

SERFF Tracking Number: AFLA-125597397 State: Arkansas  
Filing Company: American Family Life Assurance Company of Columbus State Tracking Number: 38732  
Company Tracking Number: A27000ARR  
TOI: LTC03I Individual Long Term Care Sub-TOI: LTC03I.001 Qualified  
Product Name: Long-Term Care  
Project Name/Number: /

## Filing at a Glance

Company: American Family Life Assurance Company of Columbus

Product Name: Long-Term Care SERFF Tr Num: AFLA-125597397 State: ArkansasLH  
TOI: LTC03I Individual Long Term Care SERFF Status: Closed State Tr Num: 38732  
Sub-TOI: LTC03I.001 Qualified Co Tr Num: A27000ARR State Status: Approved-Closed  
Filing Type: Form Co Status: Reviewer(s): Harris Shearer  
Authors: Eve Black, Bridget Berryman Disposition Date: 07/10/2008  
Date Submitted: 04/16/2008 Disposition Status: Approved  
Implementation Date Requested: On Approval Implementation Date:

State Filing Description:

## General Information

Project Name: Status of Filing in Domicile: Not Filed  
Project Number: Date Approved in Domicile:  
Requested Filing Mode: Review & Approval Domicile Status Comments: This filing is based on Arkansas state specific regulations, and therefore not filed in Nebraska, our state of domicile.  
Explanation for Combination/Other: Market Type: Individual  
Submission Type: New Submission Group Market Size:  
Overall Rate Impact: Group Market Type:  
Filing Status Changed: 07/10/2008  
State Status Changed: 07/10/2008 Deemer Date:  
Corresponding Filing Tracking Number:  
Filing Description:

The forms referenced below are submitted for your review and approval:

Long Term Care Policy Form A27000ARR, Outline of Coverage Form A27025ARR, Payroll Application Form A27001RARR, Payroll Basic Application Form A27002ARR, Request for Additions/Application for Reinstatement Form

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A27003ARR, Long Term Care Insurance Potential Rate Increase Disclosure Form A27093AR, Long-Term Care Insurance Personal Worksheet Form A27092AR, Notice to Applicant Regarding Replacement of Individual Accident and Sickness or Long-Term Care Insurance Form A25015AR, and Things You Should Know Before You Buy Long Term Care Insurance Form A25291AR

These form revisions are being made in accordance with Arkansas Rule & Regulation 13, Long-Term Care Insurance, as well as Chapter 97, Long-Term Care Insurance.

Policy Form A27000ARR will replace Policy Form A-27000-AR, previously approved on July 9, 2001.

Outline of Coverage Form A27025ARR will replace A-27025-AR, previously approved on July 9, 2001.

Payroll Application Form A27001RARR will replace A-27001RAR, previously approved on January 27, 2003.

Payroll Basic Application Form A27002ARR will replace A-27002-AR, previously approved on July 9, 2001.

Request for Additions/Application for Reinstatement Form A27003ARR will replace A-27003-AR, previously approved on July 9, 2001.

Long Term Care Insurance Potential Rate Increase Disclosure Form A27093AR is being filed to comply with Appendix F. This information was previously included on Outline of Coverage Form A-27025-AR.

Long-Term Care Insurance Personal Worksheet Form A27092AR will replace A-27092, previously approved on July 9, 2001.

Notice to Applicant Regarding Replacement of Individual Accident and Sickness or Long-Term Care Insurance Form A25015AR will replace A-25015, previously approved on February 15, 1994.

Things You Should Know Before You Buy Long-Term Care Insurance Form A25291AR will replace A-25291, previously filed for informational purposes on February 13, 2001.

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The information below provides details of the changes made between the previously approved forms and those now being submitted.

### Policy Form A27000ARR

1. The AFLAC brand has been changed to Aflac throughout the policy, as well as other branding.
2. Pursuant to Section 11, C (2), under the Caution Statement on the face page, our company address of 1932 Wynnton Road, Columbus, GA 31999 has been added, replacing the statement, "contact Aflac at the address shown at the bottom of this page."
3. References to "Insured" now include "Named Insured", throughout the policy.
4. Pursuant to § 23-97-304 (5) (A) and Section 8, H, the qualified long-term care insurance disclosure statement on the face page has been revised to read "...under Section 7702B(b) of the Internal Revenue Code of 1986, as amended.", replacing "Federal Tax Code, Section 7702B (B).
5. Pursuant to Section 9, E, the premium rate increase notification has been changed from 31 days to 45 days.
6. Pursuant to Section 8, E, Limitations or Conditions on Eligibility for Benefits has been added to the Index as Part 5, which caused the numbering to change.
7. Pursuant to Section 5, C and K, the definition of Adult Day-Care and Medicare have been added under Part 1, Definitions.
8. Pursuant to Section 5, I and Section 27, D (1) & (2), also under Part 1, Definitions, the following terms have been revised to read:

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• **SUBSTANTIAL ASSISTANCE:** you are considered to need Substantial Assistance in performing Activities of Daily Living (ADLs) when:

o you require hands-on assistance of another person to help you perform an ADL each and every time you perform that activity, meaning physical

assistance, minimal, moderate, or maximal, without which the individual would not be able to perform an ADL.

o you cannot perform the entire activity alone with the supports and mechanical aids that are normally available to you.

o you require supervision, including verbal cueing by another person in order to protect the Named Insured or others due to the presence of a

Cognitive Impairment.

9. Pursuant to Section 5, L and Section 6, B, Limitations and Exclusions C6 has been revised to reflect "alcoholism and drug addiction". C7 has been revised to

reflect "mental or nervous disorder", removing references to specific disorders. Also changed "similar forms of senility or senile dementia" to "related degenerative and dementing illnesses".

10. Pursuant to § 23-85-115, the autopsy criteria has been added to Physical Examinations under Uniform Provisions.

11. Pursuant to § 23-97-316, Appealing and Resolving Benefit Determinations, under Uniform Provisions, has been revised to include the specifics noted in the regulation.

12. Pursuant to Section 8, E, Limitations or Conditions on Eligibility for Benefits was added as Part 5.

13. Eligibility for the Payment of Benefits was revised to include reference to 90 days regarding requests to determine a policyholder's status as a Chronically

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III Individual, as defined under Additional Standards for Benefit Triggers for Qualified Long-Term Care Insurance Contracts, E.

14. Changed president's name and signature from Daniel P. Amos to Paul S. Amos II.

Outline of Coverage Form A27025ARR

15. The AFLAC brand has been changed to Aflac throughout the outline of coverage, as well as other branding.

Pursuant to Section 23, A (2) and the Standard Format for Outline of Coverage:

16. Numbered Outline as in regulation.

17. Revised Policy Form Series to reflect state specific policy form number.

18. Added Notice to buyer statement.

19. Added item #1.

20. Under item #3, revised "This plan is intended to be a Qualified Long-Term Care Insurance Contract" to read "Federal Tax Consequences, and

replaced "Federal Tax Code, Section 7702B(b)", with "under Section 7702B(b), Internal Revenue Code of 1986, as amended".

21. Waiver of premium benefit information is now located under item #4, Terms Under Which the Policy May be Continued in Force or Discontinued. Also added paragraph describing terms under which the company may change premiums.

22. Revised Terms Under Which The Company May Change Premiums, item #5, to include reference to the 45 day notification of a rate change.

23. Revised Long-Term Care Coverage paragraph, item #8, to include "...one (1) or more necessary or medically

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necessary diagnostic, preventive, therapeutic,  
rehabilitative, maintenance, or personal care services, provided....”

24. Moved Contingent Benefit Upon Lapse and Optional Benefits to the Additional Features, item #14.
25. Benefits has been changed to Benefits Provided By This Policy, item #9.
26. Added Eligibility for the Payment of Benefits section under item #9.
27. Moved the Pre-Existing Conditions provision to the beginning of the Limitations and Exclusions, item #10.
28. (and Section 5, L and Section 6, B) Limitations and Exclusions D6 has been revised to reflect “alcoholism and drug addiction”. D7 has been revised to reflect “mental or nervous disorder”, removing references to specific disorders. Also changed “similar forms of senility or senile dementia” to “related degenerative and dementing illnesses”.
29. Added benefit level information to Relationship of Cost of Care and Benefits, item #11.
30. Revised Alzheimer’s Disease and other Organic Brain Disorders, changing “similar forms of senility or senile dementia” to “related degenerative and dementing illnesses”.
31. Moved contact information paragraph below Additional Features, item #14.
32. Deleted Potential Rate Increase Disclosure and Contingent Nonforfeiture and created form A27093AR.  
Payroll Application Form A27001RARR and Payroll Basic Application A27002ARR
33. The AFLAC brand has been changed to Aflac throughout the policy, as well as other branding.
34. Under question 1, “last” has been changed to “past”.

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35. Under question 2, "Social Security" has been clarified to include "Disability".

36. Pursuant to Section 5, L and Section 6, B, added question 7 to further define mental or nervous disorders, calling for renumbering of remaining questions.

37. Pursuant to Section 14, A (3), Added "Are you covered by Medicaid?" under replacement questions.

38. Added check box for Potential Rate Increase Disclosure Form under "I acknowledge receipt of..."

39. Removed check box for Certification Form.

Request for Additions/Application for Reinstatement Form A27003ARR

40. The AFLAC brand has been changed to Aflac throughout the policy, as well as other branding.

41. Under question 1, "last" has been changed to "past".

42. Under question 2, "Social Security" has been clarified to include "Disability".

43. Pursuant to Section 5, L and Section 6, B, added question 7 to further define mental or nervous disorders, calling for renumbering of remaining questions.

Long-Term Care Insurance Personal Worksheet Form A27092AR

44. The AFLAC brand has been changed to Aflac throughout the form, as well as other branding.

Pursuant to Appendix B:

45. PREMIUM INFORMATION IS NOW Premium Information.

46. Added Rate Increase History header.

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- 47. Added (your savings and investments) under "Questions Related to Your Savings and Investments."
- 48. Added (check one) to "How are you planning to pay for your care during the elimination period?"
- 49. Reference to "agent" now states "associate/agent".

Notice to Applicant Regarding Replacement of Individual Accident and Sickness or Long-Term Care Insurance Form A25015AR

- 50. The AFLAC brand has been changed to Aflac throughout the form, as well as other branding.

Pursuant to Reg. Section 14, C

- 51. Moved Title above Company name and address.
- 52. Added the company street address.
- 53. Added "Save This Notice! It May Be Important To You In The Future."
- 54. References to "associate" now states "associate/agent".
- 55. Added "The above Notice to Applicant was delivered to me on:".

Things You Should Know Before You Buy Long-Term Care Insurance Form A25291AR

- 56. Branding changes have been made.
- 57. Changed format and text based on Appendix C.

These changes will not affect the premium rates currently on file with your department. Pursuant to Reg. Section 10, B

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(2), an Actuarial Addendum is included under the Supporting Documentation Schedules.

Certifications addressing Rule & Regulation 19 and 49, as well as the standards for minimum reading ease, have also been noted under the Supporting Documentation Schedules.

The appropriate filing fee is being submitted via EFT.

## Company and Contact

### Filing Contact Information

Bridget Berryman, Policy Analyst  
 1932 Wynnton Road  
 Columbus, GA 31999  
 bberryman@aflac.com  
 (706) 660-7132 [Phone]  
 (706) 660-7080[FAX]

### Filing Company Information

American Family Life Assurance Company of Columbus  
 1932 Wynnton Road  
 Columbus, GA 31999  
 (706) 323-3431 ext. [Phone]  
 CoCode: 60380  
 State of Domicile: Nebraska  
 Group Code:  
 Group Name:  
 FEIN Number: 58-0663085  
 Company Type: Life and Health  
 State ID Number:  
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## Filing Fees

Fee Required? Yes  
 Fee Amount: \$50.00  
 Retaliatory? No  
 Fee Explanation: Filing consists of policy, as well as applications, reinstatement, outline of coverage, replacement and other forms applicable to the policy.  
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
American Family Life Assurance Company of Columbus	\$50.00	04/16/2008	19623582

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved	Harris Shearer	07/10/2008	07/10/2008

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## Disposition

Disposition Date: 07/10/2008

Implementation Date:

Status: Approved

Comment:

Rate data does NOT apply to filing.

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Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice		Yes
Supporting Document	Application		Yes
Supporting Document	Health - Actuarial Justification		No
Supporting Document	Outline of Coverage		Yes
Form	Tax Qualified Long-Term Care Policy		Yes
Form	Long-Term Care Outline of Coverage		Yes
Form	Long-Term Care Payroll Application		Yes
Form	Long-Term Care Payroll Basic Application		Yes
Form	Long-Term Care Request for Addition/Application for Reinstatement		Yes
Form	Notice to Applicant Regarding Replacement of Individual Accident and Sickness or Long-Term Care		Yes
Form	Long-Term Care Personal Worksheet		Yes
Form	Long-Term Care Potential Rate Increase Disclosure		Yes
Form	Things You Should Know Before You Buy Long-Term Care		Yes

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## Form Schedule

Lead Form Number: A27000ARR

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	A27000AR R	Policy/Cont ract/Fratern al Certificate	Tax Qualified Long- Term Care Policy	Revised	Replaced Form #: A- 27000-AR Previous Filing #:	44	A27000ARR. pdf
	A27025AR R	Outline of Coverage	Long-Term Care Outline of Coverage	Revised	Replaced Form #: A- 27025-AR Previous Filing #:	42	A27025ARR. pdf
	A27001RA RR	Application/ Enrollment Form	Long-Term Care Payroll Application	Revised	Replaced Form #: A- 27001RAR Previous Filing #:	40	A27001RARR .pdf
	A27002AR R	Application/ Enrollment Form	Long-Term Care Payroll Basic Application	Revised	Replaced Form #: A- 27002-AR Previous Filing #:	42	A27002ARR. pdf
	A27003AR R	Application/ Enrollment Form	Long-Term Care Request for Addition/Application for Reinstatement	Revised	Replaced Form #: A- 27003-AR Previous Filing #:	40	A27003ARR. pdf
	A25015AR	Other	Notice to Applicant Regarding Replacement of Individual Accident and Sickness or Long-Term Care	Revised	Replaced Form #: A- 25015 Previous Filing #:	40	A25015AR.pd f
	A27092AR	Other	Long-Term Care Personal Worksheet	Revised	Replaced Form #: A- 27092 Previous Filing #:	63	A27092AR.pd f
	A27093AR	Other	Long-Term Care Potential Rate Increase Disclosure	Initial		51	A27093AR.pd f
	A25291AR	Other	Things You Should	Revised	Replaced Form #: A- 48		A25291AR.pd

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Know Before You Buy Long-Term Care 25291 f  
Previous Filing #:



## TAX-QUALIFIED LONG-TERM CARE POLICY

**This policy is intended to be a qualified long-term care insurance contract under Section 7702B(b) of the Internal Revenue Code of 1986, as amended. Please consult your tax advisor.**

**Notice to buyer:** This policy may not cover all of the costs associated with long-term care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all policy limitations.

**Caution:** The issuance of this long-term care policy is based upon your responses to the questions on your application. A copy of your application is attached. If your answers are incorrect or untrue, Aflac has the right to deny benefits or rescind your policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact Aflac at 1932 Wynnton Road, Columbus, GA 31999.

In this policy, you, the Named Insured, as shown in the Policy Schedule, will be referred to as "you" or "your." **American Family Life Assurance Company of Columbus (Aflac)**, a stock company, will be referred to as "we," "our," "us" or "Aflac."

### CONSIDERATION

This policy is issued in consideration of the statements made in your application and the payment of the required premium.

### YOUR RIGHT TO EXAMINE THIS POLICY

If you are not satisfied with this policy, you may return it for a full refund of the premium paid. You may return it by delivering or mailing it to: the duly licensed agent who took your application or to Aflac Worldwide Headquarters, 1932 Wynnton Road, Columbus, Georgia 31999. You must do this within 30 days after you receive this policy. Immediately upon such delivery or mailing, this policy will be deemed void from the Effective Date. When returning the policy under this provision please state: "This policy is returned for cancellation and refund of premium."

### THIS POLICY IS GUARANTEED-RENEWABLE FOR YOUR LIFE, SUBJECT TO OUR RIGHT TO CHANGE PREMIUMS BY CLASS.

We agree never to modify this policy while it is in force by the addition of any restrictive rider without your consent. We will never refuse to renew this policy because of any change in your health or physical condition. You are guaranteed the right to renew this policy for your lifetime by the payment of premium at the rate in effect at the beginning of each term, or until benefits under the policy are exhausted. We may change the established premium rate, but only if the rate is changed for all policies of this class. No premium change will be made because of your age or physical condition. "Class" is defined as "all policies of this form number and premium classification in your state that are then in force." In the event of a change in the established premium rate, we will notify you in writing at your last known address at least 45 days before the change becomes effective.

**AMERICAN FAMILY LIFE ASSURANCE COMPANY OF COLUMBUS (AFLAC)  
CLIENT SERVICES AND ADMINISTRATION • 1932 WYNNTON ROAD  
COLUMBUS, GEORGIA 31999 • TOLL-FREE 1.800.99.AFLAC (1.800.992.3522)**

**If we at Aflac, fail to provide you with reasonable and adequate service, you should feel free to contact:**

**ARKANSAS INSURANCE DEPARTMENT • CONSUMER SERVICES DIVISION  
1200 WEST THIRD STREET • LITTLE ROCK, ARKANSAS 72201-1904  
Telephone 501.371.2640 or 1.800.852.5494**

**Aflac Worldwide Headquarters • 1932 Wynnton Road, Columbus, Georgia 31999  
For assistance or information about this policy, call 1.800.99.AFLAC (1.800.992.3522).**

# INDEX

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## Policy Schedule

NAMED INSURED: John A. Doe

POLICY NUMBER: 111-2222

TYPE OF COVERAGE: Individual

PREMIUMS:

MODE OF PAYMENT: Monthly

Policy: \$XX

Inflation Protection Rider: \$XX

Nonforfeiture Rider: \$XX

EFFECTIVE DATE:

Policy: XX/XX/XX

Rider 1: XX/XX/XX

Rider 2: XX/XX/XX

TOTAL PREMIUM: \$XX

BENEFITS:

First -Occurrence Benefit:

[30 x Nursing Home Daily Benefit]

Nursing Home Daily Benefit:

[\$60, \$80, \$100, \$120 \$150, \$200]

BENEFIT PERIODS:

Nursing Home:[2, 3 or 5 years or Lifetime]

(365 days equals one year)

Assisted-Living: [1 or 2 years]

Home Care: [250, 400 or 500 visits]

Assisted- Living Daily Benefit:

Up to [80% of Nursing Home Daily Benefit]

Home Care Daily Benefit:

Up to [50% of Nursing Home Daily Benefit]

In witness whereof, Aflac, at its worldwide headquarters, has caused this policy to be signed by our president and secretary in the city of Columbus, Georgia, as of the Effective Date shown in the Policy Schedule.



Paul S. Amos II, President



Joey M. Loudermilk, Secretary

## PRE-EXISTING CONDITIONS

Subject to the truthful completion of your application, this policy fully covers all health conditions that you may presently have, subject to the terms of the policy, as of the policy Effective Date shown in the Policy Schedule.

**This is a legal contract between you and Aflac.  
READ YOUR POLICY CAREFULLY!**

### **Part 1 DEFINITIONS**

**Activities of Daily Living (ADLs):** activities used in measuring levels of personal functioning capacity. These activities are performed without Substantial Assistance from another individual allowing personal independence in your everyday living.

The ADLs are:

- (1) Bathing: washing oneself by sponge bath or in either a tub or shower, including the task of getting into or out of the tub or shower;
- (2) Continence: the ability to maintain control of bowel and bladder function or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene, including caring for catheter or colostomy bag;
- (3) Dressing: putting on and taking off all your items of clothing and any necessary braces, fasteners or artificial limbs;
- (4) Eating: feeding yourself by getting food into the body from a receptacle (such as a plate, cup or table) after it has been prepared for you or by a feeding tube or intravenously;
- (5) Toileting: getting to and from a toilet, getting on and off a toilet, and performing associated personal hygiene;
- (6) Transferring: moving into or out of a bed, chair or wheelchair.

**ADULT DAY-CARE:** a program for six (6) or more individuals, of social and health-related services provided during the day in a community group setting for the purpose of supporting frail, impaired elderly or other disabled adults who can benefit from care in a group setting outside the home.

**ADULT DAY-CARE FACILITY:** a facility licensed by the appropriate state licensing agency to provide Adult Day Care. The facility must be staffed by a full-time director and one or more Licensed Health Care Practitioners in attendance during all operating hours. It must operate at least five days a week for a minimum of six hours per day, but is not an overnight facility. It must also maintain written records of medical services given to each client and have

established procedures for obtaining appropriate aid in the event of a medical emergency.

**ADULT FOSTER-CARE FACILITY:** any facility or family home licensed by the Senior and Disabled Services Division or the Mental Health and Developmental Disabled Services Division to operate as an adult foster home. The facility must provide room and board and 24-hour care services, for compensation, to five or fewer adults who are not related to the operator of the facility by blood or marriage.

**ASSISTED-LIVING BENEFIT PERIOD:** the maximum number of years for which the Assisted-Living Daily Benefit can be paid for each person covered under this policy. See the attached application and the Policy Schedule for the Assisted-Living Daily Benefit Period you selected. For the purposes of this calculation, a "year" is defined as 365 days for which benefits are paid.

**ASSISTED-LIVING FACILITY:** a properly licensed facility that uses a program approach to providing or coordinating primarily continuous 24-hour care and services to support the needs of at least six inpatients. The facility must have a Licensed Health Care Practitioner under contract at all times to provide the required care and have established procedures for meal preparation and the proper administration of medications. This includes facilities licensed as hospice facilities. It does not include a hospital or clinic; a place that primarily treats the mentally ill, drug addicts or alcoholics; a Nursing Home Facility; your home; primarily a place for domiciliary, residential or retirement living, or a similar establishment.

**CARE AT HOME:** Qualified Long-Term Care Services rendered in your Home by a Home Health Care Provider due to your being a Chronically Ill Individual.

**CHRONICALLY ILL INDIVIDUAL:** any individual who has been certified by a Licensed Health Care Practitioner as: being unable to perform without Substantial Assistance from another individual at least two Activities of Daily Living for a period of at least 90 days due to a loss of functional capacity; or requiring substantial supervision to protect such individual from threats to health and safety due to severe Cognitive Impairment.

"Chronically Ill Individual" does not include any individual otherwise meeting the requirements of the preceding sentence unless, within the preceding 12-month period, a Licensed Health Care Practitioner has certified that such individual meets such requirements.

**COGNITIVE IMPAIRMENT:** the deterioration or loss of your intellectual capacity that requires you to be continually supervised for the protection of yourself and others. Your impairment must be evidenced by a clinical diagnosis as well as by results from standardized tests that measure: (1) your short-term and long-term memory (2) orientation as to person, place and time (3) your deductive or abstract reasoning and (4) your judgment as it relates to safety awareness.

**HOME:** your legal permanent personal place of residence. A "Home" cannot be a hospital, a Nursing Home Facility, an Assisted-Living Facility or any other such type facility.

**HOME CARE BENEFIT PERIOD:** the maximum number of visits for which the Home Care Daily Benefit can be paid for each person covered under this policy. See the attached application and the Policy Schedule for the Home Care Benefit Period you selected.

**HOME HEALTH CARE PROVIDER:** a registered nurse; a licensed practical or vocational nurse; licensed physical therapist; a licensed or state-certified home health aide; a licensed occupational, speech, or inhalation therapist; or a licensed medical social worker. Any license referred to herein must be issued by the state in which the individual or agency is located. The Home Health Care Provider cannot be a member of your Immediate Family or anyone who normally resides in your home or residence.

**HOSPICE FACILITY:** an inpatient facility, licensed by the state in which it is located, that provides to persons who are terminally ill a centrally administered range of services for palliative and supportive care.

**IMMEDIATE FAMILY:** anyone related to you in the following manner: your spouse, brother, or sister (includes stepbrother and stepsister), children (includes stepchildren), parents (includes stepparents), grandchildren, and father-in-law or mother-in-law, and spouses, as applicable, of any of these.

**LICENSED HEALTH CARE PRACTITIONER:** any properly licensed Physician, registered professional nurse, licensed social worker, or other licensed individual who meets the requirements as may be prescribed by the Secretary of the Treasury. The term "Licensed Health Care Practitioner" does not include you, a member of your Immediate Family or anyone who normally resides in your home or residence.

**MAINTENANCE OR PERSONAL CARE SERVICES:** care that provides needed assistance with any of your disabilities as a result of your being a Chronically Ill Individual. These services include assistance given in managing and maintaining household activities that allows you to remain safely in your home when you can not manage those activities on your own, as well as services that protect you from threats to health and safety due to severe Cognitive Impairment. The term "Maintenance or Personal Care Services" does not include assistance from a member of your Immediate Family or from anyone who normally resides in your home or residence.

**MEDICARE:** the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as then constituted or later amended.

**NURSE:** an individual who is licensed as a registered graduate nurse (RN), licensed practical nurse (LPN) or licensed vocational nurse (LVN). The term "Nurse" does not include you, a member of your Immediate Family or anyone who normally resides in your home or residence.

**NURSING HOME BENEFIT PERIOD:** the maximum number of years for which the Nursing Home Daily Benefit can be paid for each person covered under this policy. See the attached application and the Policy Schedule for the Nursing Home Benefit Period you selected. For the purposes of this calculation, a "year" is defined as 365 days for which benefits are paid.

**NURSING HOME FACILITY:** a facility or a distinctly separate part of a hospital or other institution that is licensed by the appropriate state licensing agency to engage primarily in providing skilled, intermediate or custodial care and related services to inpatients. The facility must meet all of the following criteria:

- \* It provides 24-hour-a-day nursing service under a planned program of policies and procedures developed with the advice of and is periodically reviewed and executed by a professional group of at least one Physician and one Nurse.
- \* It has a duly licensed Physician available to furnish medical care in case of an emergency.
- \* It has at least one Nurse employed there full time.
- \* It has a Nurse on duty or on call at all times.
- \* It maintains clinical records for all patients.
- \* It has appropriate methods and procedures for handling and administering drugs and biologicals.

A Nursing Home Facility is not a hospital; an Assisted-Living Facility, a personal care home or a Hospice Facility; a place that primarily treats the mentally ill, drug addicts or alcoholics; a home for the aged; a rest home; primarily a place for domiciliary, residential or retirement living, or a similar establishment. **Alzheimer's facilities that are licensed as such by the state and meet the above Nursing Home Facility requirements will be covered.**

**PHYSICIAN:** an individual, other than a Nurse, who is legally qualified and licensed to practice medicine and is operating within the scope of that license. The term "Physician" does not include you; a member of your Immediate Family; or anyone who normally resides in your home or residence.

**PLAN OF CARE:** a written document prepared and signed by a Licensed Health Care Practitioner that demonstrates you are a Chronically Ill Individual and includes a plan for the administration of Qualified Long-Term Care Services.

**POLICY EFFECTIVE DATE:** the date shown on the Policy Schedule. The Effective Date is **not** the date you signed the application for coverage.

**QUALIFIED LONG-TERM CARE SERVICES:** the necessary diagnostic, preventive, therapeutic, curative, treatment, mitigation and rehabilitative services, and Maintenance or Personal Care Services that are required by a Chronically Ill Individual and are provided according to a Plan of Care prescribed by a Licensed Health Care Practitioner.

**SUBSTANTIAL ASSISTANCE:** you are considered to need Substantial Assistance in performing Activities of Daily Living (ADLs) when:

- (1) you require hands-on assistance of another person to help you perform an ADL each and every time you perform that activity, meaning physical assistance, minimal, moderate, or maximal, without which you would not be able to perform an ADL.
- (2) you cannot perform the entire activity alone with the supports and mechanical aids that are normally available to you.
- (3) you require supervision, including verbal cueing by another person in order to protect the Named Insured or others due to the presence of a Cognitive Impairment.

**TYPE OF COVERAGE:** see your Policy Schedule to determine the type of coverage in force -- Individual or Husband/Wife.

(1) **Individual:** only you, the Named Insured listed in the Policy Schedule, are covered.

(2) **Husband/Wife:** only you, the Named Insured, and your spouse are covered.

In the event of your death, your spouse, if alive and covered hereunder, shall become the Named Insured.

If you and your covered spouse dissolve your marriage by a valid decree of dissolution of marriage, then your ex-spouse can apply for and receive, without evidence of insurability, a policy providing coverage not greater than the terminated coverage. To obtain the policy, your ex-spouse must make application to Aflac within 60 days following the entry of the decree of dissolution of marriage. If such dissolution of marriage occurs, the Named Insured under this policy at the time of the dissolution shall retain that status.

## **Part 2**

### **LIMITATIONS AND EXCLUSIONS**

- A. This policy will not pay benefits for that portion of any expense that is for services which are reimbursable under Medicare (or would be so reimbursable but for the application of the Medicare deductible or coinsurance amounts).
- B. If Medicaid is paying claims on your behalf, all benefits payable under this policy for those claims will be paid directly to Medicaid.
- C. This policy does not cover any of the following:
  - 1. services rendered by a member of your Immediate Family.
  - 2. services for which a charge would not be made in the absence of this insurance.
  - 3. care rendered by a Veterans Administration or federal government facility, unless you or your estate are charged for such care.
  - 4. being exposed to war or any act of war, declared or undeclared, or service in any of the armed forces.
  - 5. intentionally self-inflicted bodily injury or attempted suicide (while sane or insane).
  - 6. alcoholism and drug addiction.
  - 7. mental or nervous disorders. This policy will pay, however, for covered care resulting from Alzheimer's disease, or related degenerative and dementing

illnesses first diagnosed while coverage is in force.

- D. This policy will not pay benefits for care rendered outside the United States or its possessions.**

### **Part 3** **UNIFORM PROVISIONS**

**A. ENTIRE CONTRACT; CHANGES:** This policy, together with the application, endorsements and additional benefits, if any, constitutes the entire contract of insurance. Any change in this policy shall not be valid until approved in writing by our secretary and president at our worldwide headquarters. Any such change must be noted on or attached hereto. No associate (duly licensed agent) has the authority to change this policy or to waive any of its provisions.

**B. TIME LIMIT ON CERTAIN DEFENSES:** (a) For a policy that has been in force for less than six months, an insurer may rescind the policy or deny an otherwise valid long-term care insurance claim upon a showing of misrepresentation by the Named Insured that is material to the acceptance for coverage. (b) For a policy that has been in force for at least six months but less than two years, an insurer may rescind the policy or deny an otherwise valid long-term care insurance claim upon a showing of misrepresentation by the Named Insured that is both material to the acceptance for coverage and that pertains to the condition for which benefits are sought. (c) After a policy has been in force for two years, the policy is not contestable upon the grounds of misrepresentation alone: that policy may be contested only upon a showing that the Named Insured knowingly and intentionally misrepresented relevant facts relating to the Named Insured's health.

**C. TERM:** The term of this policy begins at midnight, standard time, at the place where you reside on the Effective Date shown in the Policy Schedule. It ends at midnight, at the same standard time, on the first renewal date. Each renewal term ends at midnight, at the same standard time, on the next following renewal date. Renewal dates are determined by the mode of payment. The mode of payment for the original term of this policy is shown in the Policy Schedule. An annual premium maintains this policy in force for 12 months, semiannual for six months, quarterly for three months and monthly for one month. If you fail to pay your premium by the end of the grace period, coverage under this policy terminates. If you are confined in a covered facility on the date coverage would otherwise terminate, coverage under this policy extends to the earlier of (1) the date you are discharged from such facility or (2) the date you exceed the Benefit Period for that facility.

**D. MISSTATEMENT OF AGE:** If an age has been misstated on the application, the benefits will be those the premium paid would have purchased at the correct age. We will refund all unearned premiums paid, less any benefits paid, if your misstated age at the time of application was outside the age limits for this policy.

**E. GRACE PERIOD:** A grace period of 31 days will be granted for the payment of each premium falling due after the first premium. During the grace period, this policy shall continue in force.

**F. REINSTATEMENT:** You may request reinstatement of your policy from our associate

(duly licensed agent) or from Aflac. If your policy has lapsed for nonpayment of premium and we accept a later payment without requiring an application, your policy shall be reinstated. If we require a written application and provide you with a conditional receipt, your policy will be reinstated upon our approval of the application. If we do not notify you of our disapproval in writing within 45 days of the date of your application, your policy shall be deemed reinstated. The reinstated policy shall cover only injury sustained after the date of reinstatement and sickness that begins more than 10 days after the date of reinstatement. In all other respects, we both shall have the same rights as provided under the policy immediately before the due date of the defaulted premium, subject to any provisions added in connection with the reinstatement. Any premium accepted in connection with a reinstatement will not be applied to any period prior to the date of reinstatement. If your policy lapses due to your Cognitive Impairment or loss of functional capacity, the policy will be reinstated up to six months after the date of termination. Your attending Physician's certification of your Cognitive Impairment and payment of all past due premiums will be required.

**G. NOTICE OF CLAIM:** Written notice of claim must be given within 60 days after a covered loss starts or as soon as reasonably possible. The notice can be given to us at Aflac or to our associate (duly licensed agent). Notice should include your name and policy number.

**H. CLAIM FORMS:** When we receive a notice of claim, we will send you forms for filing proofs of loss. If the forms are not given to you within 10 working days, you will meet the proofs-of-loss requirements by giving us a written statement of the nature and extent of the loss within the time limit stated in the Proofs of Loss provision.

**I. PROOFS OF LOSS:** Written proof of loss must be furnished to Aflac, at its worldwide headquarters, within 90 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time. However, such proof must be furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

**J. TIME OF PAYMENT OF CLAIMS:** All benefits payable under this policy will be paid immediately upon receipt of written proof of loss.

**K. PAYMENT OF CLAIMS:** All benefits will be payable to you unless you assign them. Any accrued benefits unpaid at your death will be paid to your estate.

**L. LEGAL ACTIONS:** Any legal action may not be brought to recover on this policy within 60 days after written proof of loss has been furnished in accordance with the requirements of this policy. Any such actions shall not be brought after three years from the time written proof of loss is required to be furnished.

**M. CONFORMITY WITH STATE STATUTES:** Any provision of this policy that, on its Effective Date, is in conflict with the statutes of the state in which the Named Insured resides on such date is hereby amended to conform to the minimum requirements of such statutes.

**N. CONFORMITY WITH INTERNAL REVENUE CODE:** Any provision of this policy that, on its Effective Date, is in conflict with the Internal Revenue Code Section 7702B(b) is hereby amended to conform to the minimum requirements of such code or any regulations thereunder.

**O. ASSIGNMENT:** We will not assume responsibility for determining the validity of an assignment of your benefits to a provider of services. No such assignment of benefits will be recognized until we have received notice of it at our worldwide headquarters.

**P. PHYSICAL EXAMINATIONS AND AUTOPSY:** At our expense, we shall have the right and opportunity to have an insured person examined by a Licensed Health Care Practitioner of our choice as often as it may be reasonably required during the pendency of a claim and to make an autopsy in case of death where it is not forbidden by law.

**Q. PROTECTION AGAINST UNINTENTIONAL LAPSE:** You have the right and are encouraged to designate an individual other than yourself to receive notification that your policy will terminate due to nonpayment of premium. We will notify the person you designate at least 30 days in advance of the impending termination. You have the right to change your designated person on each renewal date of your policy.

**R. APPEALING AND RESOLVING BENEFIT DETERMINATIONS:** If you believe that our claim decision is in error, we will reconsider your claim. You must send us a brief note (no special form needed) that tells us why you feel we should change our decision. You may authorize someone else to act for you in the appeal process. The note should include the names, addresses and phone numbers of any of the following providers whom you think we should contact to learn more about your health and the care you received: the Physicians, case managers and other health practitioners who treated you, and the facilities from which you received care or treatment. Within sixty (60) days of your request, we will provide a written explanation of the reasons for the denial and make available to you all information directly related to the denial, or, we will pay any benefits then due as a result of our reconsideration.

**S. UNEARNED PREMIUMS:** That portion of the premium paid for a period beyond the policy month in which the Named Insured died, shall be paid in a lump sum on a date no later than 30 days after the proof of the Named Insured's death has been furnished to the insurer.

Should the Named Insured cancel this policy prior to its renewal date, Aflac will refund to the Named Insured the unearned portion of such premiums paid for any period beyond the end of the policy month in which the cancellation occurred.

Upon the death of the Named Insured, the proceeds payable to the Named Insured or estate of the Named Insured, will include premiums paid for disability insurance coverage for any period beyond the end of the month in which death occurred. Exception: Where Family coverage is continued, no refund is applicable.

**T. EXTENSION OF BENEFITS:** Termination of long-term care insurance shall be without prejudice to any benefits payable for institutionalization if such institutionalization began while the long-term care insurance was in force and continues without interruption after termination. The extension of benefits beyond the period the long-term care insurance was in force may be limited to the duration of the benefit period, if any, or to payment of the maximum benefits and may be subject to any policy waiting period, and all other applicable provisions of the policy.

**Part 4**  
**CONTINGENT BENEFIT UPON LAPSE**

If we increase the established premium rate for all policies in your class, you may be eligible for contingent nonforfeiture. You are eligible for this contingent benefit if:

- \* Your premium after the increase exceeds your original premium by the percentage shown (or more) in the following table;
- \* You lapse (not pay your premiums) within 120 days of the increase; and
- \* You did not purchase a nonforfeiture rider.

Contingent nonforfeiture provides for your coverage to continue on a limited basis. The amounts payable will be equal to the amounts payable at the time your policy lapsed.

The maximum amount payable will be equal to the total premiums paid for your policy and any attached riders from the Effective Date of this policy. However, the combined benefits payable under your policy and any attached riders will not exceed the maximum amount payable for each benefit or the total benefits that would have been payable under your policy if it had remained in premium-paying status.

**Table for Determining Contingent Nonforfeiture**  
**Cumulative Premium Increase Over Initial Premium**  
**That Qualifies for Contingent Nonforfeiture**

The percentage increase is cumulative from date of original issue. It does **NOT** represent a one-time increase.

<b>Issue Age</b>	<b>Percent Increase Over Initial Premium</b>
29 and under	200%
30-34	190%
35-39	170%
40-44	150%
45-49	130%
50-54	110%
55-59	90%
60	70%
61	66%
62	62%
63	58%
64	54%
65	50%

**Part 5**  
**LIMITATIONS OR CONDITIONS ON ELIGIBILITY FOR BENEFITS**

Any individual who has been certified by a Licensed Health Care Practitioner as: being

unable to perform without Substantial Assistance from another individual at least two Activities of Daily Living for a period of at least 90 days due to a loss of functional capacity; or requiring substantial supervision to protect such individual from threats to health and safety due to severe Cognitive Impairment.

A "Chronically Ill Individual" does not include any individual otherwise meeting the requirements of the preceding sentence unless, within the preceding 12-month period, a Licensed Health Care Practitioner has certified that such individual meets such requirements.

## **Part 6**

### **ELIGIBILITY FOR THE PAYMENT OF BENEFITS**

While this policy is in force, we agree to pay the following benefits while you are receiving Qualified Long-Term Care Services as a Chronically Ill Individual as defined in Part 1, Definitions.

The following benefits are subject to the Limitations and Exclusions listed in Part 2.

Aflac may, at any time during the pendency of a claim, but no more often than every 90 days, request a new Plan of Care or request an independent Physician's statement to determine whether you are or remain a Chronically Ill Individual.

## **Part 7**

### **BENEFITS**

#### **A. FIRST-OCCURRENCE BENEFIT:**

Aflac will pay an initial First-Occurrence Benefit, as shown in the Policy Schedule, for each person covered under this policy when he or she is diagnosed as a Chronically Ill Individual as defined in Part 1, Definitions.

This benefit is payable only once per lifetime for each covered person and will be paid in addition to any other benefit in this policy. This benefit is intended to assist the covered person with the expenses associated with Qualified Long-Term Care Services as defined in Part 1, Definitions. In addition to the certification required for a Chronically Ill Individual, as defined in Part 1, we may require further information from the attending Licensed Health Care Practitioner.

**IMPORTANT NOTE FOR THE FOLLOWING BENEFITS: The Nursing Home Daily Benefit (B1), Assisted-Living Daily Benefit (C), and Home Care Daily Benefit (D) will not be paid on the same day. Only the highest eligible benefit will be paid.**

#### **B. NURSING HOME DAILY BENEFIT:**

1. Aflac will pay the Nursing Home Daily Benefit amount shown in the Policy Schedule for each day a covered person is confined and requires Qualified Long-Term Care Services in a Nursing Home Facility. This benefit is subject to the Nursing Home Benefit Period.

If, while receiving Qualified Long-Term Care Services, the covered person temporarily leaves the Nursing Home Facility, we will pay the Nursing Home Daily Benefit, shown in the Policy Schedule, for up to 21 days per calendar year, for each day there are charges to reserve his or her bed in a Nursing Home Facility.

- 2. WAIVER OF PREMIUM BENEFIT:** Aflac will waive from month to month, for the Named Insured only, any premium(s) falling due during the Named Insured's continued Nursing Home Facility confinement. This benefit will begin after the Named Insured has received Nursing Home Daily Benefits for 60 consecutive days from this policy. When Nursing Home Daily Benefits are no longer being paid, premium payments must be resumed. Once premium payments are resumed any new confinements must again satisfy the 60 day continued confinement for premiums to be waived.

If you die and your spouse becomes the new Named Insured, premiums will start again, at the Individual rate, and will be due on the first premium due date after the change. The new Named Insured will then be eligible for this benefit if the need arises.

- C. ASSISTED-LIVING DAILY BENEFIT:** Aflac will pay the charges incurred up to the Assisted-Living Daily Benefit amount shown in the Policy Schedule for each day a covered person is confined and requires Qualified Long-Term Care Services in an Assisted-Living Facility. This benefit is subject to the Assisted-Living Benefit Period.
- D. HOME CARE BENEFIT:** Aflac will pay the charges incurred up to the Home Care Daily Benefit amount as shown in the Policy Schedule for each visit during which a covered person receives Qualified Long-Term Care Services for either: Care at Home, care at an Adult Day-Care Facility, or care at an Adult-Foster Care Facility. This benefit is subject to the Home Care Benefit Period as shown in the Policy Schedule. Multiple services received on the same day will be counted as one visit; this benefit is limited to one visit per day.

**AMERICAN FAMILY LIFE ASSURANCE COMPANY of COLUMBUS (AFLAC)  
WORLDWIDE HEADQUARTERS • 1932 WYNNNTON ROAD  
COLUMBUS, GEORGIA 31999**

**Toll-Free Telephone Number: 1.800.99.AFLAC (1.800.992.3522)**

**LONG-TERM CARE INSURANCE OUTLINE OF COVERAGE  
Policy Form A27000ARR**

**Notice to buyer:** This policy may not cover all of the costs associated with long-term care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all policy limitations.

**CAUTION:** The issuance of this long-term care policy is based upon your responses to the questions on your application. A copy of your application is attached to your policy. If your answers are incorrect or untrue, Aflac has the right to deny benefits or rescind your policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact Aflac at 1932 Wynnton Road, Columbus, GA, 31999.

**(1)** This policy is an individual policy of insurance which was issued in the state of Arkansas.

**(2) PURPOSE OF OUTLINE OF COVERAGE.** This Outline of Coverage provides a very brief description of the important features of the policy. You should compare this Outline of Coverage to outlines of coverage for the other policies available to you. This is not an insurance contract, but only a summary of coverage. Only the individual policy contains governing contractual provisions. This means that the policy sets forth in detail the rights and obligations of both you and Aflac. Therefore, if you purchase this coverage, or any other coverage, it is important that you **READ YOUR POLICY CAREFULLY!**

**(3) FEDERAL TAX CONSEQUENCES.** This policy is intended to be a federally tax-qualified long-term care insurance contract under Section 7702B(b) of the Internal Revenue Code of 1986, as amended. Please consult your tax advisor.

**(4) TERMS UNDER WHICH THE POLICY MAY BE CONTINUED IN FORCE OR DISCONTINUED.**  
**RENEWABILITY: THIS POLICY IS GUARANTEED RENEWABLE.** This means you have the right, subject to the terms of your policy, to continue this policy as long as you pay your premiums on time. Aflac cannot change any of the terms of your policy on its own, except that, in the future, Aflac **MAY INCREASE THE PREMIUM YOU PAY.**

**WAIVER OF PREMIUM BENEFIT:** After the Named Insured has received benefits in a Nursing Home Facility for 60 consecutive days, we will waive from month to month any premium falling due during the Named Insured's continued Nursing Home Facility Confinement. When Nursing Home Daily Benefits are no longer being paid, premium payments must be resumed. If the Named Insured dies and the spouse becomes the new Named Insured, premiums will start again, at the Individual rate, and will be due on the first premium due date after the change. The new Named Insured will then be eligible for this benefit if the need arises.

**(5) TERMS UNDER WHICH THE COMPANY MAY CHANGE PREMIUMS:** We have the right to change the renewal premium in accordance with our table of premium rates applicable to all policies of your form and class issued in your state. No premium change will be made because of your age or physical condition. "Class" is defined as "all policies of this form number and premium classification in your state that are then in force." In the event of a change in the established premium rate, we will notify you in writing at your last known address at least 45 days before the change becomes effective.

**(6) TERMS UNDER WHICH THE POLICY MAY BE RETURNED AND PREMIUM REFUNDED.** (a) If you are not satisfied with your policy after you receive it, send it back within 30 days. Your money will be returned. (b) **RETURN OF UNEARNED PREMIUMS:** That portion of the premium paid for a period beyond the policy month in which the insured died, shall be paid in a lump sum on a date no later than 30 days after the proof of the insured's death has been furnished to the insurer. Should the insured cancel this policy prior to its renewal date, AFLAC will refund to the insured the unearned portion of such premiums paid for any period beyond the end of the policy month in which the cancellation occurred. Upon the death of an insured, the proceeds payable to the insured or estate, will include premiums paid for disability insurance coverage for any period beyond the end of the month in which death occurred. Exception: Where Family coverage is continued, no refund is applicable.

**(7) THIS IS NOT MEDICARE SUPPLEMENT COVERAGE.** If you are eligible for Medicare, review the Medicare Supplement Buyers Guide available from Aflac. Neither Aflac nor its agents represent Medicare, the federal government or any state government.

**(8) LONG-TERM CARE COVERAGE.** Policies of this category are designed to provide coverage for one (1) or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than an acute care unit of a hospital, such as in a Nursing Home Facility, in the community or in the home. The policy provides coverage in the form of a fixed-dollar indemnity benefit for covered long-term care expenses, subject to policy limitations.

**(9) BENEFITS PROVIDED BY THIS POLICY.**

**A. FIRST-OCCURRENCE BENEFIT:** Aflac will pay an initial First-Occurrence Benefit as shown in the Policy Schedule for each covered person when he or she is first diagnosed as a Chronically Ill Individual as defined in Part 1, Definitions, of the policy contract. This benefit is payable only once per lifetime for each covered person and will be paid in addition to any other benefit in the policy. This benefit is intended to assist the covered person with the expenses associated with Qualified Long-Term Care Services as defined in the policy. In addition to the certification required for a Chronically Ill Individual, we may require further information from the attending Licensed Health Care Practitioner.

**IMPORTANT NOTE FOR THE FOLLOWING BENEFITS:** The Nursing Home Daily Benefit (B1), Assisted-Living Daily Benefit (C), and Home Care Daily Benefit (D) will not be paid on the same day. Only the highest eligible benefit will be paid.

**B. NURSING HOME DAILY BENEFIT:**

1. \$ \_\_\_\_\_ per day while a covered person is confined and requires Qualified Long-Term Care Services in a Nursing Home Facility. Benefits are subject to the Nursing Home Benefit Period as shown in the Policy Schedule.

If, while receiving Qualified Long-Term Care Services, the covered person temporarily leaves the Nursing Home Facility, we will pay the Nursing Home Daily Benefit, as shown in the Policy Schedule, for up to 21 days per calendar year, for each day there are charges to reserve his or her bed in a Nursing Home Facility.

2. **WAIVER OF PREMIUM BENEFIT:** See Terms Under Which The Policy May Be Continued In Force Or Discontinued.

**C. ASSISTED-LIVING DAILY BENEFIT:** Aflac will pay the charges incurred up to the Assisted-Living Daily Benefit amount as shown in the Policy Schedule for each day a covered person is confined and requires Qualified Long-Term Care Services in an Assisted-Living Facility. This benefit is subject to the Assisted-Living Benefit Period.

**D. HOME CARE DAILY BENEFIT:** Aflac will pay the charges incurred up to the Home Care Daily Benefit amount as shown in the Policy Schedule for each visit during which a covered person receives Qualified Long Term Care Services for either: Care at Home, care at an Adult Day-Care Facility, or care at an Adult-Foster Care Facility. This benefit is subject to the Home Care Benefit Period shown in the Policy Schedule. Multiple services received on the same day will be counted as one visit; this benefit is limited to one visit per day.

**E. ELIGIBILITY FOR PAYMENT OF BENEFITS:**

While this policy is in force, we agree to pay the benefits while you are receiving Qualified Long-Term Care Services as a Chronically Ill Individual.

Aflac may, at any time during the pendency of a claim, but no more often than every 90 days, request a new Plan of Care or request an independent Physician's statement to determine whether you are or remain a Chronically Ill Individual.

**1. DEFINITIONS:**

- a. **Activities of Daily Living (ADLs):** activities used in measuring levels of personal functioning capacity. These activities are performed without Substantial Assistance from another individual allowing personal independence in your everyday living.

The ADLs are:

- (1) Bathing: washing oneself by sponge bath or in either a tub or shower, including the task of getting into or out of the tub or shower.
- (2) Continence: the ability to maintain control of bowel and bladder function or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene, including caring for catheter or colostomy bag;
- (3) Dressing: putting on and taking off all your items of clothing and any necessary braces, fasteners or artificial limbs;

- (4) Eating: feeding yourself by getting food into the body from a receptacle (such as a plate, cup or table) after it has been prepared for you or by a feeding tube or intravenously;
- (5) Toileting: getting to and from a toilet, getting on and off a toilet, and performing associated personal hygiene;
- (6) Transferring: moving into or out of a bed, chair or wheelchair.

**b. CHRONICALLY ILL INDIVIDUAL:** any individual who has been certified by a Licensed Health Care Practitioner as: being unable to perform without Substantial Assistance from another individual at least two Activities of Daily Living for a period of at least 90 days due to a loss of functional capacity; or requiring substantial supervision to protect such individual from threats to health and safety due to severe Cognitive Impairment.

"Chronically Ill Individual" does not include any individual otherwise meeting the requirements of the preceding sentence unless, within the preceding 12-month period, a Licensed Health Care Practitioner has certified that such individual meets such requirements.

**c. COGNITIVE IMPAIRMENT:** the deterioration or loss of your intellectual capacity that requires you to be continually supervised for the protection of yourself and others. Your impairment must be evidenced by a clinical diagnosis as well as by results from standardized tests that measure: (1) your short-term and long-term memory (2) orientation as to person, place and time (3) your deductive or abstract reasoning and (4) your judgment as it relates to safety awareness.

**d. PLAN OF CARE:** a written document prepared and signed by a Licensed Health Care Practitioner that demonstrates you are a Chronically Ill Individual and includes a plan for the administration of Qualified Long-Term Care Services.

**e. SUBSTANTIAL ASSISTANCE:** you are considered to need Substantial Assistance in performing Activities of Daily Living (ADLs) when:

- (1) you require hands-on assistance of another person to help you perform an ADL each and every time you perform that activity, meaning physical assistance, minimal, moderate, or maximal, without which the individual would not be able to perform and ADL.
- (2) you cannot perform the entire activity alone with the supports and mechanical aids that are normally available to you.
- (3) you require supervision, including verbal cueing by another person in order to protect the Named Insured or others due to the presence of a Cognitive Impairment.

**(10) LIMITATIONS AND EXCLUSIONS:**

- A. **PRE-EXISTING CONDITIONS:** Subject to the truthful completion of your application, this policy fully covers all health conditions that you may presently have, subject to the terms of the policy, as of the policy Effective Date shown in the Policy Schedule.
- B. This policy will not pay benefits for that portion of any expense that is for services which are reimbursable under Medicare (or would be so reimbursable but for the application of the Medicare deductible or coinsurance amounts).
- C. If Medicaid is paying claims on your behalf, all benefits payable under this policy for those claims will be paid directly to Medicaid.
- D. This policy does not cover any of the following:
  - 1. services rendered by a member of your Immediate Family.
  - 2. services for which a charge would not be made in the absence of this insurance.
  - 3. care rendered by a Veterans Administration or federal government facility, unless you or your estate are charged for such care.
  - 4. being exposed to war or any act of war, declared or undeclared, or service in any of the armed forces.
  - 5. intentionally self-inflicted bodily injury or attempted suicide (while sane or insane).
  - 6. alcoholism and drug addiction.
  - 7. mental or nervous disorders. This policy will pay, however, for covered care resulting from Alzheimer's disease, or related degenerative and dementing illnesses first diagnosed while coverage is in force.
- E. **This policy will not pay benefits for care rendered outside the United States or its possessions.**

**THIS POLICY MAY NOT COVER ALL THE EXPENSES ASSOCIATED WITH YOUR LONG-TERM CARE NEEDS.**

**(11) RELATIONSHIP OF COST OF CARE AND BENEFITS:** Because the costs of long-term care services will likely increase over time, you should consider whether and how the benefits of this plan may be adjusted. The benefit level of the policy will not increase over time. **EXCEPTION:** You are guaranteed the right to increase your benefits as provided in Optional Benefit Rider Series A-27062.

**(12) ALZHEIMER'S DISEASE AND OTHER ORGANIC BRAIN DISORDERS:** Alzheimer's disease,

or related degenerative and dementing illnesses first diagnosed while coverage is in force are covered.

**(13) PREMIUMS:**

**Policy:**

\$ \_\_\_\_\_ Modal Policy Premium

**Additional Benefits:**

Inflation Rider (Series A-27062)

\$ \_\_\_\_\_

Nonforfeiture Benefit (Series A-27051)

\$ \_\_\_\_\_

**(14) ADDITIONAL FEATURES:**

- A. The policy may be issued to individuals ages 18 through 65 on a selective basis.
- B. Applicants will be accepted or declined.
- C. **CONTINGENT BENEFIT UPON LAPSE:** If we increase the established premium rate for all policies in your class, you may be eligible for contingent nonforfeiture. You are eligible for this contingent benefit if:
  - Your premium after the increase exceeds your original premium by the percentage shown (or more) in the table referenced in the Potential Rate Increase Disclosure Form.
  - You lapse (not pay your premiums) within 120 days of the increase; and
  - You did not purchase a nonforfeiture rider.

Contingent nonforfeiture provides for your coverage to continue on a limited basis. The amounts payable will be equal to the amounts payable at the time your policy lapsed.

The maximum amount payable will be equal to the total premiums paid for your policy and any attached riders from the Effective Date of this policy. However, the combined benefits payable under your policy and any attached riders will not exceed the maximum amount payable for each benefit or the total benefits that would have been payable under your policy if it had remained in premium-paying status.

**D. OPTIONAL BENEFITS**

- 1. **LONG-TERM CARE INFLATION BENEFIT (Series A-27062):** Applied for: Yes  No   
The First-Occurrence, Nursing Home, Assisted-Living and Home Care Daily Benefits of the policy to which this rider is attached will increase by 5 percent, on a compounding basis, on each anniversary date of this rider. This compounding increase will apply only to the amount of the benefit in force on the Effective Date of this rider and not to additional amounts purchased at a later date.

2. NONFORFEITURE BENEFIT (Series A-27051): Applied for: Yes  No

If you have not paid your premium for the policy within the grace period, as provided in

your policy, your policy will terminate and no other policy benefits will be payable, except as provided by this optional benefit. See your rider for details.

**(15) CONTACT THE STATE SENIOR HEALTH INSURANCE ASSISTANCE PROGRAM IF YOU HAVE GENERAL QUESTIONS REGARDING LONG-TERM CARE INSURANCE. CONTACT THE INSURANCE COMPANY IF YOU HAVE SPECIFIC QUESTIONS REGARDING YOUR LONG-TERM CARE INSURANCE POLICY.**

**RETAIN FOR YOUR RECORDS. THIS OUTLINE OF COVERAGE IS ONLY A BRIEF SUMMARY OF THE COVERAGE PROVIDED. CONSULT THE POLICY ITSELF TO DETERMINE GOVERNING CONTRACTUAL PROVISIONS.**

**If you have any questions about the policy, please call our toll-free number 1.800.99.AFLAC (1.800.992.3522).**



**Qualified Long-Term Care Insurance (A-27000 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 Mo/Day/Year

Applicant's SS No. \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Applicant's Height \_\_\_\_\_ Applicant's Weight \_\_\_\_\_

State of Birth \_\_\_\_\_ Married  Yes  No

**(Complete spouse's name below if you are applying for Husband/Wife coverage; if no spouse or if spouse is not to be covered, put NONE in space below.)**

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

Spouse's Height \_\_\_\_\_ Spouse's Weight \_\_\_\_\_

Spouse's Occupation \_\_\_\_\_ Place of Employment \_\_\_\_\_

Address \_\_\_\_\_ ZIP Code \_\_\_\_\_ - \_\_\_\_\_  
Street or Post Office Box Apt.No.

City \_\_\_\_\_ State \_\_\_\_\_ Best day and time to call \_\_\_\_\_

Home Phone \_\_\_\_\_ Business Phone \_\_\_\_\_ for interview \_\_\_\_\_

Tobacco Use: Applicant  Yes  No  
 Spouse  Yes  No

**Type of Coverage**  Individual  Husband/Wife

**Plan Options / Benefit Period**

Benefits	<input type="checkbox"/> Plan 1	<input type="checkbox"/> Plan 2	<input type="checkbox"/> Plan 3	<input type="checkbox"/> Plan 4
Nursing Home Benefit	2 Years	3 Years	5 Years	Lifetime
Assisted-Living Benefit	1 Year	2 Years	2 Years	2 Years
Home Care Benefit	250 Visits	400 Visits	500 Visits	500 Visits

**Long-Term Care Benefit Amount Selection – Maximum Daily Amount**

Nursing Home Care Pays:	<input type="checkbox"/> \$ 60	<input type="checkbox"/> \$ 80	<input type="checkbox"/> \$100	<input type="checkbox"/> \$120	<input type="checkbox"/> \$150	<input type="checkbox"/> \$ 200
Assisted-Living Pays Up To:	\$ 48	\$ 64	\$ 80	\$ 96	\$120	\$ 160
Home Care Pays Up To:	\$ 30	\$ 40	\$ 50	\$ 60	\$ 75	\$ 100

**Optional Riders:**

- Long-Term Care Policy Inflation Rider  
 Nonforfeiture Benefit Rider

**Billing Selections:**  
 Payroll

Modes:  
 01 Weekly  01 Semimonthly  06 Semiannual  
 01 Biweekly  01 Monthly  12 Annual  
 03 Quarterly

Employee No. \_\_\_\_\_ Dept. No. \_\_\_\_\_ Billable Premium \$ \_\_\_\_\_

**IF A PERSON TO BE COVERED ANSWERS "YES" TO ANY OF QUESTIONS 1 THROUGH 10,  
A POLICY WILL NOT BE ISSUED TO THAT PERSON.**

1. In the past 12 months, has anyone to be covered under this policy been declined, rated or postponed for long-term care insurance?  Yes  No
2. Is anyone to be covered under this policy receiving disability income, workers' compensation or any state or Social Security disability benefits?  Yes  No
3. During the past six months has anyone to be covered under this policy been confined to a nursing home or an assisted-living facility or has anyone to be covered under this policy received or is currently receiving home health care or has a member of the medical profession recommended the services of a trained attendant in your residence?  Yes  No
4. Does anyone to be covered under this policy require assistance or supervision in everyday activities such as: cooking, dressing, eating, housekeeping, performing personal hygiene (bathing or toileting), shopping or walking; or does anyone to be covered use a walker, a quad- or three-prong cane, a wheelchair, a motorized scooter, a chair lift, a catheter, oxygen equipment or a respirator?  Yes  No
5. Have you or anyone to be covered under this policy ever been diagnosed with or treated for any of the following conditions:  Yes  No

* Alzheimer's disease	* Multiple sclerosis
* ALS (Lou Gehrig's disease)	* Myasthenia gravis
* Amputation due to disease	* Paget's disease
* Chronic fatigue syndrome	* Parkinson's disease
* Chronic liver disease	* Polymyositis
(excluding Hepatitis A)	* Rheumatoid arthritis
* Dementia or organic brain syndrome	* Scleroderma
* Fibromyalgia	* Stroke or TIA
* Kidney disease or disorder requiring dialysis	* Type I Diabetes
* Lupus (systemic)	* Type II Diabetes (with nephropathy, neuropathy or retinopathy)
6. In the past five years, has a member of the medical profession diagnosed or treated anyone to be covered under this policy for:  Yes  No

* Cancer (other than non-melanoma skin cancers)	* Heart attack
* Cardiomyopathy	* Heart valve replacement
* Compression fractures due to osteoporosis	* Joint replacement
7. Has a member of the medical profession diagnosed you with or treated you for any of the following:  Yes  No

* Psychotic disorders	* Bipolar affective disorder (manic depressive syndrome)
* Eating disorders	* Delusional (paranoid) disorders
* Schizophrenia	* Somatoform disorders (psychosomatic illness)
* Major depressive disorders	* Psychoneurotic disorders
8. Has anyone to be covered under this policy been charged with driving under the influence of alcohol or any narcotic within the last 12 months or been charged two or more times within the last five years, or in the last five years has anyone to be covered under this policy been counseled, treated or hospitalized for the use of drugs or alcohol?  Yes  No
9. Has anyone to be covered under this policy received treatment for or been diagnosed by a member of the medical profession as having acquired immune deficiency syndrome (AIDS) or AIDS-related complex (ARC), or has anyone to be covered under this policy tested positive for HIV?  Yes  No
10. Within the last five years, has anyone to be covered under this policy ever had or been advised to have an organ transplant or consulted with a member of the medical profession about the need to have either an organ transplant or dialysis?  Yes  No

**ANY OF QUESTIONS 11 THROUGH 14 IS ANSWERED "YES," PROVIDE DETAILS IN ITEM 15.**

11. During the past three years, has anyone to be covered under this policy received medical advice, treatment or consultation for any of the following (check all that apply and provide details in Item 15):  Yes  No

<input type="checkbox"/> Back, neck or joint injury or disorder	<input type="checkbox"/> Mental or nervous disorder or impairment
<input type="checkbox"/> Cardiac arrhythmia	<input type="checkbox"/> Osteoarthritis
<input type="checkbox"/> Chest pain or angina	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Chronic lung disease	<input type="checkbox"/> Seizures
<input type="checkbox"/> Congestive heart failure	<input type="checkbox"/> Musculoskeletal or connective tissue disease/disorder
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Tumor
<input type="checkbox"/> Heart disease or disorder	

High blood pressure/Hypertension

12. Has anyone to be covered under this policy ever been diagnosed or treated by a member of the medical profession for any cognitive impairment or experienced any memory loss or deficit, paranoia, confusion, disorientation, depression, or impaired social or occupational functioning?  Yes  No
13. During the past 12 months, has anyone to be covered under this policy had any surgical procedure or been advised by a physician to have tests, treatment or surgery that has not yet been done?  Yes  No
14. During the past two years, for other than routine checkups, has anyone to be covered under this policy been confined in a hospital as an inpatient (not including confinement due to pregnancy) or received home health care?  Yes  No

15. **(Details to Questions 11 - 14)**

	<b>Name/ Relationship</b>	<b>Condition(s)</b>	<b>Onset (mo/yr)</b>	<b>Surgery Performed? (yes/no/date)</b>	<b>Name and Address of Physician and Hospital</b>
Q #11					
Q #12					
Q #13					
Q #14					

16. Has anyone to be covered under this policy been prescribed or is anyone to be covered under this policy taking any prescription medication (other than prescription contraceptives)?  Yes  No  
 If yes, please provide the name of the person taking the prescription, the name of the medication and the dosage of any and all of the medication(s) and reason(s) for taking it below.

<b>Name</b>	<b>Medication name</b>	<b>Dosage</b>	<b>Frequency</b>	<b>Date first prescribed</b>	<b>Reason</b>

Applicant's Physician's Name _____	Phone Number _____
If no regular physician, physician last seen	
Address _____	
Date last seen by physician _____	Reason for last visit: _____

Spouse's Physician's Name \_\_\_\_\_ Phone Number \_\_\_\_\_  
If no regular physician, physician last seen  
 Address \_\_\_\_\_  
 Date last seen by physician: \_\_\_\_\_ Reason for last visit: \_\_\_\_\_

Do you have another long-term care insurance policy in force (including health care service contract or health maintenance organization contract)?  Yes  No  
 Did you have another long-term care insurance policy in force during the last 12 months?  Yes  No  
 If so, with which company? (name and address) \_\_\_\_\_  
 Policy No. \_\_\_\_\_ If that policy has lapsed, when did it lapse? \_\_\_\_\_  
 Are you covered by Medicaid?  Yes  No  
 Do you intend to replace any of your medical or health insurance coverage with this policy?  Yes  No  
 If yes, please read and sign the Replacement Notice provided by your associate/agent.

I request that a copy of my application, outline of coverage and premium rate be provided to my advisor (lawyer, financial consultant or my closest relative, etc.). (If you do not wish to name an advisor, so state on the lines below):  
 \_\_\_\_\_ ( )  
 Last Name First Name MI Phone  
 Street/P.O. Box City State ZIP Code

**Protection Against Unintended Lapse**

I request that a notice of cancellation for nonpayment of premium be provided to the person designated below. You must designate at least one person.

Last Name First Name MI  
 Street/P.O. Box  
 City State Zip Code

I understand that I have the right to designate at least one (1) person other than myself to receive notice of lapse or termination of this long-term care insurance policy for nonpayment of premium. I understand that notice will not be given until thirty (30) days after a premium is due and unpaid. I elect NOT to designate any person to receive this notice.

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

I acknowledge receipt of, if applicable:

- Outline of Coverage  Guide to Health Insurance for People  Guide to Long-Term Care  
 Replacement Notice  With Medicare  
 Potential Rate Increase Disclosure Form

**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.

**INFLATION PROTECTION:**

**I have reviewed the Outline of Coverage and the graph that compares the benefits and premiums of this policy with and without inflation protection. Specifically, I have reviewed Plans \_\_\_\_\_, and I  reject  accept (check one) the optional inflation protection.**

I understand that: (1) 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. (2) Aflac is not bound by any statement made by me, or any associate/agent of Aflac unless written herein. (3) the associate/agent cannot change the provisions of the policy or waive any of its provisions either orally or in writing. (4) the policy with this application and endorsements or riders, if any, is the entire contract of insurance. (5) no change to the policy will be valid until approved in writing by Aflac's president and secretary.

I have read, or had read to me, the completed application. My answers are complete and true to the best of my knowledge and belief.

**CAUTION:** If your answers on this application are incorrect or untrue, Aflac has the right to deny benefits or rescind your policy.

**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 associate/agent.**

**Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.**

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

Signed and dated at: \_\_\_\_\_  
City and State

**I certify that: (1) I have accurately recorded the responses to all questions on this application. (2) all questions were asked of the proposed insured. (3) I have not knowingly allowed any false or misleading statements on this application. (4) I have carefully evaluated this application and have made a full and accurate disclosure to Aflac of all factors that might affect the underwriting of the risk. I further certify that I have asked whether the applicant is currently insured under any existing long-term care insurance policy or any other health insurance policy and I have determined that the coverage applied for is not unsuitable for the proposed insured.**

List all health policies this applicant has that are still in force: \_\_\_\_\_

List all health policies you sold to this applicant that are still in force: \_\_\_\_\_

List all health policies you sold to this applicant in the past five years that are no longer in force: \_\_\_\_\_

Signature of Associate/Agent \_\_\_\_\_ Date \_\_\_\_\_

Associate/Agent's Number \_\_\_\_\_ SIT. Code: \_\_\_\_\_ Premium Collected \_\_\_\_\_

**MAKE CHECKS OR MONEY ORDERS PAYABLE TO AFLAC.  
FOR INFORMATION, CALL TOLL-FREE 1.800.99.AFLAC (1.800.992.3522).**

Writing Associate/Agent: Please complete the following - it will become part of the policy.  
**AMERICAN FAMILY LIFE ASSURANCE COMPANY OF COLUMBUS (AFLAC)**  
**CLIENT SERVICES AND ADMINISTRATION • 1932 WYNNTON ROAD • COLUMBUS, GEORGIA 31999**  
**TOLL-FREE 1.800.99.AFLAC (1.800.992.3522)**

Associate/Agent's Name \_\_\_\_\_

Associate/Agent's Address \_\_\_\_\_ Telephone \_\_\_\_\_

If we at Aflac fail to provide you with reasonable and adequate service, you should feel free to contact:

**ARKANSAS INSURANCE DEPARTMENT • CONSUMER SERVICES DIVISION**  
**1200 WEST THIRD STREET**  
**LITTLE ROCK, ARKANSAS 72201-1904**  
**Telephone 501.371.2640 or Toll-Free 1.800.852.5494**



**Qualified Long-Term Care Insurance (A-27000 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 Mo/Day/Year

Applicant's SS No. \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Address \_\_\_\_\_ ZIP Code \_\_\_\_\_ - \_\_\_\_\_  
Street or Post Office Box Apt. No.

City \_\_\_\_\_ State \_\_\_\_\_ Home Phone \_\_\_\_\_ Business Phone \_\_\_\_\_

**Type of Coverage**      Basic coverage (Individual)  
**Plan Option**

	Benefit Period		Maximum Daily Benefit Amount
Nursing Home Benefit	2 Years	Nursing Home Care Pays:	\$60
Assisted-Living Benefit	1 Year	Assisted-Living Pays Up To:	\$48
Home Care Benefit	250 Visits	Home Care Pays Up To:	\$30

**Billing Selections:**      Modes:       01 Semimonthly       06 Semiannual  
 Payroll       01 Weekly       01 Monthly       12 Annual  
 01 Biweekly       03 Quarterly

Employee No. \_\_\_\_\_ Dept. No. \_\_\_\_\_ Billable Premium \$ \_\_\_\_\_

**IF YOU ANSWER "YES" TO ANY OF QUESTIONS 1 THROUGH 10  
 A POLICY WILL NOT BE ISSUED.**

- In the past 12 months, have you been declined, rated or postponed for long-term care insurance?       Yes  No
- Are you receiving disability income, workers' compensation or any state or Social Security disability benefits?       Yes  No
- During the past six months have you been confined to a nursing home, or an assisted-living facility, or have you received or are you currently receiving home health care, or has a member of the medical profession recommended the services of a trained attendant in your residence?       Yes  No
- Do you require assistance or supervision in everyday activities such as: cooking, dressing, eating, housekeeping, performing personal hygiene (bathing or toileting), shopping or walking; or do you use a walker, a quad- or three-prong cane, a wheelchair, a motorized scooter, a chair lift, a catheter, oxygen equipment or a respirator?       Yes  No
- Have you ever been diagnosed with or treated for any of the following conditions?       Yes  No
  - \* ALS (Lou Gehrig's disease)      \* Multiple sclerosis
  - \* Alzheimer's disease      \* Myasthenia gravis
  - \* Amputation due to disease      \* Paget's disease
  - \* Chronic fatigue syndrome      \* Parkinson's disease
  - \* Chronic liver disease      \* Polymyositis
  - (excluding Hepatitis A)      \* Rheumatoid arthritis
  - \* Dementia or organic brain syndrome      \* Scleroderma
  - \* Fibromyalgia      \* Stroke or TIA
  - \* Kidney disease or disorder      \*Type I Diabetes
  - requiring dialysis      \*Type II Diabetes (with nephropathy, neuropathy or
  - \* Lupus (systemic)      retinopathy)



I acknowledge receipt of, if applicable:

- Outline of Coverage
- Replacement Notice
- Potential Rate Increase Disclosure Form
- Guide to Health Insurance for People With Medicare
- Guide to Long-Term Care

**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.

**INFLATION PROTECTION/NONFORFEITURE PROTECTION:**

**I have reviewed the Outline of Coverage and the graph that compares the benefits and premiums of this policy with and without inflation protection. I have also reviewed the Outline of Coverage with the nonforfeiture benefits. Specifically, I have reviewed Plans \_\_\_\_\_, and I  reject  accept (check one) the optional inflation protection. I  reject  accept (check one) the optional nonforfeiture rider.**

I understand that: (1) 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. (2) Aflac is not bound by any statement made by me, or any associate/agent of Aflac unless written herein. (3) the associate/agent cannot change the provisions of the policy or waive any of its provisions either orally or in writing. (4) the policy with this application and endorsements or riders, if any, is the entire contract of insurance. (5) no change to the policy will be valid until approved in writing by Aflac's president and secretary.

I have read, or had read to me, the completed application. My answers are complete and true to the best of my knowledge and belief.

**CAUTION:** If your answers on this application are incorrect or untrue, Aflac has the right to deny benefits or rescind your policy.

**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 associate/agent.**

**Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.**

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

Signed and dated at \_\_\_\_\_  
City and State

**I certify that: (1) I have accurately recorded the responses to all questions on this application; (2) all questions were asked of the proposed insured. (3) I have not knowingly allowed any false or misleading statements on this application. (4) I have carefully evaluated this application and have made a full and accurate disclosure to Aflac of all factors that might affect the underwriting of the risk. I further certify that I have asked whether the applicant is currently insured under any existing long-term care insurance policy or any other health insurance policy and I have determined that the coverage applied for is not unsuitable for the proposed insured.**

List all health policies this applicant has that are still in force: \_\_\_\_\_

List all health policies you sold to this applicant that are still in force: \_\_\_\_\_

List all health policies you sold to this applicant in the past five years that are no longer in force: \_\_\_\_\_

Signature of Associate/Agent _____	Date _____	
Associate/Agent's Number _____	SIT. Code: _____	Premium Collected _____

**MAKE CHECKS OR MONEY ORDERS PAYABLE TO AFLAC.  
FOR INFORMATION, CALL TOLL-FREE 1.800.99.AFLAC (1.800.992.3522).**

Writing Associate/Agent: Please complete the following - it will become part of the policy.

**AMERICAN FAMILY LIFE ASSURANCE COMPANY OF COLUMBUS (AFLAC)  
CLIENT SERVICES AND ADMINISTRATION • 1932 WYNNTON ROAD • COLUMBUS, GEORGIA 31999  
TOLL-FREE 1.800.99.AFLAC (1.800.992.3522)**

Associate/Agent's Name \_\_\_\_\_

Associate/Agent's Address \_\_\_\_\_ Telephone \_\_\_\_\_

If we at Aflac fail to provide you with reasonable and adequate service, you should feel free to contact:

**ARKANSAS INSURANCE DEPARTMENT • CONSUMER SERVICES DIVISION  
1200 WEST THIRD STREET  
LITTLE ROCK, ARKANSAS 72201-1904  
Telephone 501.371.2640 or Toll-Free 1.800.852.5494**

**REQUEST FOR ADDITIONS/APPLICATION FOR REINSTATEMENT  
Long-Term Care Policy Series A-27000**

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

Name of Policyholder _____	SS No. _____	
Policy Number (s) _____		
Date of Birth _____	Telephone No. _____	Best time to call _____
Current Address of Policyholder: _____		
City _____	State _____	Zip _____
Name of Employer/Payroll Account _____		

Associate/Agent's Signature _____	Writing Number _____
Licensed Resident Associate/Agent	

<input type="checkbox"/> <b>ADDITION</b>	Person(s) to Be Added _____
	Date(s) of Birth _____ Relationship _____
	Height _____ Weight _____ Tobacco Use: <input type="checkbox"/> Yes <input type="checkbox"/> No
	Spouse's Occupation _____ Place of Employment _____
	Reason(s) for Addition(s) _____
	Effective Date of Addition(s) _____
	Type of Coverage Now Desired <input type="checkbox"/> Husband/Wife

<input type="checkbox"/> <b>REINSTATEMENT</b>	Attached is \$ _____ to cover _____ months premium. I hereby apply for reinstatement of my coverage as indicated above.
---	---

**PLEASE READ THE FOLLOWING.**

All portions of this form must be completed before your application can be processed; therefore, please be sure to indicate the name of any person who has a history of the medical conditions listed, if applicable, in the spaces provided. **If none, please write the word "none".**

**IF A PERSON TO BE ADDED OR REINSTATED ANSWERS "YES"  
TO ANY OF QUESTIONS 1 THROUGH 10,  
THAT PERSON WILL NOT BE ADDED OR REINSTATED.**

1. In the past 12 months, has anyone to be covered under this policy been declined, rated or postponed for long-term care insurance?  Yes  No
2. Is anyone to be covered under this policy receiving disability income, workers' compensation or any state or Social Security disability benefits?  Yes  No
3. During the past six months: Has anyone to be covered under this policy been confined to a nursing home or an assisted-living facility or has anyone to be covered under this policy received or is anyone currently receiving home health care or has a member of the medical profession recommended the services of a trained attendant in your residence?  Yes  No
4. Does anyone to be covered under this policy require assistance or supervision in everyday activities such as: cooking, dressing, eating, housekeeping, performing personal hygiene (bathing or toileting), shopping or walking; or does anyone use a walker, a quad- or three-prong cane, a wheelchair, a motorized scooter, a chair lift, a catheter, oxygen equipment or a respirator?  Yes  No
5. Have you or anyone to be covered under this policy ever been diagnosed with or treated for any of the following conditions:  Yes  No
 

* Alzheimer's disease	* Dementia or organic brain syndrome	* Parkinson's disease
* ALS (Lou Gehrig's disease)	* Polymyositis	* Rheumatoid arthritis
* Amputation due to disease	* Lupus (systemic)	* Scleroderma
* Chronic liver disease (excluding Hepatitis A)	* Multiple sclerosis	* Myasthenia gravis
* Type I Diabetes	* Paget's disease	* Stroke or TIA
* Type II Diabetes (with nephropathy, neuropathy or retinopathy)		* Fibromyalgia
* Kidney disease or disorder requiring dialysis		* Chronic fatigue syndrome
6. In the past five years, has a member of the medical profession diagnosed or treated you or anyone to be covered under this policy for any of the following conditions:  Yes  No
 

* Cancer (other than non-melanoma skin cancers)	* Joint replacement
* Compression fractures due to osteoporosis	* Heart valve replacement
* Heart attack	* Cardiomyopathy
7. Has a member of the medical profession diagnosed you with or treated you for any of the following:  Yes  No
 

* Psychotic disorders	* Bipolar affective disorder (manic depressive syndrome)
* Eating disorders	* Delusional (paranoid) disorders
* Schizophrenia	* Somatoform disorders (psychosomatic illness)
* Major depressive disorders	* Psychoneurotic disorders
8. Has anyone to be covered under this policy been charged with driving under the influence of alcohol or any narcotic within the last 12 months or been charged two or more times within the last five years, or in the last five years has anyone to be covered under this policy been counseled, treated or hospitalized for the use of drugs or alcohol?  Yes  No
9. Has anyone to be covered under this policy received treatment for or been diagnosed by a member of the medical profession as having acquired immune deficiency syndrome (AIDS) or AIDS-related complex (ARC), or has anyone to be covered under this policy tested positive for HIV?  Yes  No
10. Within the last five years, has anyone to be covered under this policy ever had or been advised to have an organ transplant or consulted with a member of the medical profession about the need to have either an organ transplant or dialysis?  Yes  No

If any one of Questions 1 through 10 is answered "yes", the name and the relationship of the person must be shown in the following space. \_\_\_\_\_

**Any person so named will not be covered under the policy.**

**ANY OF QUESTIONS 11 THROUGH 14 IS ANSWERED "YES," PROVIDE DETAILS IN ITEM 15.**

11. During the past three years, has anyone to be covered under this policy received medical advice, treatment or consultation for (check all that apply and provide details in Item 15):  Yes  No
 

<input type="checkbox"/> Chronic lung disease	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Heart disease or disorder	<input type="checkbox"/> Tumor
<input type="checkbox"/> Musculoskeletal or connective tissue disease / disorder	<input type="checkbox"/> Seizures
<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Osteoarthritis
<input type="checkbox"/> Back, neck or joint injury or disorder	<input type="checkbox"/> High blood pressure/Hypertension
<input type="checkbox"/> Chest pain or angina	<input type="checkbox"/> Cardiac arrhythmia
<input type="checkbox"/> Congestive heart failure	<input type="checkbox"/> Mental or nervous disorder or impairment

12. Has anyone to be covered under this policy ever been diagnosed or treated by a member of the medical profession for any cognitive impairment or experienced any memory loss or deficit, paranoia, confusion, disorientation, depression, or impaired social or occupational functioning?  Yes  No
13. During the past 12 months, has anyone to be covered under this policy had any surgical procedure or been advised by a physician to have tests, treatment or surgery that has not yet been done?  Yes  No
14. During the past two years, for other than routine checkups, has anyone to be covered under this policy been confined in a hospital as an inpatient (not including confinement due to pregnancy) or received home health care?  Yes  No

15. **(Details to Questions 11 - 14)**

	<b>Name/ Relationship</b>	<b>Condition(s)</b>	<b>Onset (mo/yr)</b>	<b>Surgery Performed? (yes/no/date)</b>	<b>Name and Address of Physician and Hospital</b>
Q #11					
Q #12					
Q #13					
Q #14					

16. Has anyone to be covered under this policy been prescribed or is anyone to be covered under this policy taking any prescription medication (other than prescription contraceptives)?  Yes  No  
 If yes, please provide the name of the person taking the prescription, the name of the medication and the dosage of any and all of the medication(s) and reason(s) for taking it below.

<b>Name</b>	<b>Medication name</b>	<b>Dosage</b>	<b>Frequency</b>	<b>Date first prescribed</b>	<b>Reason</b>

Applicant's Physician's Name \_\_\_\_\_ Phone Number \_\_\_\_\_  
 If no regular physician, physician last seen \_\_\_\_\_

Address \_\_\_\_\_

Date last seen by physician \_\_\_\_\_ Reason for last visit \_\_\_\_\_

Spouse's Physician's Name \_\_\_\_\_ Phone Number \_\_\_\_\_

If no regular physician, physician last seen

Address \_\_\_\_\_

Date last seen by physician \_\_\_\_\_ Reason for last visit \_\_\_\_\_

The reinstated policy shall cover only injury sustained after the date of reinstatement and sickness that begins more than 10 days after the date of reinstatement.

**Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.**

Policyholder's Signature \_\_\_\_\_ Date \_\_\_\_\_

**MAKE CHECKS PAYABLE TO AFLAC. FOR INFORMATION, CALL TOLL-FREE  
1.800.99.AFLAC (1.800.992.3522).**

**FOR WORLDWIDE HEADQUARTERS USE ONLY**

PTD \_\_\_\_\_

\$ Applied \_\_\_\_\_

Lapsed \_\_\_\_\_

No. Months \_\_\_\_\_

Reinstated \_\_\_\_\_

New PTD \_\_\_\_\_

Premiums Applied From \_\_\_\_\_

Initials \_\_\_\_\_

**NOTICE TO APPLICANT REGARDING REPLACEMENT OF  
INDIVIDUAL ACCIDENT AND SICKNESS OR LONG-TERM CARE INSURANCE**

**AMERICAN FAMILY LIFE ASSURANCE COMPANY OF COLUMBUS (AFLAC)  
WORLDWIDE HEADQUARTERS • 1932 WYNNTON ROAD  
COLUMBUS, GEORGIA 31999**

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to your application, you intend to lapse or otherwise terminate existing accident and sickness or long-term care insurance and replace it with an individual long-term care insurance policy to be issued by Aflac. Your new policy provides thirty (30) days within which you may decide, without cost, whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

You should review this new coverage carefully, comparing it with all accident and sickness or long-term care insurance coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this new coverage is a wise decision.

**STATEMENT TO APPLICANT BY ASSOCIATE/AGENT:**

I have reviewed your current medical or health insurance coverage. I believe the replacement of insurance involved in this transaction materially improves your position.

My conclusion has taken into account the following considerations, which I call to your attention:

1. Health conditions that you may presently have (preexisting conditions), may not be immediately or fully covered under the new policy. This could result in denial or delay in payment of benefits under the new policy, whereas a similar claim might have been payable under your present policy.
2. State law provides that your replacement policy may not contain new preexisting conditions or probationary periods. Aflac will waive any time periods applicable to preexisting conditions or probationary periods in the new policy for similar benefits to the extent such time was spent under the original policy.
3. If you are replacing existing long-term care coverage, you may wish to secure the advice of your present insurer or its associate/agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.
4. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical health history. Failure to include all material information on an application may provide a basis for Aflac to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

**EXISTING INSURANCE TO BE REPLACED**

Name and Address of Insurer	Policy Number	Effective Date
_____	_____	_____
_____	_____	_____
_____	_____	_____
Signature of Associate/Agent	Date	
_____	_____	
Typed Name of Associate/Agent	Address of Associate/Agent	
_____	_____	

The above "Notice to Applicant" was delivered to me on:

Signature of Applicant \_\_\_\_\_ Date \_\_\_\_\_

White – Headquarters      Yellow - Applicant

## LONG-TERM CARE INSURANCE PERSONAL WORKSHEET

People buy long-term care insurance for many reasons. Some don't want to use their own assets to pay for long-term care. Some buy insurance to make sure they can choose the type of care they get. Others don't want their family to have to pay for care or don't want to go on Medicaid. But long term care insurance may be expensive, and may not be right for everyone.

By state law, the insurance company must fill out part of the information on this worksheet and ask you to fill out the rest to help you and the company decide if you should buy this policy.

### Premium Information

Policy Form Number(s): \_\_\_\_\_

The premium for the coverage you are considering will be \$\_\_\_\_\_ per month, or \$\_\_\_\_\_ per year.

**Type of Policy:** Guaranteed Renewable

### Aflac's Right to Increase Premiums:

Aflac has a right to increase premiums on this policy form in the future, provided it raises rates for all policies in the same class in this state.

### Rate Increase History

Aflac has sold long-term care insurance since 1989 and has sold this policy since \_\_\_\_\_. Aflac has never raised its rates for any long term care policy it has sold in this state or any other state.

### Questions Related to Your Income

How will you pay each year's premium:

From my income       From my Savings/Investments       My Family will Pay

Have you considered whether you could afford to keep this policy if the premiums were raised, for example, by 20%?

What is your annual income? (check one)

Under \$10,000     \$10 - 20,000     \$20 - 30,000     \$30 - 50,000     Over \$50,000

How do you expect your income to change over the next 10 years? (check one)

No change       Increase       Decrease

*If you will be paying premiums with money received only from your own income, a rule of thumb is that you may not be able to afford this policy if the premiums will be more than 7% of your income.*

**Will you buy inflation protection:**  Yes     No

If not, have you considered how you will pay for the difference between future costs and your daily benefit amount?

From my income       From my Savings/Investments       My Family will Pay



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WORLDWIDE HEADQUARTERS • 1932 WYNNTON ROAD  
COLUMBUS, GEORGIA 31999  
Toll-Free Telephone Number: 1.800.99.AFLAC (1.800.992.3522)**

**Long-Term Care Insurance  
Potential Rate Increase Disclosure Form**

1. **Premium Rate:** Premium Rate that is applicable to you and that will be in effect until a request is made and approved for an increase is \$\_\_\_\_\_.

2. **The premium for this policy will be shown on the schedule page of your policy.**

3. **Rate Schedule Adjustments:**

Aflac will provide a description of when premium rate adjustments will be effective and will be due on the next billing date.

4. **Potential Rate Revisions:**

**This policy is Guaranteed-Renewable.** This means that the rates for this product may be increased in the future. Your rates can NOT be increased due to your increasing age or declining health, but your rates may go up based on the experience of all policyholders with a policy similar to yours.

**If you receive a premium rate increase in the future, you will be notified of the new premium amount and you will be able to exercise at least one of the following options:**

- Pay the increased premium and continue your policy in force as is.
- Reduce your policy benefits to a level such that your premiums will not increase. (Subject to state law minimum standards.)
- Exercise your nonforfeiture option if purchased. (This option is available for purchase for an additional premium.)
- Exercise your contingent nonforfeiture rights.\* (This option may be available if you do not purchase a separate nonforfeiture option.)

**\*Contingent Nonforfeiture**

If the premium rate for your policy goes up in the future and you didn't buy a nonforfeiture option, you may be eligible for contingent nonforfeiture. Here's how to tell if you are eligible:

You will keep some long-term care insurance coverage, if:

- Your premium after the increase exceeds your original premium by the percentage shown (or more) in the following table; and
- You lapse (not pay more premiums) within 120 days of the increase.

The amount of coverage (i.e., new lifetime maximum benefit amount) you will keep will equal

the total amount of premiums you've paid since your policy was first issued. If you have already received benefits under the policy, so that the remaining maximum benefit amount is less than the total amount of premiums you've paid, the amount of coverage will be that remaining amount.

Except for this reduced lifetime maximum benefit amount, all other policy benefits will remain at the levels attained at the time of the lapse and will not increase thereafter.

Should you choose this Contingent Nonforfeiture option, your policy, with this reduced maximum benefit amount, will be considered "paid-up" with no further premiums due.

Example:

- You bought the policy at age 65 and paid the \$1,000 annual premium for 10 years, so you have paid a total of \$10,000 in premium.
- In the eleventh year, you receive a rate increase of 50%, or \$500 for a new annual premium of \$1,500, and you decide to lapse the policy (not pay the premiums).
- Your "paid-up" policy benefits are \$10,000 (provided you have at least \$10,000 of benefits remaining under your policy.)

<u>Contingent Nonforfeiture</u> Cumulative Premium Increase over Initial Premium That Qualifies for Contingent Nonforfeiture	
(Percentage increase is cumulative from date of original issue. It does NOT represent a one-time increase.)	
Issue Age	Percent Increase Over Initial Premium
29 and under	200%
30-34	190%
35-39	170%
40-44	150%
45-49	130%
50-54	110%
55-59	90%
60	70%
61	66%
62	62%
63	58%
64	54%
65	50%

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**THINGS YOU SHOULD KNOW BEFORE YOU BUY  
LONG-TERM CARE INSURANCE**

Long-Term  
Care  
Insurance

- A long term care insurance policy may pay most of the costs for your care in a nursing home. Many policies also pay for care at home or other community settings. Since policies can vary in coverage, you should read this policy and make sure you understand what it covers before you buy it.
- You should not buy this insurance policy unless you can afford to pay the premiums every year. Remember that Aflac can increase premiums in the future.
- The personal worksheet includes questions designed to help you and the company determine whether this policy is suitable for your needs.

Medicare

- Medicare does **not** pay for most long term care.

Medicaid

- Medicaid will generally pay for long-term care if you have very little income and few assets. You probably should **not** buy this policy if you are now eligible for Medicaid.
- Many people become eligible for Medicaid after they have used up their own financial resources by paying for long-term care services.
- When Medicaid pays your spouse's nursing home bills, you are allowed to keep your house and furniture, a living allowance and some of your joint assets.
- Your choice of long-term care services may be limited if you are receiving Medicaid. To learn more about Medicaid, contact your local or state Medicaid agency.

Shopper's  
Guide

- Make sure the insurance company or associate/agent gives you a copy of a book called the National Association of Insurance Commissioners' "Shopper's Guide to Long Term Care Insurance". Read it carefully. If you have decided to apply for long term care insurance, you have the right to return the policy within 30 days and get back any premium you have paid if you are dissatisfied for any reason or choose not to purchase the policy.

Counseling

- Free counseling and additional information about long term care insurance are available through your state's insurance counseling program. Contact your state insurance department

or department on aging for more information about the senior health insurance counseling program in your state.

## Facilities

- Some long-term care insurance contracts provide for benefit payments in certain facilities only if they are licensed or certified, such as in assisted living centers. However, not all states regulate these facilities in the same way. Also, many people move to a different state from where they purchased their long-term care insurance policy. Read the policy carefully to determine what types of facilities qualify for benefit payments, and to determine that payment for a covered service will be made if you move to a state that has a different licensing scheme for facilities than the one in which you purchased that policy.



SERFF Tracking Number: AFLA-125597397 State: Arkansas  
Filing Company: American Family Life Assurance Company of Columbus State Tracking Number: 38732  
Company Tracking Number: A27000ARR  
TOI: LTC03I Individual Long Term Care Sub-TOI: LTC03I.001 Qualified  
Product Name: Long-Term Care  
Project Name/Number: /

## Supporting Document Schedules

### Review Status:

**Satisfied -Name:** Certification/Notice 04/07/2008

#### Comments:

We certify that this filing meets the standards of Rule and Regulation 19, as well as Rule & Regulation 49 (Guaranty Association Notice Form A14640R is attached here for your information). The Flesch scores meet minimum standards and have been noted on the form schedule. The Consumer Information Notice is included on the policy, as well as on the payroll and payroll basic application.

#### Attachment:

A14640R.pdf

### Review Status:

**Satisfied -Name:** Application 04/07/2008

#### Comments:

The applications have been noted and attached within the form schedule, with the prior approval dates noted in the general filing description.

### Review Status:

**Satisfied -Name:** Outline of Coverage 04/07/2008

#### Comments:

The outline of coverage has been noted and attached within the form schedule.

**LIMITATIONS AND EXCLUSIONS UNDER THE ARKANSAS LIFE AND HEALTH INSURANCE  
GUARANTY ASSOCIATION ACT**

Residents of this state who purchase life insurance, annuities or health and accident insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Arkansas Life and Health Insurance Guaranty Association (“Guaranty Association”). The purpose of the Guaranty Association is to assure that policy and contract owners will be protected, within certain limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of policy owners who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by the member insurers through the Guaranty Association is not unlimited, however. And, as noted in the box below, this protection is not a substitute for consumers’ care in selecting insurance companies that are well managed and financially stable.

**DISCLAIMER**

The Arkansas Life and Health Insurance Guaranty Association (“Guaranty Association”) may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions and require continued residency in this state. You should not rely on coverage by the Guaranty Association in purchasing an insurance policy or contract.

Coverage is NOT provided for your policy or contract or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life and variable annuity contract.

Insurance companies or their agents are required by law to provide you with this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Guaranty Association to induce you to purchase any kind of insurance policy.

The Arkansas Life and Health Insurance Guaranty Association  
C/O The Liquidation Division  
1023 West Capitol  
Little Rock, Arkansas 72201

Arkansas Insurance Department  
1200 West Third Street  
Little Rock, Arkansas 72201-1904

The state law that provides for this safety-net is called the Arkansas Life and Health Insurance Guaranty Association Act (“Act”). Below is a brief summary of the Act’s coverages, exclusions and limits. This summary does not cover all provisions of the Act; nor does it in any way change anyone’s rights or obligations under the Act or the rights or obligations of the Guaranty Association.

**COVERAGE**

Generally, individuals will be protected by the Guaranty Association if they live in this state and hold a life, annuity or health insurance contract or policy, or if they are insured under a group insurance contract issued by a member insurer. The beneficiaries, payees or assignees of policy or contract owners are protected as well, even if they live in another state.

## EXCLUSIONS FROM COVERAGE

However, persons owning such policies are NOT protected by the Guaranty Association if:

- They are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- The insurer was not authorized to do business in this state;
- Their policy or contract was issued by a nonprofit hospital or medical service organization, an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policy or contract owner is subject to future assessments, or by an insurance exchange.

The Guaranty Association also does NOT provide coverage for:

- Any policy or contract or portion thereof which is not guaranteed by the insurer or for which the owner has assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract;
- Any policy of reinsurance (unless an assumption certificate was issued);
- Interest rate yields that exceed an average rate;
- Dividends and voting rights and experience rating credits;
- Credits given in connection with the administration of a policy by a group contract holder;
- Employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- Unallocated annuity contracts (which give rights to group contractholders, not individuals);
- Unallocated annuity contracts issued to/in connection with benefit plans protected under Federal Pension Benefit Corporation ("FPBC") (whether the FPBC is yet liable or not);
- Portions of an unallocated annuity contract not owned by a benefit plan or a government lottery (unless the owner is a resident) or issued to a collective investment trust or similar pooled fund offered by a bank or other financial institution);
- Portions of a policy or contract to the extent assessments required by law for the Guaranty Association are preempted by State or Federal law;
- Obligations that do not arise under the policy or contract, including claims based on marketing materials or side letters, riders, or other documents which do not meet filing requirements, or claims for policy misrepresentations, or extra-contractual or penalty claims;
- Contractual agreements establishing the member insurer's obligations to provide book value accounting guarantees for defined contribution benefit plan participants (by reference to a portfolio of assets owned by a nonaffiliate benefit plan or its trustees).

## LIMITS ON AMOUNT OF COVERAGE

The Act also limits the amount the Guaranty Association is obligated to cover: The Guaranty Association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the Guaranty Association will pay a maximum of \$300,000—no matter how many policies or contracts there were with the same company, even if they provided different types of coverages. Within this overall \$300,000 limit, the Association will not pay more than \$300,000 in health insurance benefits, \$300,000 in present value of annuity benefits, or \$300,000 in life insurance death benefits or net cash surrender values—again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverages. There is a \$1,000,000 limit with respect to any contract holder for unallocated annuity benefits, irrespective of the number of contracts held by the contract holder. These are limitations for which the Guaranty Association is obligated before taking into account either its subrogation and assignment rights or the extent to which these benefits could be provided out of the assets of the impaired or insolvent insurer.