FL) for all prescriptions].
2. Radiation therapy.
3. The insertion of interstitial or intracavitary application of radium or radioisotopes.

If delivery of radiation or chemotherapy is other than listed above, benefits will be subject to a monthly maximum of \$800 (A-75100-FL) or \$1,200 (A-75300-FL). Treatments must be FDA- or NCI-approved for the treatment of cancer. This benefit does not pay for laboratory tests, diagnostic X-rays, immunoglobulins, immunotherapy, colony-stimulating factors, therapeutic devices, simulations, dosimetries, treatment plannings, or other procedures related to these therapy treatments. Benefits will not be paid for each day the radium or radioisotope remains in the body or for each day of continuous infusion of medications dispensed by a pump or implant. No lifetime maximum. This benefit is not payable the same day the Experimental Treatment Benefit is paid.

**EXPERIMENTAL TREATMENT BENEFIT** *Aflac will pay \$200 (A-75100-FL) or \$300 (A-75300-FL) per day* when a charge is incurred for a covered person who receives one or more of the following experimental cancer treatments, prescribed by a physician, for the purpose of modification or destruction of abnormal tissue:

- Treatment administered by medical personnel in a physician's office, clinic, or hospital.
- Self-injected medications [limited to \$200 (A-75100-FL) or \$300 (A-75300-FL) per daily treatment, subject to a monthly maximum of \$1,600 (A-75100-FL) or \$2,400 (A-75300-FL)].

- Medications dispensed by a pump [limited to \$200 (A-75100-FL) or \$300 (A-75300-FL) for the initial prescription and \$200 (A-75100-FL) or \$300 (A-75300-FL) for each refill, subject to a monthly maximum of \$800 (A-75100-FL) or \$1,200 (A-75300-FL)].
- Oral medications, regardless of where administered [limited to \$200 (A-75100-FL) or \$300 (A-75300-FL) per prescription, subject to a monthly maximum of \$800 (A-75100-FL) or \$1,200 (A-75300-FL) for all prescriptions].

Treatments must be approved by the National Cancer Institute (NCI) as viable experimental treatments for cancer. This benefit does not pay for laboratory tests, diagnostic X-rays, immunoglobulins, immunotherapy, colony-stimulating factors, therapeutic devices, or other procedures related to these therapy treatments. Benefits will not be paid for each day of continuous infusion of medications dispensed by a pump or implant. No lifetime maximum. This benefit is not payable the same day the Radiation and Chemotherapy Benefit is paid.

**IMMUNOTHERAPY BENEFIT:** *Aflac will pay \$300 (A-75100-FL) or \$500 (A-75300-FL) per calendar month* during which a charge is incurred for a covered person who receives immunoglobulins or colony-stimulating factors as prescribed by a physician as part of a treatment regimen for internal cancer. Any medications paid under the Radiation and Chemotherapy Benefit or the Experimental Treatment Benefit will not be paid under the Immunotherapy Benefit. Lifetime maximum of \$1,500 (A-75100-FL) or \$2,500 (A-75300-FL) per covered person.

**ANTINAUSEA BENEFIT:** *Aflac will pay \$100 (A-75100-FL) or \$150 (A-75300-FL) per calendar month* during which a charge is incurred for a covered person who receives anti-nausea drugs that are prescribed while receiving radiation or chemotherapy treatments.

**NURSING SERVICES BENEFIT:** *Aflac will pay \$100 (A-75100-FL) or \$150 (A-75300-FL) per 24-hour day* if, while confined in a hospital, a covered person requires and is charged for private nursing services other than those regularly furnished by the hospital. Services must be required and authorized by the attending physician. This benefit is not payable for private nurses who are members of your immediate family. This benefit is payable for only the number of days the Hospital Confinement Benefit is payable.

**SURGICAL/ANESTHESIA BENEFIT:** *Aflac will pay the indemnity (\$95 to \$3,000 – A-75100-FL or \$100 to \$5,000 – A-75300-FL) listed in the Schedule of Operations* when a surgical operation is performed on a covered person for a diagnosed internal cancer and a charge is incurred. If any operation for the treatment of cancer is performed other than those listed, Aflac will

pay an amount comparable to the amount shown for the operation most similar in severity and gravity. (Exceptions: Surgery for skin cancer will be payable under the Skin Cancer Surgery Benefit. Reconstructive surgery will be paid under the Reconstructive Surgery Benefit.) Two or more surgical procedures performed through the same incision will be considered one operation, and the highest eligible benefit will be paid.

*Aflac will pay an indemnity benefit equal to 25 percent of the amount shown in the Schedule of Operations for the administration of anesthesia during a covered surgical operation. The combined benefits payable in the Surgical/Anesthesia Benefit for any one operation will not exceed \$3,750 (A-75100-FL) or \$6,250 (A-75300-FL).*

**OUTPATIENT HOSPITAL SURGICAL BENEFIT** *Aflac will pay \$200 (A-75100-FL) or \$300 (A-75300-FL) when a surgical operation is performed on a covered person for a diagnosed internal cancer and an operating room charge is incurred. Surgeries must be performed on an outpatient basis in a hospital, to include an ambulatory surgical center. This benefit is not payable for surgery performed in a physician's office or for skin cancer surgery. This benefit is payable in addition to the Surgical/Anesthesia Benefit, is payable once per day, and is not payable on the same day as the Hospital Confinement Benefit.*

**PROSTHESIS BENEFIT:** *Aflac will pay \$2,500 (A-75100-FL) or \$3,000 (A-75300-FL) when a charge is incurred for surgically implanted prosthetic devices that are prescribed as a direct result of surgery for cancer treatment. Lifetime maximum of \$5,000 (A-75100-FL) or \$6,000 (A-75300-FL) per covered person.*

*Aflac will pay \$200 (A-75100-FL) or \$250 (A-75300-FL) when a charge is incurred for nonsurgically implanted prosthetic devices that are prescribed as a direct result of cancer treatment. Lifetime maximum of \$400 (A-75100-FL) or \$500 (A-75300-FL) per covered person.*

The Prosthesis Benefit does not include coverage for a breast transverse rectus abdominus myocutaneous (TRAM) flap procedure listed under the Reconstructive Surgery Benefit.

**RECONSTRUCTIVE SURGERY BENEFIT:** *Aflac will pay the indemnity (\$325 to \$2,500 – A-75100-FL or \$350 to \$3,000 – A-75300-FL) listed when a surgical operation is performed on a covered person for reconstructive surgery for the treatment of cancer and a charge is incurred for the specific procedure. Aflac will pay an indemnity benefit equal to 25 percent of the amount shown in the policy for the administration of anesthesia during a covered reconstructive surgical operation. If any reconstructive surgery is performed other than those listed, Aflac will pay an amount comparable to the amount shown in the policy for the operation most similar in severity and gravity.*

**IN-HOSPITAL BLOOD AND PLASMA BENEFIT:** *Aflac will pay \$50 (A-75100-FL) or \$150 (A-75300-FL) times the number of days paid under the Hospital Confinement Benefit if a covered person receives blood and/or plasma during a covered hospital confinement and a charge is incurred. This benefit does not pay for immunoglobulins, immunotherapy, or colony-stimulating factors.*

**OUTPATIENT BLOOD AND PLASMA BENEFIT:** *Aflac will pay \$200 (A-75100-FL) or \$250 (A-75300-FL) for each day a covered person receives blood and/or plasma transfusions for the treatment of cancer as an outpatient in a physician's office, clinic, hospital, or ambulatory surgical center, and a charge is incurred. This benefit does not pay for immunoglobulins, immunotherapy, or colony-stimulating factors.*

**SECOND SURGICAL OPINION BENEFIT:** *Aflac will pay \$200 (A-75100-FL) or \$300 (A-75300-FL) when a charge is incurred for a second surgical opinion concerning cancer surgery for a diagnosed cancer by a licensed physician. This benefit is not payable the same day the NCI Evaluation/ Consultation Benefit is payable.*

**TRANSPORTATION BENEFIT:** *Aflac will pay 40 cents per mile (A-75100-FL) or 50 cents per mile (A-75300-FL) for round-trip transportation between the hospital or medical facility and the residence of the covered person when a covered person requires cancer treatment that has been prescribed by the local attending physician. Benefits are limited to \$1,200 (A-75100-FL) or \$1,500 (A-75300-FL) per round trip. This benefit will be paid only for the covered person for whom the treatment is prescribed. If the treatment is for a dependent child and commercial travel (coach-class plane, train, or bus fare) is necessary, Aflac will pay this benefit for up to two adults to accompany the dependent child. This benefit is not payable for transportation to any hospital/facility located within a 50-mile radius of the residence of the covered person or for transportation by ambulance to or from any hospital.*

**LODGING BENEFIT:** *Aflac will pay \$50 (A-75100-FL) or \$60 (A-75300-FL) per day when a charge is incurred for lodging for you or any one adult family member when a covered person receives cancer treatment at a hospital or medical facility more than 50 miles from the covered person's residence. This benefit is not payable for lodging occurring more than 24 hours prior to treatment or for lodging occurring more than 24 hours following treatment. This benefit is limited to 90 days per calendar year.*

**STEM CELL TRANSPLANTATION BENEFIT:** *Aflac will pay \$2,500 (A-75100-FL) or \$5,000 (A-75300-FL) when a charge is incurred if a covered person receives a peripheral stem cell transplantation for the treatment of cancer. This benefit does not include the harvesting, storage, and subsequent reinfusion of bone marrow from the recipient*

or a matched donor under general anesthesia. This benefit is payable once per covered person. Lifetime maximum of \$2,500 (A-75100-FL) or \$5,000 (A-75300-FL) per covered person.

**HOSPICE BENEFIT:** *Aflac will pay a one-time benefit of \$500 (A-75100-FL) or \$1,000 (A-75300-FL) for the first day and \$50 per day thereafter for hospice care when a covered person is diagnosed with cancer, therapeutic intervention directed toward the cure of the disease is medically determined no longer appropriate, and the covered person's prognosis is one in which there is a life expectancy of six months or less as the direct result of cancer. This benefit is not payable the same day the Home Health Care Benefit is payable. Lifetime maximum of \$12,000 per covered person.*

*All of the following benefits are the same for A-75100-FL and A-75300-FL.*

**SKIN CANCER SURGERY BENEFIT:** *Aflac will pay the indemnity (\$100 to \$600) listed when a surgical operation is performed on a covered person for a diagnosed skin cancer and a charge is incurred for the specific procedure. The benefit listed in the policy includes anesthesia services.*

Exception: If skin cancer is diagnosed during hospitalization, benefits shall be limited to the day(s) the covered person actually received treatment for skin cancer [such as a malignant tumor, ulcer, pimple, or mole that may arise on the surface of the body (skin), including melanomas classified as Clark's Levels I and II, or a Breslow level less than or equal to 1.5 mm]. No benefits will be payable for expenses incurred prior to the 30th day after the effective date shown in the Policy Schedule.

**NATIONAL CANCER INSTITUTE (NCI) EVALUATION/CONSULTATION BENEFIT:** *Aflac will pay \$500 when a covered person seeks evaluation or consultation at an NCI-designated cancer center as a result of receiving a prior diagnosis of internal cancer. The purpose of the evaluation/consultation must be to determine the appropriate course of cancer treatment. If the NCI-designated cancer center is more than 50 miles from the covered person's residence, Aflac will pay \$250 for the transportation and lodging of the covered person receiving the evaluation/consultation.*

This benefit is also payable at the Aflac Cancer Center & Blood Disorders Service of Children's Healthcare of Atlanta. This benefit is not payable the same day the Second Surgical Opinion Benefit is payable. This benefit is payable only once under the policy per covered person.

**AMBULANCE BENEFIT:** *Aflac will pay \$200 for ground ambulance transportation or \$1,000 for air ambulance transportation when a charge is incurred for ambulance transportation of a covered person to or from a hospital where the covered person is confined overnight for cancer treatment. The ambulance service must be performed by a licensed professional ambulance company. This benefit is limited to two trips per confinement.*

**BONE MARROW TRANSPLANTATION BENEFIT:** *Aflac will pay \$10,000 when a covered person incurs a charge for a bone marrow transplantation for the treatment of cancer. This does not include the harvesting of peripheral blood cells or stem cells and subsequent reinfusion. Aflac will pay the covered person's bone marrow donor the greater of \$1,000 or medical costs, to the same extent and limitations as costs associated with the covered person for a covered bone marrow transplant. Lifetime maximum of \$10,000 per covered person.*

**EXTENDED-CARE FACILITY BENEFIT:** *Aflac will pay \$100 per day when a charge is incurred if a covered person receives Hospital Confinement Benefits and, within 30 days of hospital confinement, is confined to an extended-care facility, a skilled nursing facility, a rehabilitation unit or facility, a transitional care unit or any bed designated as a swing bed, or to a section of the hospital used as such. This benefit is limited to the same number of days that the covered person received Hospital Confinement Benefits. For each day this benefit is payable, Hospital Confinement Benefits are not payable. If more than 30 days separates a stay in an extended-care facility, benefits are not payable for the second confinement unless the covered person was again confined to a hospital prior to the second such confinement. Lifetime maximum of 365 days per covered person.*

**HOME HEALTH CARE BENEFIT:** *Aflac will pay \$50 per day when a charge is incurred for home health care or health supportive services when provided on a covered person's behalf within seven days of release from the hospital for the treatment of cancer. The attending physician must prescribe such services to be performed in the home of the covered person and certify that, if these services were not available, the covered person would have to be hospitalized to receive the necessary care, treatment, and services. These services must be performed by a person who is licensed, certified, or otherwise duly qualified to perform such services on the same basis as if the services had been performed in a health care facility. This benefit is not payable the same day the Hospice Benefit is payable. This benefit is limited to ten visits per hospitalization and 30 visits in any calendar year for each covered person.*

*The following benefits have no lifetime maximum: Hospital Confinement, Medical Imaging, Radiation and Chemotherapy, Experimental Treatment, Antinausea, Nursing Services, Surgical/Anesthesia, Outpatient Hospital Surgical, Skin Cancer Surgery, Reconstructive Surgery, In-Hospital Blood and Plasma, Outpatient Blood and Plasma, Second Surgical Opinion, Ambulance, Transportation, Lodging, Home Health Care, and Cancer Screening Wellness.*

**WAIVER OF PREMIUM BENEFIT:** If you, due to having internal cancer, are completely unable to do all of the usual and customary duties of your occupation [or, if you are not employed: are completely unable to perform two or more of the activities of daily living (ADLs) without the assistance of another person] for a period of 90 continuous days, Aflac will waive, from month to month, any premiums falling due during your continued inability. For premiums to be waived, Aflac will require an employer's statement (if applicable) and a physician's statement of your inability to perform said duties or activities, and may each month thereafter require a physician's statement that total inability continues. Aflac may ask for and use an independent consultant to determine whether you can perform an ADL without assistance.

Aflac will also waive, from month to month, any premiums falling due while you are receiving hospice benefits under the Hospice Benefit.

**GUARANTEED-RENEWABLE:** The policy is guaranteed-renewable for your lifetime, subject to Aflac's right to change premiums by class upon any renewal date.

**EFFECTIVE DATE:** The effective date of the policy is the date shown in the Policy Schedule, not the date the application is signed. The policy is available through age 70 on payroll deduction and through age 64 on direct billing. The payroll rate may be retained after one month's premium payment on payroll deduction.

**FAMILY COVERAGE:** Family coverage includes the insured, spouse, and dependent children. Newborn children are automatically insured from the moment of birth. One-parent family coverage includes the insured and all dependent children.

**LIMITATIONS AND EXCLUSIONS:** Aflac pays only for treatment of cancer, including direct extension, metastatic spread, or recurrence. Benefits are not provided for premalignant conditions; conditions with malignant potential; complications of cancer; or any other disease, sickness, or incapacity. Pathological proof of diagnosis must be submitted. Clinical diagnosis will be accepted when a pathological diagnosis cannot be made, provided medical evidence sustains the diagnosis and the covered person receives treatment for cancer.

The 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 two years 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.

The First-Occurrence Benefit is not payable for: (1) any internal cancer diagnosed or treated before the effective date of the policy and the subsequent recurrence, extension, or metastatic spread of such internal cancer that is diagnosed prior to the effective date of the policy; (2) cancer diagnosed during the policy's 30-day waiting period; or (3) the diagnosis of skin cancer or melanomas classified as Clark's Levels I and II, or a Breslow level less than or equal to 1.5 mm. Any covered person who has had a previous diagnosis of cancer will not be eligible for a First-Occurrence Benefit under the policy for a recurrence, extension, or metastatic spread of that same cancer.

A hospital does not include any institution, or part thereof, used as a hospice unit, including any bed designated as a hospice bed; a swing bed; a convalescent home; a rest or nursing facility; a psychiatric unit; a rehabilitation unit or facility; an extended-care facility; a skilled nursing facility; or a facility primarily affording custodial or educational care, care or treatment for persons suffering from mental diseases or disorders, care for the aged, or care for persons addicted to drugs or alcohol.

A physician does not include a member of your immediate family.

# OPTIONAL RIDER BENEFITS TO YOUR CANCER PLAN

## FIRST-OCCURRENCE BUILDING BENEFIT RIDER

Rider A-75050

*Riders become a part of the policy and are subject to all policy provisions unless otherwise stated. The effective date of the rider is the effective date of the policy to which it is attached or the effective date of the rider as stated on the Policy Schedule, if later. The rider will terminate if the policy to which it is attached terminates or if the premiums for the rider are not paid.*

**FIRST-OCCURRENCE BUILDING BENEFIT:** This benefit can be purchased in units of \$100 each, up to a maximum of five units or \$500. All amounts cited in the rider are for one unit of coverage. If more than one unit has been purchased, then the amounts listed must be multiplied by the number of units in force. The First-Occurrence Benefit will be increased by \$100 for each unit purchased on each rider anniversary date while the rider remains in force. This benefit will be paid under the same terms as the First-Occurrence Benefit. This benefit will cease to build for each covered person on the anniversary date of the rider following the covered person's 65th birthday or at the time internal cancer is diagnosed for that covered person, whichever occurs first. However, regardless of the age of the covered person on the effective date of the rider, this benefit will accrue for a period of at least five years unless internal cancer is diagnosed prior to the fifth year of coverage.

Note: For State of Florida Employees:

Policy A-75100-FL (Level 1) is sold with three units only.

Policy A-75300-FL (Level 3) is sold with five units only.

The rider is guaranteed-renewable for your lifetime, subject to Aflac's right to change premiums by class upon any renewal date.

# OPTIONAL RIDER BENEFITS TO YOUR CANCER PLAN

## SPECIFIED-DISEASE RIDER

Rider A-75052

*The rider becomes a part of the policy and is subject to all policy provisions unless otherwise stated.*

While coverage is in force, if an insured person is first diagnosed with one or more of the covered specified diseases and is hospitalized for treatment of the covered specified disease, Aflac will pay the amounts listed below.

### INITIAL HOSPITALIZATION BENEFIT: \$1,000

The covered person must be confined for 12 hours or more. This benefit is payable only once per period of confinement and once per calendar year for each covered person.

A period of confinement is a hospital confinement that starts while the policy is in force. If the confinement follows a previously covered confinement, it will be deemed a continuation of the first confinement unless it is the result of an entirely different sickness or injury, or unless the confinements are separated by 30 days or more.

### HOSPITAL CONFINEMENT BENEFIT

\$200 per day for Days 1–30

\$500 per day for Days 31+

Specified disease is defined as one or more of the diseases listed below:

1. Adrenal hypofunction (Addison's disease)
2. Amyotrophic lateral sclerosis (ALS or Lou Gehrig's disease)
3. Botulism
4. Bubonic plague
5. Cerebral palsy
6. Cholera
7. Cystic fibrosis
8. Diphtheria
9. Encephalitis (including encephalitis contracted from West Nile virus)
10. Huntington's chorea
11. Legionnaires' disease
12. Malaria
13. Meningitis (bacterial)
14. Multiple sclerosis
15. Muscular dystrophy

16. Myasthenia gravis
17. Necrotizing fasciitis
18. Osteomyelitis
19. Polio
20. Rabies
21. Reye's syndrome
22. Scarlet fever
23. Scleroderma
24. Sickle cell anemia
25. Systemic lupus
26. Tetanus
27. Toxic shock syndrome
28. Tuberculosis
29. Tularemia
30. Typhoid fever
31. Variant Creutzfeldt-Jakob disease (mad cow disease)
32. Yellow fever

For benefits to be paid, these diseases must be first diagnosed by a physician 30 days following the effective date of the rider. The diagnosis must be made by and upon a tissue specimen, culture, and/or titer. If any of these diseases is diagnosed before the rider has been in effect for 30 days, benefits for that disease will be paid only for loss incurred after the rider has been in force two years.

### TERMINATION

The rider will terminate if the policy to which it is attached terminates or if the premium for the rider is not paid.

### EFFECTIVE DATE

The effective date of the rider is the effective date of the policy or the effective date of the rider, as stated in the Policy Schedule, if later.

# AFLAC'S PERSONAL HOSPITAL INTENSIVE CARE PROTECTION

Hospital Intensive Care Insurance Policy A-1820B-FL

## DAILY HOSPITAL INTENSIVE CARE UNIT BENEFIT

Benefits will be paid if you or any covered person incurs a charge for confinement in a hospital intensive care unit (ICU). This benefit is limited to 15 days per period of confinement. No lifetime maximum.

**\$600 per day (Days 1–7)**

**\$1,000 per day (Days 8–15)**

Exception: During the first ten months the policy is in force, if a covered child is confined in a hospital intensive care unit within the first 28 days after birth, we will pay \$250 per day for hospital intensive care unit confinement of Days 1 through 15.

## DAILY SUBACUTE INTENSIVE CARE UNIT BENEFIT

Benefits will be paid for up to a total of 15 days when a covered person incurs a charge for the following:

(1) confinement in a subacute intensive care unit (step-down unit) or (2) confinement in a hospital intensive care unit (ICU) after exhaustion of benefits payable under the Daily Hospital Intensive Care Unit Benefit above.

**\$250 per day**

Benefits payable for the Daily Subacute Intensive Care Unit/ Hospital Intensive Care Unit Benefit (combination of 1 and 2) are limited to a total of 15 days per covered period of confinement. No lifetime maximum.

Note: Benefits payable under the Daily Hospital Intensive Care Unit Benefit or Daily Subacute Intensive Care Unit/ Hospital Intensive Care Unit Benefit are not payable on the same day. If a covered person is charged for both on the same day, Aflac will pay only the highest eligible benefit. Confinements not separated by 30 days or more from a previously covered confinement are considered a continuation of the previous period of confinement.

## HUMAN ORGAN TRANSPLANT BENEFIT

A benefit will be paid as a result of a human organ transplant procedure when a covered person is confined in a hospital and receives one or more of the following: kidney, liver, heart, heart-lung, lung, or pancreas transplant.

**\$25,000 per occurrence**

Transplant procedures involving more than one organ will be considered to be one organ transplant procedure. This benefit is not payable for transplants involving

mechanical or animal organs and is limited to one procedure per 180-day period. No lifetime maximum.

## AMBULANCE BENEFIT

Benefits will be paid for the actual charges incurred for ground ambulance transportation of a covered person to and from a hospital where the covered person is confined in a hospital intensive care unit or subacute intensive care unit.

**Up to \$250**

Benefits will be paid for the actual charges incurred for air ambulance transportation of a covered person to and from a hospital where the covered person is confined in a hospital intensive care unit or subacute intensive care unit.

**Up to \$2,000**

This benefit is limited to two trips per confinement. The ambulance service must be performed by a licensed professional or licensed volunteer ambulance company. No lifetime maximum.

## CONTINUATION OF COVERAGE BENEFIT

If you are paying your premiums through payroll deduction and you leave your employer for any reason after your policy has been in force for six months and Aflac has received premiums for six consecutive months, Aflac will waive all monthly premiums due for the policy and riders, if any, up to the date your premium payments are re-established. You or your employer must notify us in writing within 30 days of the date your premium payments cease due to your leaving employment. For you to take advantage of this benefit, you must re-establish premium payments within two months from the date you left the employer who was remitting your premiums. You can re-establish your premium payments through your new employer's payroll deduction process or direct payment to Aflac.

This benefit will again become available once you have re-established your premium payments through an employer's payroll deduction process for a period of six months and Aflac has received premiums for six consecutive months. Payroll deduction means your premium is remitted to Aflac for you by your employer through a payroll deduction process.

## LIMITATIONS AND EXCLUSIONS

All benefits payable under the policy will be reduced by one-half for losses that start on or after the policy anniversary date following the 70th birthday of a covered person. Benefits are not payable for losses that begin before the policy effective date shown in the Policy Schedule. The policy will not cover any person who has attained age 65 prior to the effective date of the policy unless the policy is issued on a payroll deduction basis. If issued on a payroll deduction basis, the policy will not cover any person who has attained age 70 prior to the effective date of the policy.

No benefits will be payable for losses caused by or resulting from: intentionally self-inflicted bodily injury or attempted suicide; participation in or the attempt to participate in any illegal activity that is classified as a felony, whether charged or not (the term *felony* is as defined by the law of the jurisdiction in which the activity takes place); exposure to war or any act of war, declared or undeclared, or service in the armed forces; the treatment of mental or nervous disorder or disease; alcoholism or drug dependency; any loss sustained or contracted due to a covered person's being intoxicated or under the influence of alcohol, drugs or any narcotic unless administered on the advice of a physician and taken according to the physician's instructions (the term *intoxicated* refers to that condition as defined by the law of the jurisdiction in which the injury or cause of the loss occurred); confinement in units such as surgical recovery rooms, privately monitored rooms, observation units, labor or delivery rooms, or other facilities that do not meet the standards for a hospital intensive care unit or subacute intensive care unit (step-down unit). Newborn children will not be covered for routine nursing or routine well-baby care, but we will pay the policy benefits because of their sickness or injury, including congenital anomaly.

The term *hospital* is defined as a legally licensed hospital which is accredited by the Joint Commission on Accreditation of Hospitals, the American Osteopathic Association, or the Commission on the Accreditation of Rehabilitative Facilities. The term *hospital* includes ambulatory surgical centers. Provided that medical or rehabilitative treatment for the disease covered by the policy is actually being received by an insured, we will not deny any claim for payment when the treatment is provided in any hospital meeting the above definitions. No claim will be denied because such hospital lacks major surgical facilities and is primarily of a rehabilitative nature, if such rehabilitation is specifically for treatment of a physical disability.

## GUARANTEED-RENEWABLE FOR YOUR LIFETIME WITH BENEFITS REDUCED AT AGE 70

The policy is guaranteed-renewable for your lifetime with benefits reduced at age 70. It is subject to Aflac's right to change the applicable table of premium rates by class upon any renewal date.

## FAMILY COVERAGE

Family coverage includes the insured, spouse, and all dependent children. Newborn children are automatically covered under the terms of the policy from the moment of birth. Adopted children are covered from the date of petition.

## EFFECTIVE DATE

The effective date of the policy is the date shown in the Policy Schedule, not the date the application is signed. The payroll rate may be retained after one month's premium payment on payroll deduction.

**American Family Life Assurance Company of Columbus (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
- 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 will not be effective until \_\_\_\_\_,  
if issued. No benefits will be due 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.

Policyholder's Printed Name: \_\_\_\_\_

Address: \_\_\_\_\_

Policy Number: \_\_\_\_\_

Signature of Applicant: \_\_\_\_\_

Date Signed: \_\_\_\_\_

Signature of Associate: \_\_\_\_\_





**Application for Cancer Indemnity Insurance (A-75000 Series)**  
 Application to: American Family Life Assurance Company of Columbus (AFLAC)  
 Worldwide Headquarters: Columbus, Georgia 31999

New  
 Conversion  
 Policy Number: \_\_\_\_\_

**To Be Completed by Applicant: Please Print in Black Ink**

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 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 \_\_\_\_\_ Apt. No. \_\_\_\_\_  
Street or Post Office Box

City \_\_\_\_\_ State \_\_\_\_\_ ZIP Code \_\_\_\_\_

Home Telephone ( ) \_\_\_\_\_ Work 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 \_\_\_\_\_ State of Florida \_\_\_\_\_ EEID \_\_\_\_\_ Payroll Account 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 and provide policy number and company name here: \_\_\_\_\_

**TO BE COMPLETED BY AFLAC AGENT**

**Check Coverage Desired:**

<input type="checkbox"/> Individual	<input type="checkbox"/> One-Parent Family
<input type="checkbox"/> Two-Parent Family	

Level 1: Policy (Series A-75100)	<input type="checkbox"/> CCAIPA	<input type="checkbox"/> CCAIPD	<input checked="" type="checkbox"/> Pre-tax <input type="checkbox"/> After-tax
Level 3: Policy (Series A-75300)	<input type="checkbox"/> CCAIPC	<input type="checkbox"/> CCAIPF	

**Optional Rider:**

<b>Building Benefit Rider (Series A-75050) Units _____</b>	<input type="checkbox"/> CCAIPG	<input type="checkbox"/> CCAIPK
<b>Specified-Disease Rider (Series A-75052)</b>	<input type="checkbox"/> CCAIPJ	<input type="checkbox"/> CCAIPM

New rider  Retain current rider

<b>Billing Method:</b>	<b>Mode:</b>	<input type="checkbox"/> 01 Semimonthly	<input type="checkbox"/> 06 Semiannual
<input checked="" type="checkbox"/> Payroll Deduction	<input type="checkbox"/> 01 Weekly	<input checked="" type="checkbox"/> 01 Monthly	<input type="checkbox"/> 12 Annual
	<input type="checkbox"/> 01 14-Day Biweekly	<input type="checkbox"/> 03 Quarterly	
	<input type="checkbox"/> 01 28-Day Biweekly		

Employee No. \_\_\_\_\_ Dept. No. \_\_\_\_\_ Agent's No. \_\_\_\_\_

Billable Premium \$ \_\_\_\_\_ Premium Collected \$ \_\_\_\_\_ Sit. Code \_\_\_\_\_

**PLEASE COMPLETE THE FOLLOWING QUESTIONS:**

1. 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 7 or number 5 if this is a conversion. If yes, please complete numbers 2 and 3.
2. Was any Cancer referred to in number 1 an internal Cancer (which includes melanoma of Clark's Level III or higher, or a Breslow level greater than 1.5 mm):  Yes  No
- (a) diagnosed or treated within the last five years (two years for breast cancer) or for which preventive Hormonal Therapy has been received within the last 12 months?  Yes  No  
If yes, was it the  Named Insured  Spouse  Child? Name of the child(ren):

---

**Any individual(s) indicated above will not be covered under the policy.**

- (b) last diagnosed or treated over five years (two years for breast cancer) ago?  Yes  No  
If yes, was it the  Named Insured  Spouse  Child? Name of the child(ren):

---

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

3. Was any Cancer referred to in number 1 a Skin Cancer (which includes melanoma of Clark's Level I or II, or a Breslow level less than or equal to 1.5 mm):  Yes  No
- (a) diagnosed or treated within the last five years?  Yes  No  
If yes, was it the  Named Insured  Spouse  Child? Name of the child(ren):

---

**Any individual(s) indicated above will be issued a Skin Cancer Exclusion Rider. Benefits will not be payable under this policy for the indicated individual for the treatment of Skin Cancer.**

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

---

**Any individual(s) indicated above will not be issued a Skin Cancer Exclusion Rider. Benefits will be payable under this policy for the indicated individual for the treatment of Skin Cancer.**

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If you answered yes to number 1 and this is a conversion, please complete the conversion section below.

**YOU MUST COMPLETE THIS SECTION IF THIS IS A CONVERSION.**

**IF** your answer to number 1 above was "yes," complete number 4 below. If no, skip to number 5.

4. Have you or any person to be covered under this policy received benefits, other than Wellness Benefits, under your existing AFLAC Cancer policy in the last five years (two years for breast cancer)?  Yes  No  
If yes, was it  Named Insured  Spouse  Child? Name of the child(ren):

---

**Any individual(s) indicated above will not be covered under the policy.**

5. 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.
6. I acknowledge that I was offered the Building Benefit Rider and declined it. I understand that by not applying for the Building Benefit Rider that I will lose the building benefit amount accrued in my previous policy, if any.  
 Yes  
Applicant's Initials \_\_\_\_\_  
 N/A

7. I understand that the Effective Date of this policy will be the date recorded on the Policy Schedule by AFLAC. **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 two years 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.
8. I acknowledge receipt of, if applicable:
- |   |  |
|---|--|
| <input type="checkbox"/> Fair Credit Reporting Notice | <input type="checkbox"/> <i>Guide to Health Insurance for People with Medicare</i> |
| <input type="checkbox"/> Replacement Notice           | <input type="checkbox"/> Outline of Coverage                                       |
9. 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 may require for proper underwriting; (b) AFLAC is not bound by any statement made by me, or any agent of AFLAC, 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; (e) no change to the policy will be valid until approved by AFLAC's secretary and president and noted in or attached to the policy; and (f) all statements in this application are representations and not warranties.

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

**Complete this section if applicant is applying for Specified-Disease Rider Series A-75052.**

**American Family Life Assurance Company of Columbus (AFLAC)  
Worldwide Headquarters: 1932 Wynnton Road, Columbus, Georgia 31999**

**SUPPLEMENTAL MEDICAL INFORMATION QUESTIONNAIRE FOR SPECIFIED-DISEASE RIDER**

Have you or has anyone to be covered under this policy ever had adrenal hypofunction (Addison's disease), ALS (amyotrophic lateral sclerosis) or Lou Gehrig's disease, botulism, bubonic plague, cerebral palsy, cholera, cystic fibrosis, diphtheria, encephalitis (including Encephalitis contracted from West Nile virus), Huntington's chorea, Legionnaires' disease, malaria, meningitis (bacterial), multiple sclerosis, muscular dystrophy, myasthenia gravis, necrotizing fasciitis, osteomyelitis, polio, rabies, Reye's syndrome, scarlet fever, scleroderma, sickle-cell anemia, systemic lupus, tetanus, toxic shock syndrome, tuberculosis, tularemia, typhoid fever, Variant Creutzfeldt-Jakob disease (mad cow disease), or yellow fever in any form?  Yes  No

If yes, was it the:  Named Insured  Spouse  Child?

If "child," please list the name of the child(ren) \_\_\_\_\_.

Any person(s) named will not be covered under Specified-Disease Rider Form Series A-75052.

**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 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 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 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. I realize that any false statement or misrepresentation hereon may result in loss of coverage under the policy.

**Any person who knowingly and with intent to injure, defraud or deceive any insurer, files a statement of claim or an application containing any false, incomplete or misleading information, is guilty of a felony of the third degree.**

Applicant's Signature \_\_\_\_\_ Date \_\_\_\_\_

Agent's Signature \_\_\_\_\_ Date \_\_\_\_\_  
Licensed Resident Agent

Typed or Printed Name of Agent: \_\_\_\_\_

Agent Telephone Number: \_\_\_\_\_

Agent Address: \_\_\_\_\_

Agent Florida License Number: \_\_\_\_\_

**MAKE CHECK OR MONEY ORDER PAYABLE TO AFLAC.  
FOR INFORMATION, CALL TOLL-FREE 1-800-99-AFLAC (1-800-992-3522).**

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).





**Application for Hospital Intensive Care Unit Insurance (A-18200 Series)**  
 Application to American Family Life Assurance Company of Columbus (AFLAC)  
 Worldwide Headquarters: Columbus, Georgia 31999

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 SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Dependent Children  Yes  No

**(Complete 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. #

City \_\_\_\_\_ State \_\_\_\_\_ ZIP Code \_\_\_\_\_

Home Telephone ( ) \_\_\_\_\_ Work Telephone ( ) \_\_\_\_\_

Policy owner's Name \_\_\_\_\_ Relationship to Applicant \_\_\_\_\_  
(if other than applicant)

Address \_\_\_\_\_ Owner's SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Street or Post Office Box Apt. #

City \_\_\_\_\_ State \_\_\_\_\_ ZIP Code \_\_\_\_\_

Name of Employer \_\_\_\_\_ State of Florida \_\_\_\_\_ EEID \_\_\_\_\_

Do you have any other hospital intensive care coverage with AFLAC?  Yes  No If yes, this must be an upgrade of that coverage. If yes, give current policy number and see Item #11.  
 Policy Number: \_\_\_\_\_

Is this insurance intended to replace any other hospital intensive care insurance now in force?  Yes  No  
 Name of company and policy number to be replaced \_\_\_\_\_  
 If yes, please read and sign the Replacement Notice provided by your agent, if applicable.

**TO BE COMPLETED BY AFLAC AGENT**

**Check Coverage Desired:**  Individual  Family  Pre-tax  After-tax

Policy (Series A-18200) **EHIC70**

**Billing Method:**  Payroll Deduction  Share Deductions/Credit Union

**Mode:**  01 Weekly  01 Biweekly  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. Has anyone to be covered been diagnosed with or treated by a member of the medical profession in the last five years for: angina, congestive heart failure, heart attack or stroke?  Yes  No
- 2. Has anyone to be covered had or been advised of the need to have coronary angioplasty, coronary atherectomy, coronary bypass surgery, heart valve surgery or surgery for congenital heart defects within the last five years?  Yes  No
- 3. Has anyone to be covered ever been treated or diagnosed by a member of the medical profession with chronic liver disease, chronic kidney disease or impaired kidney function (not including kidney stones) or been treated with dialysis by a member of the medical profession?  Yes  No
- 4. Has anyone to be covered tested positive for exposure to the HIV infection or been diagnosed as having ARC or AIDS caused by the HIV infection or other sickness or condition derived from such infection?  Yes  No
- 5. Within the last five years, has anyone to be covered ever had or been advised to have an organ transplant or consulted with a member of the medical profession about the need to have an organ transplant?  Yes  No
- 6. If any one of Questions 1 through 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. \_\_\_\_\_

**APPLICANT'S STATEMENTS AND AGREEMENTS:**

- 7. I understand that the Effective Date of the policy will be the date recorded in the Policy Schedule by AFLAC Worldwide Headquarters. **Benefits of this policy reduce to half at age 70.**
- 8. I understand that the policy I am applying for will not cover any person who has attained age 70 prior to the Effective Date of the policy.
- 9. I acknowledge receipt of, if applicable:
  - Fair Credit Reporting Notice
  - Replacement Notice
  - Outline of Coverage
  - Guide To Health Insurance for People with Medicare
- 10. I understand that the insurance I am applying for will be issued based solely upon the written answers to questions and information asked for in this application; statements in this application are representations and not warranties; AFLAC is not bound by any statement made by me, the applicant, or any agent of AFLAC unless written herein; the agent cannot change the provisions of the policy or waive any of its provisions either orally or in writing; the policy together with this application, endorsements, benefit agreements and riders, if any, is the entire contract of insurance; and no change to the policy will be valid until approved by AFLAC's secretary and president, which must be noted in or attached to the policy.

11. If this is an application for an upgrade of coverage, the following conditions shall 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 above shall be void, and coverage shall 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 above will be paid under the previous policy. (b) Any person(s) not listed in Item 6 above, if eligible, will be covered under the new policy. (c) The Time Limit on Certain Defenses provision shall run from the Effective Date of the original policy. Any premium paid on the original policy that is unearned as of the Effective Date of the new policy shall be applied to the new policy.

**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 only applies in Arizona, California, Georgia, Illinois, Maine, Minnesota, Montana, Nevada, North Carolina, Oregon and Virginia.

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. I realize that any false statement or misrepresentation hereon may result in loss of coverage under the policy.

Any person who knowingly and with intent to injure, defraud or deceive any insurer, files a statement of claim or an application containing any false, incomplete or misleading information, is guilty of a felony of the third degree.

Applicant's Signature \_\_\_\_\_ Date \_\_\_\_\_

I certify I personally saw the applicant when the application was completed and each question was asked of the applicant and answered as recorded. All answers are correct to the best of my knowledge.

Agent's Signature \_\_\_\_\_ Date \_\_\_\_\_  
Licensed Agent

Agent's Writing Number \_\_\_\_\_ Sit. Code \_\_\_\_\_

Typed or Printed Name of Agent \_\_\_\_\_ Agent's Telephone No. \_\_\_\_\_

Agent's Address \_\_\_\_\_ Agent's Florida License No. \_\_\_\_\_

**Make check or money order payable to AFLAC. For information, call toll-free 1-800-99-AFLAC (1-800-992-3522).**

**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).

## HOW TO FILE A CLAIM:

1. Obtain a claim form from your Capital Insurance agent/representative, from Aflac's Customer Service Center, or from Aflac's Web site.
2. To file a cancer claim: Have the doctor complete the Physician's Statement section of the claim form, and submit the pathology report and any other doctor bills or itemized hospital bills relating to the cancer treatment.
3. To file an intensive care claim: Submit an itemized hospital bill indicating the number of days in the intensive care unit and the charges. If the bill fails to indicate the diagnosis, the Physician's Statement must be completed by the doctor.
4. Filing for the Cancer Screening Wellness Benefit does not require a claim form, only a billing statement indicating the covered person's name, date of test, test performed, and policy number.

Aflac Worldwide Headquarters  
Attn: Claims Department  
1932 Wynnton Road  
Columbus, Georgia 31999  
1.877.44.AFLAC (1.877.442.3522)

## HOW TO APPLY:

1. Contact your regional Capital Insurance representative (listed on the back cover of this brochure) to complete the enclosed Aflac application. Aflac's application is in addition to the online state enrollment process. To obtain information about Aflac insurance, contact your regional Capital Insurance representative or call Capital Insurance Agency toll-free at 1-800-780-3100.
2. To complete the state enrollment process, contact the People First Service Center toll-free at 1-866-663-4735, or visit their Web site at <https://peoplefirst.myflorida.com>.

**Note:** You may apply for this coverage during the first 60 days of employment or during the annual open enrollment period. Enrollment will not be complete unless both the state enrollment process and an Aflac application are completed.

**Please return the Aflac application to:  
Capital Insurance Agency, Inc.  
P.O. Box 15949  
Tallahassee, FL 32317**

Plan	Monthly Payroll Premiums			
	One-Parent Benefit Plan Code	Individual	One-Parent Family	Two-Parent Family
<b>Cancer</b>				
A-75100-FL Only (Level 1)	6500	\$ 18.70	\$ 21.70	\$ 30.50
A-75100-FL (Level 1) SDR**		\$ 18.70 \$ 1.80	\$ 21.70 \$ 2.70	\$ 30.50 \$ 3.90
A-75100-FL + SDR	6501	\$ 19.70	\$ 23.20	\$ 32.50
A-75100-FL (Level 1) BBR* (3 units)		\$ 18.70 \$ 1.00	\$ 21.70 \$ 1.50	\$ 30.50 \$ 2.00
A-75100-FL + BBR (3 units)	6502	\$ 20.50	\$ 24.40	\$ 34.40
A-75100-FL (Level 1) BBR* (3 units) SDR**		\$ 18.70 \$ 1.80 \$ 1.00	\$ 21.70 \$ 2.70 \$ 1.50	\$ 30.50 \$ 3.90 \$ 2.00
A-75100-FL + BBR + SDR	6503	\$ 21.50	\$ 25.90	\$ 36.40
A-75300-FL Only (Level 3)	6510	\$ 33.50	\$ 40.20	\$ 55.90
A-75300-FL (Level 3) SDR**		\$ 33.50 \$ 3.00	\$ 40.20 \$ 4.50	\$ 55.90 \$ 6.50
A-75300-FL + SDR	6511	\$ 34.50	\$ 41.70	\$ 57.90
A-75300-FL (Level 3) BBR* (5 units)		\$ 33.50 \$ 1.00	\$ 40.20 \$ 1.50	\$ 55.90 \$ 2.00
A-75300-FL + BBR (5 units)	6512	\$ 36.50	\$ 44.70	\$ 62.40
A-75300-FL (Level 3) BBR* (5 units) SDR**		\$ 33.50 \$ 3.00 \$ 1.00	\$ 40.20 \$ 4.50 \$ 1.50	\$ 55.90 \$ 6.50 \$ 2.00
A-75300-FL + BBR + SDR	6513	\$ 37.50	\$ 46.20	\$ 64.40
*BBR – Building Benefit Rider **SDR – Specified-Disease Rider				
Hospital Intensive Care A-1820B-FL	7000	\$ 8.70	\$ 16.64	\$ 16.64

**CAPITAL INSURANCE AGENCY, INC.**

***"We're Here To Help You!"***

Contact the Capital Insurance Agency regional office in your area for assistance.

Home Office  
1425 E. Piedmont Dr.  
Suite 301  
Tallahassee, FL 32308

P.O. Box 15949  
Tallahassee, FL  
32317-5949

850.386.3100  
1.800.780.3100  
850.386.7116 fax  
capitalinsurance@capitalins.com



**Regional Locations**

**Region 1**

Robert W. "Buck" Miller, LUTCF, CLU  
Tallahassee  
850.671.2029  
1.800.226.9808  
850.671.2149 fax  
northwestregion@capitalins.com

**Region 3**

Doug Moore, LUTCF  
Winter Park  
407.673.1254  
1.800.416.1618  
407.673.1255 fax  
centralregion@capitalins.com

**Region 2**

David L. Corbin, LUTCF, CLF  
Tallahassee  
850.942.2323  
1.800.881.1871  
850.942.2360 fax  
northeastregion@capitalins.com

**Region 4**

David K. Mobley  
Brandon  
813.839.8800  
1.800.940.2048  
813.839.8860 FAX  
southcentralregion@capitalins.com

**Jacksonville**

904.731.9800  
1.800.940.9800  
904.731.4293 fax  
northeastregionjax@capitalins.com

**Region 5**

Mariam Spaulding, LUTCF  
Coral Springs  
954.341.8705  
1.800.940.5656  
954.341.5311 fax  
southflregion@capitalins.com

[www.capitalins.com](http://www.capitalins.com)

**We've got you  
under our wing.<sup>®</sup>**

**aflac.com** || **1.800.99.AFLAC** (1.800.992.3522)

American Family Life Assurance Company of Columbus

Worldwide Headquarters | 1932 Wynnton Road | Columbus, Georgia 31999