

Peace of Mind *and*  
Real Cash Benefits



PERSONAL CANCER INDEMNITY/  
PERSONAL HOSPITAL INTENSIVE  
CARE INSURANCE

PCI

Prepared for:  
*State of Florida Employees*



Marketed & Serviced by:  
Capital Insurance Agency, Inc.  
1-800-780-3100



## Added Protection for You and Your Family

Chances are you know someone who's been affected, directly or indirectly, by cancer. You also know the toll it's taken on them—physically, emotionally, and financially. That's why we've developed the Aflac Personal Cancer Indemnity insurance policy. The plan pays a cash benefit upon initial diagnosis of a covered cancer, with a variety of other benefits payable throughout cancer treatment. You can use these cash benefits to help pay out-of-pocket medical expenses, the rent or mortgage, groceries, or utility bills—the choice is yours.

And while you can't always predict the future, here at Aflac we believe it's good to be prepared. The Aflac Personal Cancer Indemnity plan is here to help you and your family better cope financially if a positive diagnosis of cancer ever occurs. That way you can worry less about what may be ahead.

### The Personal Cancer Indemnity insurance policy has:

- No lifetime limit—policy won't terminate based on number or dollar amount of claims paid.
- No network restrictions—you choose your own medical treatment provider.
- No coordination of benefits—we pay regardless of any other insurance.

## 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 BENEFIT RIDER

### HOSPITAL INTENSIVE CARE PLAN

## AFLAC'S PERSONAL CANCER INDEMNITY PLAN POLICY SUMMARIES

<b>BENEFIT</b>	<b>(People First Plan Code No. 6500) A-75100-FL (LEVEL 1)</b>	<b>(People First Plan Code No. 6510) A-75300-FL (LEVEL 3)</b>
<b>Wellness</b>	\$40/calendar year, per covered person	\$75/calendar year, per covered person
<b>First-Occurrence</b>	\$1,500 Insured & Spouse \$2,250 (child)	\$5,000 Insured & Spouse \$7,500 (child)
<b>Hospital Confinement</b>	\$200/day (Days 1–30) \$400/day (Days 31+)	\$300/day (Days 1–30) \$600/day (Days 31+)
<b>Medical Imaging</b>	\$100 1x per year, per covered person	\$200 1x per year, per covered 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 per covered person	\$500/month Lifetime Max \$2,500 per covered person
<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 of covered hospital confinement	\$150 times the number of days of covered hospital confinement
• Outpatient	\$200/day	\$250/day
<b>Second Surgical Opinion</b>	\$200	\$300
<b>NCI Evaluation/ Consultation</b>	Consultation \$500 (once per covered person) Travel & Lodging \$250 (over 50 miles)	Consultation \$500 (once per covered 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
• Dependent Child		
<b>Lodging</b>	\$50/day Limit 90 days/calendar year (must be more than 50 miles from insured's residence)	\$60/day Limit 90 days/calendar year (must be more than 50 miles from insured's residence)
<b>Bone Marrow Transplantation</b>	\$10,000 Lifetime Maximum: \$10,000 per covered person	\$10,000 Lifetime Maximum: \$10,000 per covered person
• Bone Marrow Donor	\$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 (limited to 10 visits per hospitalization; limited to 30 visits per calendar year, per covered person)	\$50/day (limited to 10 visits per hospitalization; limited to 30 visits per calendar year, per covered person)
<b>Waiver of Premium</b>	Yes	Yes
<b>Optional Specified-Disease Rider</b>	Covers 32 diseases	Covers 32 diseases
<b>Optional Building Benefit Rider</b>	\$300/year build	\$500/year build

# AFLAC'S PERSONAL CANCER INDEMNITY

## CANCER INDEMNITY INSURANCE

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

# PCI



*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.*

**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*

## PEACE of MIND. CASH BENEFITS.

OUR INSURANCE POLICIES HELP PROVIDE BOTH.

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.

## 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.

An ambulatory surgical center does not include a physician's or dentist's office, a clinic, or any other such location.

A bone marrow transplantation does not include the harvesting of peripheral blood cells or stem cells and subsequent reinfusion.

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 stem cell transplantation does not include the harvesting, storage, and subsequent reinfusion of bone marrow from the recipient or a matched donor under general anesthesia.

If skin cancer is diagnosed during hospitalization, benefits will 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.

## TERMS YOU NEED TO KNOW

**ACTIVITIES OF DAILY LIVING (ADLS): MAINTAINING CONTINENCE:** controlling urination and bowel movements, including your ability to use ostomy supplies or other devices such as catheters; **TRANSFERRING:** moving between a bed and a chair, or a bed and a wheelchair; **DRESSING:** putting on and taking off all necessary items of clothing; **TOILETING:** getting to and from a toilet, getting on and off a toilet, and performing associated personal hygiene; **EATING:** performing all major tasks of getting food into your body.

**CANCER:** A disease manifested by the presence of a malignant tumor characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue. Cancer also includes leukemia and Hodgkin's disease. Premalignant conditions or conditions with malignant potential, including myelodysplastic and myeloproliferative disorders, will not be considered cancer.

**COVERED PERSON:** Any person insured under the coverage type you applied for: individual (named insured listed in the Policy Schedule), one-parent family (named insured and dependent children), or two-parent family (named insured, spouse, and dependent children). Newborn children are automatically insured from the moment of birth. If coverage is for individual only and you desire uninterrupted coverage for a newborn child, you must notify Aflac in writing within 60 days of the birth of your child, and Aflac will convert the policy to one-parent family or two-parent family coverage and advise you of the additional premium due. Coverage provided under any one-parent family or two-parent family will continue to include any other dependent child, regardless of age, who is incapable of self-sustaining employment by reason of mental retardation or physical handicap, and who became so incapacitated prior to age 26 and while covered under the policy. Dependent children are your natural children, stepchildren, or legally adopted children who are under age 26.

**EFFECTIVE DATE:** The date(s) shown in the Policy Schedule. The effective date of the policy is not the date you signed the application for coverage, but the date recorded by Aflac in the Policy Schedule. The policy is available through age 70 on payroll deduction.

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

**PHYSICIAN:** A legally qualified person, other than a member of your immediate family, who is licensed as a physician by the state to treat the type of condition for which a claim is made.



# OPTIONAL RIDER BENEFITS TO THE 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.*

**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.

**TERMINATION:** The rider will terminate if the policy to which it is attached terminates, when the benefit has been paid for all covered persons, 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 to which it is attached or the effective date of the rider, as stated in the Policy Schedule, if later.

# OPTIONAL RIDER BENEFITS TO THE CANCER PLAN SPECIFIED-DISEASE BENEFIT RIDER

Rider A-75052

*Riders become part of the policy and are subject to all policy provisions, unless otherwise stated.*

## SPECIFIED-DISEASE BENEFITS

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

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

The covered person must be confined to a hospital for 12 or more hours as a result of receiving treatment for a specified disease. 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 (continuous confinement)

\$500 per day for Days 31+ (continuous confinement)

### DEFINITION OF COVERED DISEASES

*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

## 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.

The Daily Hospital Intensive Care Unit Benefit does not provide benefits for confinement in units such as surgical recovery rooms, progressive care, intermediate care, private monitored rooms, observation units, telemetry units; subacute intensive care units\* (step-down units), or other facilities that do not meet the standards for a hospital intensive care unit.

A subacute intensive care unit (step-down unit) does not include an observation unit; a bed, ward, or semiprivate room with or without monitoring equipment; an emergency room; a surgical recovery room; or a labor or delivery room.

## 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.

## COVERED PERSON

Any person insured under the coverage type you applied for: individual (named insured listed in the Policy Schedule), family (named insured, spouse, and dependent children). Newborn children are automatically insured from the moment of birth. The coverage under any family policy shall continue to include any dependent child, regardless of age, who is incapable of self-sustaining employment by reason of mental retardation or physical handicap, and who became so incapacitated while covered and prior to age 26. Dependent children are your natural children, stepchildren, or legally adopted children who are under age 26. You must notify us, in writing, of the birth of a child within 60 days after the birth. If timely notice is given, we will not charge an additional premium for coverage of the newborn child for the duration of the notice period. If timely notice is not given, we will change the applicable additional premium from the date of birth. We will not deny coverage for a child due to your failure to notify us within the 60-day period.

## 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.

\*Benefits for confinement in a subacute care facility are paid under the Daily Subacute Intensive Care Unit Benefit.

**American Family Life Assurance Company of Columbus**  
**(herein referred to as 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/Specified Disease
- Hospital Intensive Care

policy (policies) that I am applying for or if already issued, will not be effective until \_\_\_\_\_  
\_\_\_\_\_. No benefits will be due to 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.

**Reissues only**

\_\_\_\_\_ (policyholder's initials) I certify my medical condition has not changed from the time I  
originally applied for coverage and I understand that any pre-existing condition clauses and  
applicable waiting periods will begin as of the newly selected effective date above.

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

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

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

Signature of Applicant/Policyholder: \_\_\_\_\_

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

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



**American Family Life Assurance Company of Columbus**  
**(herein referred to as Aflac)**  
**Worldwide Headquarters • Columbus, GA 31999**  
**For information, call toll-free 1.800.99.AFLAC (1.800.992.3522).**

**Suitability Notice**

I, \_\_\_\_\_, have reviewed the benefits and premium of the insurance  
Proposed Insured's Name

policy(ies) and/or riders that I am applying for and agree to the following.

- I understand the impact that the premium for this coverage has on my paycheck/income;
- I understand the impact that the total Aflac premium for this coverage and any other Aflac coverage has on my paycheck/income and believe it to be appropriate for me; and
- I have considered all of my existing health insurance coverage, with Aflac and/or with other carriers, and believe this additional coverage is appropriate for my insurance needs. I further understand that I can contact Aflac and/or other insurance carriers to assist in evaluating the suitability of insurance coverage for me.

Proposed Insured's Signature \_\_\_\_\_ Date \_\_\_\_\_

I certify that I have advised the applicant to consider the impact that this Aflac coverage has on his or her paycheck/income, and I agree with the applicant's decision that it is appropriate for purchase.

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

## AUTHORIZATION TO OBTAIN INFORMATION

**MAIL TO:** American Family Life Assurance Company of Columbus  
1932 Wynnton Road  
Columbus, Georgia 31999-0001

<b>Primary Policyholder's Name:</b>	<b>SSN(optional):</b>	<b>Date of Birth:</b>
<b>Policy Number(s):</b>		
<b>Address:</b>		
<b>Name of Individual Subject to Disclosure (if not the primary policyholder):</b>		<b>Date of Birth:</b>
<b>Relationship to Primary Policyholder:</b> <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner		

I authorize the following to give information (as defined below) to American Family Life Assurance Company of Columbus, American Family Life Assurance Company of New York, and Continental American Insurance Company (collectively, "Aflac"): any medical professional, medical care institution, pharmacy-related service organizations, insurer (including Aflac, with respect to other Aflac 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" includes 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 are required as part of the underwriting process in order to determine eligibility for insurance or to evaluate a claim for benefits during the time this authorization is valid.

I understand that any disclosure of health information to Aflac 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 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 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 has taken action in reliance on this authorization, or (2) other law provides Aflac with the right to contest a claim under the policy or the policy itself. My revocation must be submitted in writing to Aflac, Policy Service, 1932 Wynnton Road, Columbus, Georgia 31999.

Unless otherwise revoked, I agree that this authorization will expire on the earlier of the date Aflac notifies me of its declination of my application for coverage or, if a policy is issued, two years from the date this authorization is signed.

I agree that a copy of this authorization is as valid as the original and that I or an authorized representative may request a copy of this authorization.

\_\_\_\_\_  
Signature of Individual Subject to Disclosure

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

If this authorization has been signed by a personal representative on behalf of an individual, his/her authority to act on behalf of the individual must be set forth here:

\_\_\_\_\_  
Printed Name of Legal/Personal Representative

\_\_\_\_\_  
Legal Relationship (e.g. *Power of Attorney*)



**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 ( ) \_\_\_\_\_

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 Payroll Account Number **OB217**

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**

<b>Check Coverage Desired:</b>	<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
Level 3: Policy (Series A-75300)	<input type="checkbox"/> CCAIPC	<input type="checkbox"/> CCAIPF	<input type="checkbox"/> After-tax

**Optional Rider:**

<b>Building Benefit Rider (Series A-75050)</b> Units _____ <input type="checkbox"/> No rider <input type="checkbox"/> New rider <input type="checkbox"/> Retain current rider	<input type="checkbox"/> CCAIPG	<input type="checkbox"/> CCAIPK
<b>Specified-Disease Rider (Series A-75052)</b> <input type="checkbox"/> No rider <input type="checkbox"/> New rider <input type="checkbox"/> Retain current rider	<input type="checkbox"/> CCAIPJ	<input type="checkbox"/> CCAIPM

<b>Billing Method:</b> <input checked="" type="checkbox"/> Payroll Deduction	<b>Mode:</b> <input type="checkbox"/> 01 Weekly <input type="checkbox"/> 01 14-Day Biweekly <input type="checkbox"/> 01 28-Day Biweekly	<input type="checkbox"/> 01 Semimonthly <input checked="" type="checkbox"/> 01 Monthly <input type="checkbox"/> 03 Quarterly <input type="checkbox"/> 06 Semiannual <input type="checkbox"/> 12 Annual
Employee No. _____ Dept. No. _____ Agent's No. _____	Billable Premium \$ _____ Premium Collected \$ <b>PR</b>	Sit. Code <b>C</b>

**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):  
(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):  
(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.**

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:
- Fair Credit Reporting Notice
  - Guide to Health Insurance for People with Medicare*
  - Replacement Notice
  - 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 **(Client SSN)** \_\_\_\_\_

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 Monthly  03 Quarterly  06 Semiannual  12 Annual

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

Billable Premium: \$ \_\_\_\_\_ Premium Collected: \$ **PR** Sit. Code: **0**

**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).

# DISCLOSURE STATEMENT

**AMERICAN FAMILY LIFE ASSURANCE COMPANY OF COLUMBUS  
(herein referred to as Aflac)**

Worldwide Headquarters • 1932 Wynnton Road • Columbus, Georgia 31999  
For information, call 1.800.99.AFLAC (1.800.992.3522).  
Visit our website at aflac.com

A Stock Company

Applicant's Name: \_\_\_\_\_

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

**THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES.**

**MINIMUM ESSENTIAL COVERAGE DEFINITION**

The type of coverage an individual needs to have to meet the individual responsibility requirement under the Affordable Care Act. This includes individual market policies, job-based coverage, Medicare, Medicaid, CHIP, TRICARE and certain other coverage.

I certify, by signing below, that I am covered by a major medical policy or other coverage that satisfies the minimum essential coverage under the Affordable Care Act.

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

\_\_\_\_\_  
Date



**American Family Life Assurance Company of Columbus**  
**(herein referred to as Aflac)**  
**Worldwide Headquarters • Columbus, GA 31999**  
**For information, call toll-free 1.800.99.AFLAC (1.800.992.3522).**

**Replacement Notice**

I, \_\_\_\_\_, have reviewed the benefits, limitations, exclusions, and costs of  
Proposed Insured's Name

the insurance policy(ies) and/or riders that I am applying for and agree to the following.

- If I am applying to replace existing Aflac coverage or coverage with another carrier with this policy, I acknowledge that the policies and/or rider(s) may have different benefits, limitations, exclusions, and costs and that I should compare them to determine which is best for me. If I am replacing existing Aflac coverage, I understand and agree that I am terminating my current Aflac policy and/or rider(s) for this Aflac policy.

Proposed Insured's Signature \_\_\_\_\_ Date \_\_\_\_\_



## HOW TO FILE A CLAIM:

Completing the claims process is fast and easy.

### To Submit Claims Online

1. Log in to Aflac Policyholder Services and access Aflac SmartClaim®:
2. Click Start a SmartClaim to begin the process of filing an online claim.
3. Electronically submit (upload) all requested supporting documentation.
4. Click *Submit*.

For claims that cannot be submitted online, Aflac SmartClaim® will also provide the correct form you need.

### To Use Other Submission Channels

If you choose not to submit your claim online, you can access a claim form at [www.aflac.com/claimforms](http://www.aflac.com/claimforms).

1. Complete the form
2. Attach all required supporting documents.
3. Include your policy number, policyholder name, and date of birth or mailing address.

Claims may be faxed to 877.44.AFLAC (877.442.3522).

Claims may be mailed to:

American Family Life Assurance Company of Columbus  
ATTN: Claims Department  
1932 Wynnton Road  
Columbus, GA 31999

## 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 website 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	Benefit Plan Code	Monthly Payroll Premiums		
		Individual	One-Parent Family	Two-Parent Family
Cancer				
A-75100-FL Only (Level 1)	6500	\$ 18.70	\$ 21.70	\$ 30.50
A-75100-FL (Level 1) SDR**		\$ 18.70 \$ 1.00	\$ 21.70 \$ 1.50	\$ 30.50 \$ 2.00
A-75100-FL + SDR	6501	\$ 19.70	\$ 23.20	\$ 32.50
A-75100-FL (Level 1) BBR* (3 units)		\$ 18.70 \$ 1.80	\$ 21.70 \$ 2.70	\$ 30.50 \$ 3.90
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 \$ 1.00	\$ 40.20 \$ 1.50	\$ 55.90 \$ 2.00
A-75300-FL + SDR	6511	\$ 34.50	\$ 41.70	\$ 57.90
A-75300-FL (Level 3) BBR* (5 units)		\$ 33.50 \$ 3.00	\$ 40.20 \$ 4.50	\$ 55.90 \$ 6.50
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!"*

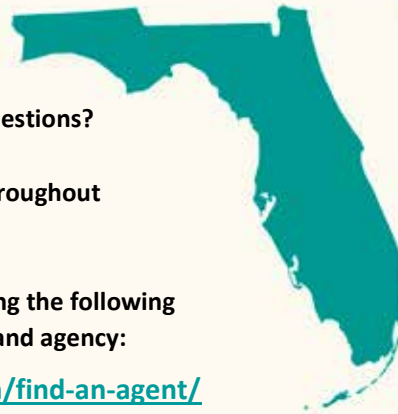
## FIND A LOCAL AGENT

Do you have general or enrollment questions?

Our agents are strategically located throughout the State to better serve you.

Find a Licensed Agent in your area by using the following link and providing your work county and agency:

<https://www.capitalins.com/team/find-an-agent/>



## HOME OFFICE

**Mailing** P.O. Box 15949  
Tallahassee, FL 32317

**Physical** 2457 Care Drive, Ste. A-200  
Tallahassee, FL 32308



**Local** 850.386.3100

**Toll Free** 800.780.3100

**Fax** 850.385.8126

**Email** [groupdepartment@capitalins.com](mailto:groupdepartment@capitalins.com)

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

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

Underwritten by:  
American Family Life Assurance Company of Columbus  
Worldwide Headquarters | 1932 Wynnton Road | Columbus, Georgia 31999

