

SERFF Tracking Number: AFLA-125900873 State: Arkansas
Filing Company: American Family Life Assurance Company of Columbus State Tracking Number: 41904
Company Tracking Number: A57500
TOI: H111 Individual Health - Disability Income Sub-TOI: H111.004 Other
Product Name: Short Term Disability
Project Name/Number: Short Term Disability/

Filing at a Glance

Company: American Family Life Assurance Company of Columbus

Product Name: Short Term Disability SERFF Tr Num: AFLA-125900873 State: ArkansasLH
TOI: H111 Individual Health - Disability Income SERFF Status: Closed State Tr Num: 41904
Sub-TOI: H111.004 Other Co Tr Num: A57500 State Status: Approved-Closed
Filing Type: Form/Rate Co Status: Reviewer(s): Rosalind Minor
Author: Connie Gates Disposition Date: 02/10/2009
Date Submitted: 01/28/2009 Disposition Status: Approved-Closed
Implementation Date Requested: On Approval Implementation Date:

State Filing Description:

General Information

Project Name: Short Term Disability Status of Filing in Domicile: Authorized
Project Number: Date Approved in Domicile: 09/29/2008
Requested Filing Mode: Review & Approval Domicile Status Comments:
Explanation for Combination/Other: Market Type: Individual
Submission Type: New Submission Group Market Size:
Overall Rate Impact: Group Market Type:
Filing Status Changed: 02/10/2009 Explanation for Other Group Market Type:
State Status Changed: 02/10/2009
Deemer Date: Corresponding Filing Tracking Number:
Filing Description:
RE: Short-Term Disability Policy Form A57500AR, Disability Benefit for On-the-Job Injury Rider Form A57550, Additional Units of Disability Rider Form A57551, Payroll Application Form A575PAPP, Union Application Form A575UAPP, Underwriting Application Auwall, Signature Forms AssignAR and AssignAR, Outline of Coverage Form A57525AR, and Application for Reinstatement Form A57503AR.

Limited Benefit Short-Term Disability Policy Form A57500LBAR and Outline of Coverage Form A57525LBAR.

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Dear Mr. Musgrove:

Referenced forms are submitted for your review and approval. Nebraska, our state of domicile, has approved similar versions of the A57500 series on September 29, 2008. Limited Benefit Short-Term Disability Policy Series A57500LB was not filed in Nebraska as same was not required by the state.

Short-Term Disability Policy Form A57500AR pays disability benefits when the insured is disabled due to a covered sickness or covered off-the-job injury. The policy will pay for total or partial disability. We have included a new benefit titled Transitional Benefit. This benefit will pay the insured who doesn't work full-time at time of disability due to their covered sickness or off-the-job injury. There are five occupational classes.

Short-Term Disability Policy Form A57500LBAR pays disability benefits when the insured is disabled due to a covered sickness or covered off-the-job injury and only provides for a three month benefit period option. The policy will pay for total or partial disability. We have included a new benefit titled Transitional Benefit. This benefit will pay the insured who doesn't work full-time at time of disability due to their covered sickness or off-the-job injury. There are four occupational classes

The policies are available in unit values with the applicant having the option of choosing the unit amounts best suited for their individual needs. The policies will be marketed through payroll deduction and on a union basis to applicants age 18 through 64.

Our payroll deduction billing is for the individual market only and does not imply that this is a true group. All policies sold are sold on an individual basis and each insured is issued an individual policy.

Disability Benefit for On-the-Job Injury Rider Form A57550 pays benefits for disabilities occurring On-the-Job only.

Additional Units of Disability Benefit Rider Form A57551 pays additional amounts of benefits for Sickness or On-the-Job Injury. The additional amounts will reflect the same elimination and benefit periods as those for the policy.

Payroll Application Form A575PAPP will be used to make application for the policies and the optional rider forms on a

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I certify that the forms submitted herewith meet the applicable provisions of Rule and Regulation 18 of the Arkansas Insurance Department Regulations as well as meeting the applicable requirements of Arkansas Insurance Department.

I certify the following form complies with the requirements of Rule and Regulation 49 of the Arkansas Insurance Department Regulations, Life and Disability Guaranty Fund Notices.

I certify the following forms comply with the requirements of Arkansas Statute Annotated Sections 23-80-201 through 23-80-208, cited as the Life and Disability Insurance Policy Language Simplification Act.

I certify that the enclosed forms meet the minimum reading ease score for the FLESCH test. I further certify the scores for each form are as follows:

FLESCH Score Grade Level

Short Term Disability Policy Form A57500AR

50.044

10

Limited Benefit Short-Term Disability Policy Form A57500LBAR 50.044 10

On-the-Job Disability Benefit Rider Form A57550 87.725 3

Additional Units Disability Benefit Rider Form A57551 84.766 4

Payroll Application Form A575PAPP 103.815 1

Signature Form A575SICAR 66.891 7

Signature Form A575SICAR 74.252 4

Union Application Form A575UAPP 61.768 7

Reinstatement Application Form A57503AR 72.013 5

Underwriting Application Form Auwall 85.648 2

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Outline of Coverage Form A57525AR 50.495 10

Outline of Coverage Form A57525LBAR 53.853 10

An actuarial memorandum and rate sheets are enclosed for your review and approval. The appropriate filing fee and/or certification form are also included.

Aflac reserves the right to alter the format of the forms without refileing due to future technology changes, i.e. paper size, font, font type, line ending or page ending changes. Be assured that any minimum font-size requirements will be met. Any changes to wording or content would be filed for prior approval. We have included brackets in all forms around the address, telephone number, web site, and officer signatures in the event these change in the future. We also reserve the right to use these forms in an electronic format, but Aflac certifies we will retain the filed final print format.

This filing has been prepared by Connie Gates. Should you have any questions or comments concerning this submission, please do not hesitate to call her collect at (706) 596-5048, by fax at (706) 660-7080 or email at cgates@aflac.com.

Company and Contact

Filing Contact Information

Connie Gates, Policy Analyst
1932 Wynnton Road
Columbus, GA 31999
cgates@aflac.com
(706) 596-5048 [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
Group Code:
Group Name:
FEIN Number: 58-0663085

State of Domicile: Nebraska
Company Type: Life and Health
State ID Number:

Filing Fees

SERFF Tracking Number: AFLA-125900873 State: Arkansas
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Fee Required? Yes
Fee Amount: \$100.00
Retaliatory? No
Fee Explanation: 2 policies

see note in "Supporting Documentation" tab
"fee certification"

Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
American Family Life Assurance Company of Columbus	\$0.00	01/28/2009	

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	02/10/2009	02/10/2009
Accepted For Informational Purposes	Rosalind Minor	02/04/2009	02/04/2009
Approved-Closed	Rosalind Minor	02/02/2009	02/02/2009

Amendments

Item	Schedule	Created By	Created On	Date Submitted
Signature Page	Form	Connie Gates	02/10/2009	02/10/2009
Outline of Coverage	Form	Connie Gates	02/04/2009	02/04/2009
Limited Benefit	Form	Connie Gates	02/04/2009	02/04/2009
Outline of Coverage Certification/Notice	Supporting Document	Connie Gates	02/04/2009	02/04/2009
Outline of Coverage	Supporting Document	Connie Gates	02/04/2009	02/04/2009

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Item Type	Item Name	Item Status	Public Access
Supporting Document (revised)	Certification/Notice	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	No
Supporting Document (revised)	Outline of Coverage	Approved-Closed	Yes
Supporting Document	Filing Fee Certification	Approved-Closed	Yes
Supporting Document	Certification/Notice	Replaced	Yes
Supporting Document	Outline of Coverage	Replaced	Yes
Form	Short-term Disability Policy	Approved-Closed	Yes
Form	On-the-Job Injury Rider	Approved-Closed	Yes
Form	Additional Units of Disability Rider	Approved-Closed	Yes
Form	Payroll Application	Approved-Closed	Yes
Form	Union Application	Approved-Closed	Yes
Form	Underwriting Application	Approved-Closed	Yes
Form	Application for Reinstatement	Approved-Closed	Yes
Form	Limited Benefit Short-term Disability Policy	Approved-Closed	Yes
Form (revised)	Outline of Coverage	Approved-Closed	Yes
Form	Outline of Coverage	Replaced	Yes
Form (revised)	Limited Benefit Outline of Coverage	Approved-Closed	Yes
Form	Limited Benefit Outline of Coverage	Replaced	Yes
Form (revised)	Signature Page	Approved-Closed	Yes
Form	Signature Page	Replaced	Yes
Form	Signature Page	Approved-Closed	Yes

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Form	Union Application	Approved-Closed	Yes
Form	Underwriting Application	Approved-Closed	Yes
Form	Application for Reinstatement	Approved-Closed	Yes
Form	Limited Benefit Short-term Disability Policy	Approved-Closed	Yes
Form (revised)	Outline of Coverage	Approved-Closed	Yes
Form	Outline of Coverage	Replaced	Yes
Form (revised)	Limited Benefit Outline of Coverage	Approved-Closed	Yes
Form	Limited Benefit Outline of Coverage	Replaced	Yes
Form (revised)	Signature Page	Approved-Closed	Yes
Form	Signature Page	Replaced	Yes
Form	Signature Page	Approved-Closed	Yes

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Disposition

Disposition Date: 02/02/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Form	Short-term Disability Policy	Approved-Closed	Yes
Form	On-the-Job Injury Rider	Approved-Closed	Yes
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Form	Payroll Application	Approved-Closed	Yes
Form	Union Application	Approved-Closed	Yes
Form	Underwriting Application	Approved-Closed	Yes
Form	Application for Reinstatement	Approved-Closed	Yes
Form	Limited Benefit Short-term Disability Policy	Approved-Closed	Yes
Form (revised)	Outline of Coverage	Approved-Closed	Yes
Form	Outline of Coverage	Replaced	Yes
Form (revised)	Limited Benefit Outline of Coverage	Approved-Closed	Yes
Form	Limited Benefit Outline of Coverage	Replaced	Yes
Form (revised)	Signature Page	Approved-Closed	Yes
Form	Signature Page	Replaced	Yes
Form	Signature Page	Approved-Closed	Yes

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 Project Name/Number: Short Term Disability/

Amendment Letter

Amendment Date:
 Submitted Date: 02/10/2009

Comments:

Rosalind,

Form AssignAR does NOT contain the agent's certification statement and will be used in situations where the associate/agent is unable to be present at the time of application. So, the Signature Form AssignAR has been amended by removing the Associate Name/Address and Phone number lines.

Thank you
 Connie Gates

Changed Items:

Form Schedule Item Changes:

Form Schedule Item Changes:

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
AssignAR	Application/ESignature enrollment Form	Page	Initial				67	AssignAR.pdf

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Amendment Letter

Amendment Date:
 Submitted Date: 02/04/2009

Comments:

Please note the outlines previously submitted mistakenly had AR added to the form number when they should have been base forms.

I have attached the base Outline of Coverage Forms and an updated letter with the correct form numbers listed for the Outline of Coverage Forms.

Changed Items:

Form Schedule Item Changes:

Form Schedule Item Changes:

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
A57525	Outline of Coverage	Outline of Coverage	Initial				50	A57525.pdf

Form Schedule Item Changes:

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
A57525LB	Outline of Coverage	Limited Benefit Outline of Coverage	Initial				54	A57525LB.pdf

Supporting Document Schedule Item Changes:

Satisfied -Name: Certification/Notice

Comment: The filing letter includes Rule & Regulation 19, Rule & Regulation 49, and the required Flesch Certification along with the required officer signature.

Page two: Rule & Regulation 19, Rule & Regulation 49, and the required Flesch Certification

Page three: officer signature

57500LB DTG letterhead2.pdf

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Form Schedule

Lead Form Number: A57500

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	A57500AR	Policy/Cont	Short-term Disability ract/Fratern Policy al Certificate	Initial		50	A57500AR.pdf
Approved-Closed	A57550	Policy/Cont	On-the-Job Injury ract/Fratern Rider al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial		88	A57550.pdf
Approved-Closed	A57551	Policy/Cont	Additional Units of ract/Fratern Disability Rider al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial		85	A57551.pdf
Approved-Closed	A575PAPP	Application/	Payroll Application Enrollment Form	Initial		104	A575PAPP.pdf
Approved-Closed	A575UAPP	Application/	Union Application Enrollment Form	Initial		62	A575UAPP.pdf
Approved-Closed	Auwall	Application/	Underwriting Enrollment Application Form	Initial		86	Auwall.pdf

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Approved- Closed	A57503AR	Application/ Enrollment Form	Application for Reinstatement	Initial	72	A57503AR.pdf
Approved- Closed	A57500LB AR	Policy/Cont ract/Fratern al Certificate	Limited Benefit Short-term Disability Policy	Initial	50	A57500LBAR.pdf
Approved- Closed	A57525	Outline of Coverage	Outline of Coverage	Initial	50	A57525.pdf
Approved- Closed	A57525LB	Outline of Coverage	Limited Benefit Outline of Coverage	Initial	54	A57525LB.pdf
Approved- Closed	AsignAR	Application/ Enrollment Form	Signature Page	Initial	67	AsignAR.pdf
Approved- Closed	AsigncAR	Application/ Enrollment Form	Signature Page	Initial	74	AsigncAR.pdf

SHORT-TERM DISABILITY POLICY

NOTICE TO BUYER: This policy pays benefits for short-term Disability caused by Sickness or Off-the-Job Injury. Read it carefully with the Outline of Coverage, if applicable.

The Named Insured shown in the Policy Schedule will be referred to as “you,” “your,” or “yours.” **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 statements made in your application and the payment of the premium shown in the Policy Schedule. A copy of your application is attached and is a part of this policy. The following paragraphs set forth the definitions of terms, the limitations and exclusions, the insurance benefits, and other provisions.

YOUR RIGHT TO EXAMINE THIS POLICY

It is important to us that you are satisfied with this policy. If you are not satisfied, you may return it within 30 days after you receive it. Send it to your associate (duly licensed agent) or to Aflac [Worldwide Headquarters, 1932 Wynnton Road, Columbus, Georgia 31999]. You will receive a full refund of all premiums paid, and your policy will be void from its Effective Date. If you return this policy, please note in writing: “This policy is returned for cancellation and refund of premium.”

IMPORTANT NOTICE

Please read your application attached to this policy. This policy is issued on the basis that the information shown on the application is correct and complete. Statements made in the application are deemed representations and not warranties. Carefully check the application. Write to us within 30 days of the date you receive this policy if any information on the application is not correct or complete. Incorrect or incomplete information may result in the denial of claims or voiding of the policy. No associate (duly licensed agent) may change this policy or waive any of its provisions.

THIS POLICY IS GUARANTEED-RENEWABLE TO AGE 70, SUBJECT TO AFLAC’S RIGHT TO CHANGE PREMIUMS BY CLASS UPON ANY RENEWAL DATE.

We agree that this policy will never be restricted by the addition of any rider without your consent, nor will renewal be refused because of any change in your health or physical condition. You are guaranteed the right to renew this policy until the policy anniversary date following your 70th birthday by the timely payment of premiums at the rate in effect at the beginning of each term. **Your coverage will terminate on the policy anniversary date following your 70th birthday.**

Aflac may change the established premium rate, but only if the rate is changed for all policies of this class. While this policy is in force, no change will be made in your class because of age, sex, or physical condition. “Class” means all policies of this form number and premium classification in your state that are then in force. If the established premium rate changes, Aflac will notify you in writing at your last known address, as shown in our records, at least 30 days before the change becomes effective.

PRE-EXISTING CONDITION LIMITATIONS

A Pre-existing Condition is an illness, disease, infection, disorder, or injury for which, within the 12-month period before the Effective Date of coverage, medical advice, consultation, or treatment was recommended or received, or for which symptoms existed that would ordinarily cause a prudent person to seek diagnosis, care, or treatment. Disability caused by a Pre-existing Condition or reinjuries to a Pre-existing Condition will not be covered unless it begins more than 12 months after the Effective Date of coverage.

**AMERICAN FAMILY LIFE ASSURANCE COMPANY OF COLUMBUS (AFLAC)
CLIENT SERVICES AND ADMINISTRATION**

**[WORLDWIDE HEADQUARTERS • 1932 WYNNTON ROAD • COLUMBUS, GEORGIA 31999
FOR ASSISTANCE OR INFORMATION ABOUT THIS POLICY, CALL 1-800-99-AFLAC (1-800-992-3522).
FOR CLAIM FORMS, VISIT OUR WEB SITE AT AFLAC.COM.]**

**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.**

INDEX

Named Insured..... Policy Schedule
Definitions Part 1
Limitations and Exclusions..... Part 2
Uniform Provisions Part 3
Benefits Part 4

Policy Schedule

NAMED INSURED: John A. Doe

POLICY NUMBER: 111-2222

TYPE OF COVERAGE: Individual Only

COVERAGE: XXXXXX
AAABBB

MODE OF PAYMENT: Monthly

ELIMINATION PERIODS:

Policy, On-the-Job Rider &
Additional Disability Rider:
Injury: 0, 7, 14, 30, 60, 90, 180 Days
Sickness: 7, 14, 30, 60, 90, 180 Days

BENEFIT PERIODS:

Policy: 6, 12, 18, 24 Months
On-the-Job Rider: 6, 12, 18, 24 Months
Additional Disability Rider: 6, 12, 18, 24 Months

EFFECTIVE DATES

Policy: XX/XX/XXXX
On-the-Job Rider: XX/XX/XXXX
Additional Units Rider: XX/XX/XXXX
Additional Units Rider: XX/XX/XXXX
Additional Units Rider: XX/XX/XXXX

PREMIUMS

Policy: \$XX.xx
Rider: \$XX.xx
Additional Units Rider: \$XX.xx
Additional Units Rider: \$XX.xx
Additional Units Rider: \$XX.xx

Monthly Disability
Benefit Payable

Short-Term Disability Benefit: \$100 (units) \$
RIDERS
On-the-Job Injury Disability Benefit Rider: \$100 (units) \$
Additional Units Disability Benefit Rider: \$100 (units) \$

In witness whereof, Aflac's president and secretary signed this policy in Columbus, Georgia, as of the policy Effective Date shown in the Policy Schedule.

[Handwritten signature of Paul S. Amos II]

Paul S. Amos II, President

[Handwritten signature of Joey M. Loudermilk]

Joey M. Loudermilk, Secretary]

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

**Part 1
DEFINITIONS**

- A. BASE PAY EARNINGS:** your gross salary or wages for your Full-Time Job. This does not include variable pay such as overtime (unless contractual), bonuses, or other incentives. If you are self-employed, the term “Base Pay Earnings” means your business’s gross income minus the allowable business deductions from that business. (For tax purposes, Base Pay Earnings is referred to as “net earnings.”)
- B. BENEFIT PERIOD:** the maximum number of days after the Elimination Period, if any, for which you can be paid benefits for any one or Successive Periods of Disability. Each new Benefit Period is subject to a new Elimination Period. See the Policy Schedule for the Benefit Period you selected. For the purposes of this calculation, a “month” is defined as 30 days for which benefits are paid. See definition of “Successive Periods of Disability.”
- C. COMPLICATIONS OF PREGNANCY:** (1) conditions requiring medical treatment prior to or subsequent to the termination of a pregnancy whose diagnoses are distinct from pregnancy but that are adversely affected by pregnancy or caused by pregnancy, such as acute nephritis; nephrosis; cardiac decompensation; missed abortion; disease of the vascular, hemopoietic, nervous, or endocrine systems; and similar medical and surgical conditions of comparable severity; (2) non-elective cesarean deliveries, hyperemesis gravidarum and pre-eclampsia requiring hospital confinement, ectopic pregnancy that is terminated, and spontaneous termination of pregnancy that occurs during a period of gestation in which a viable birth is not possible.

Complications of Pregnancy do not include premature delivery without incidence, multiple gestation pregnancy, false labor, occasional spotting, prescribed rest during pregnancy, morning sickness and similar conditions associated with the management of a difficult pregnancy not constituting a classifiably distinct pregnancy complication. Elective cesarean deliveries are not considered Complications of Pregnancy.

- D. DAILY DISABILITY BENEFIT:** one-thirtieth of the applicable monthly Disability Benefit shown in the Policy Schedule.
- E. DISABILITY:**
1. **TOTAL DISABILITY:** being under the care and attendance of a Physician due to a condition that causes you to be unable to perform the material and substantial duties of your Full-Time Job and not working at any job.
 2. **PARTIAL DISABILITY:** being under the care and attendance of a Physician due to a condition that causes you to be unable to perform the material and substantial duties of your Full-Time Job, but able to work at any job earning less than 80 percent of your Base Pay Earnings of your Full-Time Job at the time you became disabled.
 3. **TRANSITIONAL DISABILITY:** being under the care and attendance of a Physician due to a condition that causes you to be unable to perform the material and substantial duties of any job.

- F. EFFECTIVE DATE:** the date(s) coverage begins as shown in the Policy Schedule. The Effective Date of this policy **is not** the date you signed the application for coverage.
- G. ELIMINATION PERIOD:** the number of consecutive days at the beginning of your period of Disability for which no benefits are payable. See the Policy Schedule for the Elimination Period you selected. Each new Benefit Period is subject to a new Elimination Period.
- H. FULL-TIME JOB:** your primary job at which you work 19 or more hours per week for pay or benefits.
- I. IMMEDIATE FAMILY:** anyone related to you in the following manner: spouse; brothers or sisters (includes stepbrothers and stepsisters); children (includes stepchildren); parents (includes stepparents); grandchildren; father- or mother-in-law; brother- or sister-in-law; and spouses, as applicable, of any of these.
- J. INJURY:** a bodily injury caused directly by an accident, independent of Sickness, disease, bodily infirmity, or any other cause, occurring on or after the Effective Date of coverage and while coverage is in force.
- K. MEDICALLY NECESSARY:** treatment, services, or supplies necessary and appropriate for the diagnosis or treatment of a Sickness or an Injury based upon generally accepted medical practice.
- L. OFF-THE-JOB INJURY:** an Injury that occurs while you are not working at any job for pay or benefits.
- M. ON-THE-JOB INJURY:** an Injury that occurs while you are working at any job for pay or benefits.
- N. PHYSICIAN:** a person legally qualified to practice medicine, other than you or a member of your Immediate Family, who is licensed as a Physician by the state where treatment is received to treat the type of condition for which a claim is made.
- O. SICKNESS:** an illness, disease, infection, or any other abnormal physical condition, independent of Injury, occurring on or after the Effective Date of coverage and while coverage is in force.
- P. SUCCESSIVE PERIODS OF DISABILITY:** separate periods of Disability, if caused by the **same or a related condition** and not separated by 180 days or more, are considered a continuation of the prior Disability. Once the maximum Benefit Period has been paid, you will not be eligible for a new Benefit Period or any Disability benefits due to the same or a related condition unless you have been released by a Physician from the prior Disability and are no longer qualified to receive Disability benefits for a period of 180 days. Separate periods of Disability resulting from **unrelated causes** are considered a continuation of the prior Disability unless they are separated by your returning to work at a Full-Time Job for 14 working days, during which you are performing the material and substantial duties of such job and are no longer qualified to receive Disability benefits. Periods of Disability meeting either of these separation requirements will begin a new Benefit Period, subject to a new Elimination Period.

Part 2
LIMITATIONS AND EXCLUSIONS

- A. Disability caused by a Pre-existing Condition or reinjuries to a Pre-existing Condition will not be covered unless it begins more than 12 months after the Effective Date of coverage.
- B. Aflac will not pay benefits for a Disability that is being treated outside the territorial limits of the United States.
- C. Aflac will not pay benefits whenever coverage provided by this policy is in violation of any U.S. economic or trade sanctions. If the coverage violates U.S. economic or trade sanctions, such coverage shall be null and void.
- D. Aflac will not pay benefits for a Disability that is caused by or occurs as a result of any bacterial, viral, or microorganism infection or infestation or any condition resulting from insect, arachnid, or other arthropod bites or stings as a Disability due to an Injury; such disability will be covered to the same extent as a Disability due to Sickness.
- E. **Aflac will not pay benefits for a disability that is caused by or occurs as a result of your:**
 - 1. Pregnancy or childbirth within the first ten months of the Effective Date of coverage. (Complications of Pregnancy will be covered to the same extent as a Sickness);
 - 2. Using any drug, narcotic, hallucinogen, or chemical substance (unless administered by a Physician and taken according to the Physician's instructions), or voluntarily taking any kind of poison or inhaling any kind of gas or fumes;
 - 3. Participating in any activity or event, including the operation of a vehicle, while under the influence of a controlled substance (unless administered by a Physician and taken according to the Physician's instructions) or while intoxicated ("intoxicated" means that condition as defined by the law of the jurisdiction in which the accident occurred);
 - 4. Participating in, or attempting to participate in, an illegal activity that is defined as a felony, whether charged or not ("felony" is as defined by the law of the jurisdiction in which the activity takes place); or being incarcerated in any type penal institution;
 - 5. Intentionally self-inflicting a bodily injury or committing or attempting suicide, while sane or insane;
 - 6. Having cosmetic surgery or other elective procedures that are not Medically Necessary;
 - 7. Having dental treatment except as a result of Injury;
 - 8. Being exposed to war or any act of war, declared or undeclared;
 - 9. Actively serving in any of the armed forces, or units auxiliary thereto, including the National Guard or Reserve;
 - 10. Donating an organ within the first 12 months of the Effective Date of this policy; or

11. Mental or emotional disorders, including but not limited to the following: bipolar affective disorder (manic-depressive syndrome), delusional (paranoid) disorders, psychotic disorders, somatoform disorders (psychosomatic illness), eating disorders, schizophrenia, anxiety disorders, depression, stress or post-partum depression. This policy will pay, however, for covered disabilities resulting from Alzheimer's disease, or similar forms of senility or senile dementia, first manifested while coverage is in force.

Benefits will be paid for only one Disability at a time even if the Disability is caused by more than one Sickness, more than one Injury, or a Sickness and an Injury.

Part 3 **UNIFORM PROVISIONS**

- A. ENTIRE CONTRACT; CHANGES:** This policy, together with the application, endorsements, benefit agreements, riders, and attached papers, if any, constitutes the entire contract of insurance. No change in this policy is valid until approved in writing by the president and secretary of Aflac at our worldwide headquarters. Any such change must be noted hereon 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:** After two years from the Effective Date of this policy, no misstatements, except fraudulent misstatements, made by you in the application shall be used to void this policy or to deny a claim for Disability commencing after the expiration of such two-year period. No claim for loss incurred or Disability commencing after 12 months from the Effective Date of coverage shall be reduced on the grounds that a sickness or physical condition, not excluded from coverage by name or specific description, had existed prior to the Effective Date of coverage. Coverage for Pre-existing Conditions will not be reduced or denied after the policy has been in force 12 months.
- C. TERM:** You are guaranteed the right to renew this policy until the policy anniversary date following your 70th birthday by the timely payment of premiums at the rate in effect at the beginning of each term. Your coverage will terminate on the policy anniversary date following your 70th birthday. 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 will maintain this policy in force for 12 months, semiannual for six months, quarterly for three months, and monthly for one month. Premium for a term is due on the first day of that term. **If you fail to pay your premium by the end of the grace period, coverage under this policy will terminate.** If you are receiving short-term Disability benefits on the date coverage would otherwise terminate, coverage under this policy will be extended to the earlier of the date you are no longer qualified to receive Disability benefits or to the end of the Benefit Period, whichever occurs first.
- D. 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 will continue in force.
- E. MISSTATEMENT OF AGE:** If your age has been misstated on the application, the benefits will be those the premium paid would have purchased at the correct age. Aflac 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.

- F. REINSTATEMENT:** You may request reinstatement of your policy from your 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 will 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 your application is received at our worldwide headquarters, your policy will be deemed reinstated. The reinstated policy will cover only loss resulting from a condition that begins on or after the date of reinstatement. In all other respects, you and Aflac will 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 be applied to a period for which premium was due, but not to any period more than 60 days prior to the date of reinstatement.
- G. MISSTATEMENT OF OCCUPATION OR INCOME:** If your occupation has been misstated, the benefits will be those that the premiums paid would have purchased for your correct occupation. If your income has been misstated, the benefit payable will be that which would have been allowed for your true income level and any overpayment of premium will be refunded.
- H. 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 Aflac at our worldwide headquarters, [1932 Wynnton Rd, Columbus, GA 31999], or to your associate (duly licensed agent). The notice of claim should include the name of the covered person and the policy number.
- I. CLAIM FORMS:** When we receive a notice of claim, we will send you forms for filing proof of loss. If the forms are not sent to you within ten working days after the giving of such notice, you will meet the proof-of-loss requirements by giving us a written statement of the nature and extent of the loss within the time limit stated in the Proof of Loss provision.
- J. PROOF OF LOSS:** Written proof of loss must be furnished to Aflac at our worldwide headquarters within 90 days after the date of such loss. Failure to furnish such proof within the time required will not invalidate or 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 15 months from the time proof is otherwise required.
- K. TIME OF PAYMENT OF CLAIMS:** All benefits payable under this policy will be paid immediately upon receipt of due written proof of loss.
- L. PAYMENT OF CLAIMS:** All benefits will be payable to you unless assigned by you or by operation of law. Any accrued benefits unpaid at your death will be paid to your estate.
- M. LEGAL ACTIONS:** No legal action may 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. No such action may be brought after three years from the time written proof of loss is required to be furnished.
- N. CONFORMITY WITH STATE AND FEDERAL STATUTES:** Any provision of this policy that, on its Effective Date, is in conflict with the statutes of the state in which it was issued or with

any federal statute is hereby amended to conform to the minimum requirements of such statutes.

- O. PHYSICAL EXAMINATIONS AND AUTOPSY:** Aflac, at its own expense, will have the right and opportunity to examine a covered person when and as often as it may be reasonably required during the pendency of a claim hereunder, and to make an autopsy in the case of death where autopsy is not forbidden by law.
- P. ASSIGNMENT:** Aflac 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 receive notice at our worldwide headquarters that you have specifically assigned the benefits of your Aflac policy.
- Q. OTHER INSURANCE WITH AFLAC:** If you are covered under more than one Aflac policy with disability benefits, only one disability benefit chosen by you or your estate, as the case may be, will be effective. Aflac will return all premiums paid for the canceled benefits from the date of duplication, less any benefits paid under these policies from such date.
- R. REFUND OF UNEARNED PREMIUMS:** That portion of the premium paid for a period beyond the end of 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 Aflac.

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.

Part 4 **BENEFITS**

Aflac will pay the following benefits, as applicable, if your Disability is caused by a covered Sickness or covered Off-the-Job Injury and occurs while this coverage is in force. All benefits are subject to the Limitations and Exclusions, Pre-existing Condition Limitations, and other policy terms.

Disability due to pregnancy and childbirth is payable to the same extent as a covered Sickness. Disability benefits for childbirth will only be payable after this policy has been in force ten months. The maximum Benefit Period allowed for childbirth is six weeks for noncesarean delivery and eight weeks for cesarean delivery, less the Elimination Period, unless you furnish proof that your Disability continues beyond these time frames.

Benefits will be paid for only one Disability at a time even if the Disability is caused by more than one Sickness, more than one Injury, or a Sickness and an Injury. **We reserve the right to meet with you during the pendency of a claim or to use an independent consultant and Physician's statement to determine whether you are qualified to receive Disability benefits. You must be under the care and attendance of a Physician for these benefits to be payable. Benefits will cease on the date of your death.**

- A. TOTAL DISABILITY BENEFIT:** If you have a Full-Time Job at the time of your Sickness or Off-the-Job Injury, we will insure you as follows while coverage is in force:

If your covered Sickness or covered Off-the-Job Injury causes your Total Disability within 90 days of your last treatment for your covered Sickness or covered Off-the-Job Injury, we will pay you the Daily Disability Benefit for each day of your Disability or your Successive Periods of Disability. This benefit is payable up to the Benefit Period you selected and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled "Term", and the definitions of "Benefit Period" and "Successive Periods of Disability."

You will no longer be qualified to receive this benefit upon the earlier of your: (1) being released by your Physician to perform the material and substantial duties of your Full-Time Job or (2) working at any job.

B. PARTIAL DISABILITY BENEFIT: If you have a Full-Time Job at the time of your Sickness or Off-the-Job Injury, we will insure you as follows while coverage is in force:

If your covered Sickness or covered Off-the-Job Injury causes your Partial Disability within 90 days of your last treatment for your covered Sickness or covered Off-the-Job Injury, we will pay you the Daily Disability Benefit for each day of your Disability or your Successive Periods of Disability. This benefit is payable up to the Benefit Period you selected and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled "Term", and the definitions of "Benefit Period" and "Successive Periods of Disability."

You will no longer be qualified to receive this benefit upon the earlier of your: (1) being released by your Physician to perform the material and substantial duties of your Full-Time Job or (2) working at any job earning 80 percent or more of your pre-Disability Base Pay Earnings.

C. TRANSITIONAL DISABILITY BENEFIT: If you do not have a Full-Time Job at the time of your Sickness or Off-the-Job Injury, we will insure you as follows while coverage is in force:

If your covered Sickness or covered Off-the-Job Injury causes your Transitional Disability within 15 days of your last treatment for your covered Sickness or covered Off-the-Job Injury, we will pay you one-half of the Daily Disability Benefit for each day you remain unable to work at any job. This benefit is payable for a maximum period of three months of Disability or Successive Periods of Disability and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled "Term", and the definition of "Successive Periods of Disability."

You will no longer be qualified to receive this benefit upon the earlier of your: (1) being released by your Physician to perform the material and substantial duties of any job or (2) working at any job. **This benefit is limited to a lifetime maximum period of a total of three months, regardless of the number of Disabilities or the duration of any Disability.**

IF YOU HAVE ANY OTHER DISABILITY BENEFIT IN FORCE WITH US, ONLY ONE DISABILITY BENEFIT IS PAYABLE.

[AMERICAN FAMILY LIFE ASSURANCE COMPANY OF COLUMBUS (AFLAC)

Worldwide Headquarters • Columbus, Georgia 31999]

A Stock Company

This **DISABILITY BENEFIT FOR ON-THE-JOB INJURY RIDER** is a part of the policy and is subject to all policy provisions unless modified herein.

Part 1

EFFECTIVE DATE

The Effective Date of this rider is as stated in the Policy Schedule.

Part 2

TIME LIMIT ON CERTAIN DEFENSES

After two years from the Effective Date of this rider, no misstatements, except fraudulent misstatements, made by you in the application for this rider shall be used to void this rider or to deny a claim for Disability commencing after the expiration of such two-year period. No claim for loss incurred or Disability commencing after 12 months from the Effective Date of coverage for this rider shall be reduced on the grounds that a sickness or physical condition, not excluded from coverage by name or specific description, had existed prior to the Effective Date of coverage for this rider. Coverage for Pre-existing Conditions will not be reduced or denied after the rider has been in force 12 months.

Part 3

BENEFITS

Aflac will pay the following benefits, as applicable, if your Disability is caused by a covered On-the-Job Injury and occurs while this coverage is in force. All benefits are subject to the Limitations and Exclusions, Pre-existing Condition Limitations provision, and other policy terms.

Benefits will be paid for only one Disability at a time even if the Disability is caused by more than one Injury. **We reserve the right to meet with you during the pendency of a claim or to use an independent consultant and Physician's statement to determine whether you are qualified to receive Disability benefits. You must be under the care and attendance of a Physician for these benefits to be payable. Benefits will cease on the date of your death.**

A. TOTAL DISABILITY BENEFIT: If you have a Full-Time Job at the time of your On-the-Job Injury, we will insure you as follows while coverage is in force:

If your covered On-the-Job Injury causes your Total Disability within 90 days of your last treatment for your covered On-the-Job Injury, we will pay you the Daily Disability Benefit for the On-the-Job Injury Disability Rider for each day of your Disability or your Successive Periods of Disability. This benefit is payable up to the Benefit Period you selected and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled "Term", and the definitions of "Benefit Period" and "Successive Periods of Disability."

You will no longer be qualified to receive this benefit upon the earlier of your: (1) being released by your Physician to perform the material and substantial duties of your Full-Time Job or (2) working at any job.

B. PARTIAL DISABILITY BENEFIT: If you have a Full-Time Job at the time of your On-the-Job Injury, we will insure you as follows while coverage is in force:

If your covered On-the-Job Injury causes your Partial Disability within 90 days of your last treatment for your covered On-the-Job Injury, we will pay you the Daily Disability Benefit for the On-the-Job Injury Disability Rider for each day of your Disability or your Successive Periods of Disability. This benefit is payable up to the Benefit Period you selected and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled "Term", and the definitions of "Benefit Period" and "Successive Periods of Disability."

You will no longer be qualified to receive this benefit upon the earlier of your: (1) being released by your Physician to perform the material and substantial duties of your Full-Time Job or (2) working at any job earning 80 percent or more of your pre-Disability Base Pay Earnings.

C. TRANSITIONAL DISABILITY BENEFIT: If you do not have a Full-Time Job at the time of your On-the-Job Injury, we will insure you as follows while coverage is in force:

If your covered On-the-Job Injury causes your Transitional Disability within 15 days of your last treatment for your covered On-the-Job Injury, we will pay you one-half of the Daily Disability Benefit for the On-the-Job Injury Disability Rider for each day you remain unable to work at any job. This benefit is payable for a maximum period of three months of Disability or Successive Periods of Disability and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled "Term", and the definition of "Successive Periods of Disability."

You will no longer be qualified to receive this benefit upon the earlier of your: (1) being released by your Physician to perform the material and substantial duties of any job or (2) working at any job. **This benefit is limited to a lifetime maximum period of a total of three months, regardless of the number of Disabilities or the duration of any Disability.**

IF YOU HAVE ANY OTHER DISABILITY BENEFIT IN FORCE WITH US, ONLY ONE DISABILITY BENEFIT IS PAYABLE.

Part 4
TERMINATION

This rider will terminate upon the earlier of the termination of the policy to which this rider is attached, failure to pay the premiums for this rider, or your death.

In witness whereof, Aflac's president and secretary signed this rider in Columbus, Georgia, as of the rider Effective Date shown in the Policy Schedule.



[Paul S. Amos II, President



Joey M. Loudermilk, Secretary]

AMERICAN FAMILY LIFE ASSURANCE COMPANY OF COLUMBUS (AFLAC)
[Worldwide Headquarters • Columbus, Georgia 31999]
A Stock Company

This **ADDITIONAL UNITS OF DISABILITY BENEFIT RIDER** is a part of the policy and is subject to all policy provisions unless modified herein.

Part 1
EFFECTIVE DATE

The Effective Date of this rider is as stated in the Policy Schedule.

Part 2
TIME LIMIT ON CERTAIN DEFENSES

After two years from the Effective Date of this rider, no misstatements, except fraudulent misstatements, made by you in the application for this rider shall be used to void this rider or to deny a claim for Disability commencing after the expiration of such two-year period. No claim for loss incurred or Disability commencing after 12 months from the Effective Date of coverage for this rider shall be reduced on the grounds that a sickness or physical condition, not excluded from coverage by name or specific description, had existed prior to the Effective Date of coverage for this rider. Coverage for Pre-existing Conditions will not be reduced or denied after the rider has been in force 12 months.

Part 3
BENEFITS

Aflac will pay the following benefits, as applicable, if your Disability is caused by a covered Sickness or covered Off-the-Job Injury and occurs while this coverage is in force. All benefits are subject to the Limitations and Exclusions, Pre-existing Condition Limitations, and other policy terms.

Disability due to pregnancy and childbirth is payable to the same extent as a covered Sickness. Disability benefits for childbirth will only be payable after this rider has been in force ten months. The maximum Benefit Period allowed for childbirth is six weeks for noncesarean delivery and eight weeks for cesarean delivery, less the Elimination Period, unless you furnish proof that your Disability continues beyond these time frames.

Benefits will be paid for only one Disability at a time even if the Disability is caused by more than one Sickness, more than one Injury, or a Sickness and an Injury. **We reserve the right to meet with you during the pendency of a claim or to use an independent consultant and Physician's statement to determine whether you are qualified to receive Disability benefits. You must be under the care and attendance of a Physician for these benefits to be payable. Benefits will cease on the date of your death.**

This benefit will be paid under the same terms as the applicable Total Disability Benefit, Partial Disability Benefit, or Transitional Disability Benefit as described in your policy. The additional units of coverage will only be payable for a Disability that begins after the Effective Date of this rider.

A. TOTAL DISABILITY BENEFIT: If you have a Full-Time Job at the time of your Sickness or Off-the-Job Injury, we will insure you as follows while coverage is in force:

If your covered Sickness or covered Off-the-Job Injury causes your Total Disability within 90 days of your last treatment for your covered Sickness or covered Off-the-Job Injury, we will pay you the Daily Disability Benefit for the Additional Units of Disability Benefit Rider for each day of your Disability or your Successive Periods of Disability. This benefit is payable up to the Benefit Period you selected and is subject to the Elimination Period shown in the Policy

Schedule. Also see the Uniform Provision titled "Term", and the definitions of "Benefit Period" and "Successive Periods of Disability."

You will no longer be qualified to receive this benefit upon the earlier of your: (1) being released by your Physician to perform the material and substantial duties of your Full-Time Job or (2) working at any job.

B. PARTIAL DISABILITY BENEFIT: If you have a Full-Time Job at the time of your Sickness or Off-the-Job Injury, we will insure you as follows while coverage is in force:

If your covered Sickness or covered Off-the-Job Injury causes your Partial Disability within 90 days of your last treatment for your covered Sickness or covered Off-the-Job Injury, we will pay you the Daily Disability Benefit for the Additional Units of Disability Benefit Rider for each day of your Disability or your Successive Periods of Disability. This benefit is payable up to the Benefit Period you selected and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled "Term", and the definitions of "Benefit Period" and "Successive Periods of Disability."

You will no longer be qualified to receive this benefit upon the earlier of your: (1) being released by your Physician to perform the material and substantial duties of your Full-Time Job or (2) working at any job earning 80 percent or more of your pre-Disability Base Pay Earnings.

C. TRANSITIONAL DISABILITY BENEFIT: If you do not have a Full-Time Job at the time of your Sickness or Off-the-Job Injury, we will insure you as follows while coverage is in force:

If your covered Sickness or covered Off-the-Job Injury causes your Transitional Disability within 15 days of your last treatment for your covered Sickness or covered Off-the-Job Injury, we will pay you one-half of the Daily Disability Benefit for the Additional Units of Disability Benefit Rider for each day you remain unable to work at any job. This benefit is payable for a maximum period of three months of Disability or Successive Periods of Disability and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled "Term", and the definition of "Successive Periods of Disability."

You will no longer be qualified to receive this benefit upon the earlier of your: (1) being released by your Physician to perform the material and substantial duties of any job or (2) working at any job. **This benefit is limited to a lifetime maximum period of a total of three months, regardless of the number of Disabilities or the duration of any Disability.**

Part 4
TERMINATION

This rider will terminate upon the earlier of the termination of the policy to which this rider is attached, failure to pay the premiums for this rider, or your death.

In witness whereof, Aflac's president and secretary signed this rider in Columbus, Georgia, as of the rider Effective Date shown in the Policy Schedule.



Paul S. Amos II, President



Joey M. Loudermilk, Secretary]

CHECK COVERAGE DESIRED: [Class: A B C E

Benefit Periods:	<input type="checkbox"/> 3 Months <input type="checkbox"/> 12 Months <input type="checkbox"/> 24 Months (maximum of 30 units) <input type="checkbox"/> 6 Months <input type="checkbox"/> 18 Months (maximum of 30 units)
Elimination Periods: Injury/Sickness	<input type="checkbox"/> 0/7 Days <input type="checkbox"/> 0/14 Days <input type="checkbox"/> 7/14 Days <input type="checkbox"/> 14/14 Days <input type="checkbox"/> 0/30 Days* <input type="checkbox"/> 30/30 Days* (*not available with 3-month Benefit Period) <input type="checkbox"/> 60/60 Days** <input type="checkbox"/> 90/90 Days** <input type="checkbox"/> 180/180 Days** (**not available with 3- or 6-month Benefit Period)

	No. of Units Purchased for this Application	Premium	
<input type="checkbox"/> Base Policy Series A57500			<input type="checkbox"/> Pre-Tax or <input type="checkbox"/> After-Tax
<input type="checkbox"/> On-the-Job Injury Rider Series A57550			
<input type="checkbox"/> Additional Units of Disability Benefit Rider Series A57551 (applies to base policy only) Current Units: _____ (includes any additional units previously purchased) (must match policy elimination and benefit periods)			
NOTE: Each unit is equal to a \$100 monthly benefit.	Total Premium]		

TO BE COMPLETED BY APPLICANT

- Do you work fewer than [19] hours per week in your primary job at which you work for pay or benefits and which is considered full time employment by your employer listed on the first page of this application? Yes No
- Do you have disability coverage that you purchased that will remain in force, which combined with this applied for coverage, will exceed 70 percent of your gross monthly income? Yes No
- If your Industry Class is E, have you been employed for less than 12 months with the employer listed on the front page of this application? Yes No
 N/A
- I certify that my gross annual income (without overtime, unless contractual; bonuses; or other incentives) for my full-time job is \$_____. If you are self-employed, your gross annual income is your net earnings. I understand that this information will be verified at the time of claim. **Annual income must be [\$15,000] or greater for coverage to be issued.**

If you answered Yes to any Question 1–3, a policy will not be issued; therefore, do not submit this application.

- Do you have any of Aflac's accident policies with disability benefits? Yes No
 If yes, please complete the Supplemental Notification section at the end of this application and be aware that you cannot have this policy without canceling those disability benefits with Aflac.

APPLICANT'S STATEMENTS AND AGREEMENTS

- I understand that the Effective Date of the policy will be the date recorded in the Policy Schedule by Aflac Worldwide Headquarters. It is not the date this application was signed by me.
- I understand that coverage is not provided for an illness, disease, infection, disorder, or injury for which, within the 12-month period before the Effective Date of coverage, medical advice, consultation, or treatment was recommended or received, or for which symptoms existed that would ordinarily cause a prudent person to seek diagnosis, care, or treatment. Disability caused by a Pre-existing Condition or reinjuries to a Pre-existing Condition will not be covered unless it begins more than 12 months after the Effective Date of coverage.
- I acknowledge receipt of, if applicable:

<input type="checkbox"/> Replacement Notice	<input type="checkbox"/> <i>Guide to Health Insurance for People With Medicare</i>
<input type="checkbox"/> Outline of Coverage	<input type="checkbox"/> Fair Credit Reporting Notice

- I understand that (1) the policy of insurance I am now applying for will be issued based upon the written answers to the questions and information asked for in this application and any other pertinent information Aflac may require for proper underwriting; (2) the policy, together with this application, endorsements, benefit agreements, riders, and attached papers, if any, constitutes the entire contract of insurance; and (3) no change to the policy will be valid until approved by Aflac's president and secretary, and noted in or attached to the policy.
- I understand that (1) Aflac is not bound by any statement made by me, or any associate/agent of Aflac, unless written herein and (2) the associate/agent cannot change the provisions of the policy or waive any of its provisions either orally or in writing.
- I understand that the premium amount listed on this application represents the premium amount that my employer will remit to Aflac on my behalf. I further understand that this amount, because of my employer's billing/payroll practices, may differ from the amount being deducted from my paycheck or the premium amount quoted to me on an online enrollment system, if applicable.
- If I am applying to replace existing Aflac coverage with this policy, I acknowledge that the policies may have different benefits and that I should make a comparison to personally determine which is best for me. I understand and agree that I am terminating my current Aflac policy and its benefits for the benefits provided in this Aflac policy.
- I have reviewed the statements and answers I have provided on this application. I understand that this policy is to be issued based upon these statements and answers, and any other pertinent information Aflac may require for proper underwriting. The answers are complete and true. I understand that all statements made in this application are deemed representations and not warranties but that material misrepresentations herein may result in loss of coverage under this policy. I further understand that I am signing this application one time even though I may have used it to apply for more than one policy.

SUPPLEMENTAL NOTIFICATION

COMPLETE IF YOU ARE REPLACING/TERMINATING EXISTING AFLAC DISABILITY COVERAGE.

I, _____, am applying for Aflac's short-term disability policy. I currently have disability benefits under Aflac accident/disability Policy Number _____. I understand that I must cancel existing Aflac disability coverage to purchase this short-term disability policy.

- Please cancel the disability riders attached to my accident policy, but keep my accident policy in force.
- I wish to retain my spouse disability rider. I may retain the spouse disability rider **ONLY** if the accident policy remains in force.
- Please cancel my entire accident policy (with Disability Benefits) number _____. I understand that I will be terminating benefits provided for in my current accident policy that are not provided for in the new short-term disability policy.

NOTICE OF INFORMATION PRACTICES

To issue an insurance policy, Aflac may need to obtain additional information about you and any other persons proposed for insurance. Some information will come from you and some may come from other sources. That information and any other subsequent information collected by Aflac may in some circumstances be disclosed to third parties without your specific consent. You have the right to access and correct the information collected about you, except information that relates to a claim or to a civil or criminal proceeding. If you wish to have a more detailed explanation of our information practices, please submit a written request to our worldwide headquarters. This notice applies only in Arizona, California, Connecticut, Georgia, Illinois, Maine, Massachusetts, Minnesota, Nevada, New Jersey, North Carolina, Ohio, Oregon, and Virginia.

**INFORMATION REGARDING THE MEDICAL INFORMATION BUREAU (MIB)
PRENOTICE**

Information regarding your insurability will be treated as confidential. Aflac may, however, make a brief report thereon to MIB, Inc., formerly known as the Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file. Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB toll-free at 1-866-692-6901 (TTY 1-866-346-3642).

If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

Aflac may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its web site at www.mib.com.

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

I authorize the following to give information (as defined below) to American Family Life Assurance Company of Columbus (Aflac) or any person or entity acting on its part: any medical professional, medical care institution, insurer (including Aflac, with respect to other Aflac coverages), reinsurer, government agency (including departments of public safety and motor vehicle departments), MIB, Inc., formerly known as the Medical Information Bureau, consumer reporting agency, or employer.

"Information" means facts or opinions relating to my past, present, or future physical or mental health or condition (excluding psychotherapy notes), employment, other insurance coverage, driving record, or any other medical or nonmedical facts that Aflac deems appropriate to determine eligibility for insurance or to evaluate a claim for benefits during the time this authorization is valid. I also authorize Aflac to give information to MIB, Inc.

I understand that any disclosure of health information to Aflac for the purpose of determining eligibility for coverage other than health plan coverage means the information may no longer be protected by federal privacy regulations. I further understand, however, that such information may be redisclosed only in accordance with other applicable laws or regulations.

I understand that this information will be used by Aflac for enrollment or to determine eligibility for insurance or for underwriting or risk rating (where applicable) purposes and, should coverage be issued, the information may be used to contest a claim for benefits or the issuance of the policy itself during the contestability period provided in the policy.

I understand that Aflac is conditioning the issuance of coverage on the provision of this authorization, and that, while I may refuse to sign this authorization, my refusal to do so could result in coverage not being issued.

I understand that I may revoke this authorization at any time, except to the extent that (1) Aflac has taken action in reliance on this authorization or (2) other law provides Aflac with the right to contest a claim under the policy or the policy itself. My revocation must be submitted in writing to Aflac, [Attn: Policy Service, 1932 Wynnton Road, Columbus, GA 31999].

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

I agree that a copy of this authorization is as valid as the original.



Application for Short-Term Disability Insurance (A57500 Series)
 Application to American Family Life Assurance Company of Columbus (Aflac)
 [Worldwide Headquarters • Columbus, Georgia 31999]

<input type="checkbox"/> New
<input type="checkbox"/> Conversion
<input type="checkbox"/> Additional Units
Policy Number: _____

Please Print in Black Ink – To Be Completed by Proposed Insured

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

State of Birth _____ DOB _____ Sex _____ SSN _____ - _____ - _____
 Month/Day/Year (optional)

Address _____ Street or Post Office Box _____ Apt. No. _____

City _____ State _____ ZIP _____

Home Telephone (____) _____ Business Telephone (____) _____ Best Time to Call _____

E-Mail Address (optional) _____

Account Name _____ Account No. _____

Name of Employer _____ Type of Business _____

Job Duties _____

Job Title _____

Occupation Class _____ Industry Code _____
 (Completed by associate/agent) (Completed by associate/agent)

Is the purchase of this coverage intended to replace any other disability insurance now in force? Yes No
 Not applicable

If Yes, please read and sign the Replacement Notice provided by your associate/agent, if applicable, and provide the policy number here: _____.

TO BE COMPLETED BY AFLAC ASSOCIATE/AGENT

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

Mode:
 01 Monthly
 03 Quarterly
 06 Semiannual
 12 Annual

Assoc./Agent No. _____ Sit. Code _____ Billable Premium \$ _____ Premium Collected \$ _____

CHECK COVERAGE DESIRED: Class: A B C E

Benefit Periods:	<input type="checkbox"/> 3 Months <input type="checkbox"/> 6 Months <input type="checkbox"/> 12 Months <input type="checkbox"/> 18 Months <input type="checkbox"/> 24 Months
Elimination Periods:	<input type="checkbox"/> 0/7 Days <input type="checkbox"/> 0/14 Days <input type="checkbox"/> 7/14 Days <input type="checkbox"/> 14/14 Days
Injury/Sickness	<input type="checkbox"/> 0/30 Days* <input type="checkbox"/> 30/30 Days* (*not available with 3-month Benefit Period) <input type="checkbox"/> 60/60 Days** <input type="checkbox"/> 90/90 Days** <input type="checkbox"/> 180/180 Days** (**not available with 3- or 6-month Benefit Period)

	No. of Units Purchased for this Application	Premium	
<input type="checkbox"/> Base Policy Series A57500			<input type="checkbox"/> After-Tax Only
<input type="checkbox"/> On-the-Job Injury Rider Series A57550			
<input type="checkbox"/> Additional Units of Disability Benefit Rider Series A57551 (applies to base policy only)			
Current Units: _____ (includes any additional units previously purchased) (must match policy elimination and benefit periods)			
NOTE: Each unit is equal to a \$100 monthly benefit.	Total Premium]		

TO BE COMPLETED BY PROPOSED INSURED

- Do you work fewer than [19] hours per week in your primary job at which you work for pay or benefits and which is considered full time employment by your employer listed on the first page of this application? Yes No
- Do you have disability coverage that will remain in force, which combined with this applied for coverage, will exceed 55 percent of your gross monthly income? Yes No
- If your Industry Class is E, have you been employed for less than 12 months with the employer listed on the front page of this application? Yes No
 N/A
- I certify that my gross annual income (without overtime, unless contractual; bonuses; or other incentives) for my full-time job is \$_____. If you are self-employed, your gross annual income is your net earnings. I understand that this information will be verified at the time of claim. **Annual income must be [\$15,000] or greater for coverage to be issued.**

If you answered Yes to any Question 1–3, a policy will not be issued; therefore, do not submit this application.

- Do you have any of Aflac's accident policies with disability benefits? Yes No
If yes, please complete the Supplemental Notification section at the end of this application and be aware that you cannot have this policy without canceling those disability benefits with Aflac.

APPLICANT'S STATEMENTS AND AGREEMENTS

- I understand that the Effective Date of the policy will be the date recorded in the Policy Schedule by Aflac Worldwide Headquarters. It is not the date this application was signed by me.
- I understand that coverage is not provided for an illness, disease, infection, disorder, or injury for which, within the 12-month period before the Effective Date of coverage, medical advice, consultation, or treatment was recommended or received, or for which symptoms existed that would ordinarily cause a prudent person to seek diagnosis, care, or treatment. Disability caused by a Pre-existing Condition or reinjuries to a Pre-existing Condition will not be covered unless it begins more than 12 months after the Effective Date of coverage.
- I acknowledge receipt of, if applicable:
 - Replacement Notice *Guide to Health Insurance for People With Medicare*
 - Outline of Coverage Fair Credit Reporting Notice
- I understand that (1) the policy of insurance I am now applying for will be issued based upon the written answers to the questions and information asked for in this application and any other pertinent information Aflac may require for proper underwriting; (2) the policy, together with this application, endorsements, benefit agreements, riders, and attached papers, if any, constitutes the entire contract of insurance; and (3) no change to the policy will be valid until approved by Aflac's president and secretary, and noted in or attached to the policy.
- I understand that (1) Aflac is not bound by any statement made by me, or any associate/agent of Aflac, unless written herein and (2) the associate/agent cannot change the provisions of the policy or waive any of its provisions either orally or in writing.

- I understand that the premium amount listed on this application represents the premium amount that my employer will remit to Aflac on my behalf. I further understand that this amount, because of my employer's billing/payroll practices, may differ from the amount being deducted from my paycheck or the premium amount quoted to me on an online enrollment system, if applicable.
- If I am applying to replace existing Aflac coverage with this policy, I acknowledge that the policies may have different benefits and that I should make a comparison to personally determine which is best for me. I understand and agree that I am terminating my current Aflac policy and its benefits for the benefits provided in this Aflac policy.
- I have reviewed the statements and answers I have provided on this application. I understand that this policy is to be issued based upon these statements and answers, and any other pertinent information Aflac may require for proper underwriting. The answers are complete and true. I understand that all statements made in this application are deemed representations and not warranties but that material misrepresentations herein may result in loss of coverage under this policy. I further understand that I am signing this application one time even though I may have used it to apply for more than one policy.

SUPPLEMENTAL NOTIFICATION

COMPLETE IF YOU ARE REPLACING/TERMINATING EXISTING AFLAC DISABILITY COVERAGE.

I, _____, am applying for Aflac's short-term disability policy. I currently have disability benefits under Aflac accident/disability Policy Number _____. I understand that I must cancel existing Aflac disability coverage to purchase this short-term disability policy.

- Please cancel the disability riders attached to my accident policy, but keep my accident policy in force.
- I wish to retain my spouse disability rider. I may retain the spouse disability rider **ONLY** if the accident policy remains in force.
- Please cancel my entire accident policy (with Disability Benefits) number _____. I understand that I will be terminating benefits provided for in my current accident policy that are not provided for in the new short-term disability policy.

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

I agree that a copy of this authorization is as valid as the original.

PAYROLL / UNION

SHORT TERM DISABILITY – THIS POLICY PROVIDES INDIVIDUAL COVERAGE ON THE APPLICANT ONLY; THEREFORE, THE FOLLOWING QUESTIONS ONLY APPLY TO THE APPLICANT.

PLEASE COMPLETE THE FOLLOWING QUESTIONS

1. Is anyone to be covered currently disabled due to sickness or injury, or has anyone to be covered been out of work or disabled due to sickness or injury more than 5 consecutive days within the last 12 months (excluding routine childbirth)? Yes No
2. Has anyone to be covered been hospitalized more than 24 hours within the last 12 months for reasons other than routine childbirth? Yes No
3. Does anyone to be covered have any condition for which any medical procedure (including but not limited to surgery, child delivery, organ or bone marrow transplant) has been planned or the possibility of which has been discussed with medical personnel? Yes No
4. Has anyone to be covered been to see a member of the medical profession about a medical condition that has yet to be diagnosed? Yes No
5. Has anyone to be covered, within the last five years: been convicted of a felony; been charged two or more times with operating a vehicle while under the influence of alcohol or drugs; been charged three or more times with a moving violation; or is currently on parole or incarcerated in a correctional institution? Yes No
6. Does anyone to be covered currently have or in the last 12 months, has anyone to be covered been diagnosed with or treated for any of the following conditions or had any of the following procedures: Yes No

AIDS
HIV-positive diagnosis
Systemic lupus
muscular dystrophy
Parkinson's Disease
cystic fibrosis
pulmonary hypertension
renal hypertension
Crohn's disease
Ileitis

regional enteritis
ulcerative colitis
ulcerative proctitis
vascular insufficiency (circulatory problems)
diabetes (Type II) diagnosed prior to age 30
any sort of back, neck, or joint disorder
carpal tunnel syndrome
psoriatic arthritis
rheumatoid arthritis
sciatica

Application to American Family Life Assurance Company of Columbus (Aflac)
[Worldwide Headquarters • Columbus, Georgia 31999]

7. Within the last 5 years, has anyone to be covered been diagnosed with or treated for any of the following conditions or had any of the following procedures: Yes No

- | | |
|---|--|
| heart attack
cardiomyopathy
bypass/stents/angioplasty
atrial fibrillation
implant of pacemaker/defibrillator
heart surgery (including valve replacement or correction)
congestive heart failure
stroke/TIA
chronic obstructive pulmonary disease (COPD)
emphysema
pulmonary fibrosis
diabetes and used tobacco after diagnosis | diabetes treated with insulin
diabetes with complications to include nephropathy; neuropathy; or retinopathy
kidney disease or disorder (not including stones)
liver disease or disorder (excluding Hepatitis A)
fibromyalgia
chronic fatigue syndrome
sarcoidosis
multiple sclerosis
alcohol or drug abuse
internal cancer (to include myelodysplastic blood disorder and myeloproliferative blood disorder)
melanoma (Clark's Level III or higher, or a Breslow Level greater than 1.5 mm) |
|---|--|

If you answered Yes to any question 1 - 7, you are not eligible for any disability coverage; therefore, do not submit this application.

**PLEASE COMPLETE THE FOLLOWING QUESTIONS IF YOU ARE APPLYING FOR MORE THAN 20 UNITS OF COVERAGE OR A BENEFIT PERIOD GREATER THAN 12 MONTHS.
Additional underwriting may be required.**

8. During the last 6 months, have you received any medical treatment, including injections, or been prescribed or taken medications (other than prescription contraceptives)? Yes No
If yes, please provide descriptive information below.

Medical Conditions/Treatments	Onset (mo/yr)	Surgery Performed? (If yes, provide the type of procedure and date)	Date Last Treated	Released by Physician	For Hypertension and Diabetes, List the Average Reading (for the last three months)
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	

Application to American Family Life Assurance Company of Columbus (Aflac)
 [Worldwide Headquarters • Columbus, Georgia 31999]

Medication Name	Dosage	Date First Prescribed	Medical Condition

9. Has anyone to be covered used tobacco products or products containing nicotine of any type in the last 12 months? Yes No

10. a. Do you have any individual disability income coverage in force? Yes No
 b. Do you have any group disability income coverage in force? Yes No

If yes to 10a or 10b, please list your monthly benefit amounts/percentages: _____, your benefit period: _____, and your Elimination Period: _____.

PLEASE COMPLETE THE FOLLOWING QUESTION IF YOU ARE APPLYING FOR THE ON-THE-JOB INJURY RIDER.

11. Are you covered by worker's compensation or a similar law in your full-time job? Yes No

Similar laws include but are not limited to the following:

- Railroad Retirement Act
- Jones Act
- Maritime Doctrine of Maintenance
- Wages or Cure
- Longshoremen's and Harbor Worker's Acts

If you answered Yes, you are not eligible for On-the-Job Injury Rider coverage; and therefore, this rider will not be issued.

APPLICATION FOR REINSTATEMENT
SHORT-TERM DISABILITY INSURANCE FOR A57500 SERIES
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 _____		SSN _____	
Policy Number _____	Date of Birth _____		
Current Address of Policyholder _____			
City _____	State _____	ZIP _____	Telephone No. _____
Former Address of Policyholder _____			
City _____	State _____	ZIP _____	
Name of Employer _____			

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

PLEASE MAKE THE FOLLOWING CHANGES TO MY POLICY:

<input type="checkbox"/> OCCUPATION CLASS CHANGE ONLY - Please note that all occupation class changes are subject to review and approval.
[Class: <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> E]
Type of Business _____
Job Duties _____
Job Title _____

TO BE COMPLETED IF APPLYING FOR REINSTATEMENT OR AN OCCUPATION CLASS CHANGE ON PAYROLL SALES ONLY.

1. Do you work fewer than [19] hours per week in your primary job at which you work for pay or benefits and which is considered full time employment by your employer listed on the first page of this application? Yes No

2. Do you have disability coverage that you purchased that will remain in force, which combined with this applied for coverage, will exceed 70 percent of your gross monthly income? Yes No

3. If your Industry Class is E, have you been employed for less than 12 months with the employer listed on the front page of this application? Yes No
 N/A

4. I certify that my gross annual income (without overtime, unless contractual; bonuses; or other incentives) for my full-time job is \$_____. If you are self-employed, your gross annual income is your net earnings. I understand that this information will be verified at the time of claim. **Annual income must be [\$15,000] or greater for coverage to be issued.**

If you answered Yes to any Question 1–3, a policy will not be reinstated. If applying for an occupation class change and you answered Yes to any Question 1-3, an occupation class change will not be allowed.

**TO BE COMPLETED IF APPLYING FOR REINSTATEMENT
OR AN OCCUPATION CLASS CHANGE ON UNION SALES ONLY.**

1. Do you work fewer than [19] hours per week in your primary job at which you work for pay or benefits and which is considered full time employment by your employer listed on the first page of this application? Yes No
2. Do you have disability coverage that will remain in force, which combined with this applied for coverage, will exceed 55 percent of your gross monthly income? Yes No
3. If your Industry Class is E, have you been employed for less than 12 months with the employer listed on the front page of this application? Yes No
 N/A
4. I certify that my gross annual income (without overtime, unless contractual; bonuses; or other incentives) for my full-time job is \$_____. If you are self-employed, your gross annual income is your net earnings. I understand that this information will be verified at the time of claim. **Annual income must be [\$15,000] or greater for coverage to be issued.**

If you answered Yes to any Question 1–3, a policy will not be reinstated. If applying for an occupation class change and you answered Yes to any Question 1-3, an occupation class change will not be allowed.

**TO BE COMPLETED IF APPLYING FOR REINSTATEMENT
OR AN OCCUPATION CLASS CHANGE ON PAYROLL OR UNION SALES.**

1. Do you have any of Aflac's accident policies with disability benefits? Yes No
If yes, please complete the Supplemental Notification section at the end of this application and be aware that you cannot have this policy without canceling those disability benefits with Aflac.

**PLEASE COMPLETE THE FOLLOWING QUESTIONS FOR
REINSTATEMENT OF THE SHORT-TERM DISABILITY POLICY.**

**THIS POLICY PROVIDES INDIVIDUAL COVERAGE ON THE POLICYHOLDER ONLY;
THEREFORE, THE FOLLOWING QUESTIONS ONLY APPLY TO THE POLICYHOLDER.**

1. Is anyone to be covered currently disabled due to sickness or injury, or has anyone to be covered been out of work or disabled due to sickness or injury more than 5 consecutive days within the last 12 months (excluding routine childbirth)? Yes No
2. Has anyone to be covered been hospitalized more than 24 hours within the last 12 months for reasons other than routine childbirth? Yes No
3. Does anyone to be covered have any condition for which any medical procedure (including but not limited to surgery, child delivery, organ or bone marrow transplant) has been planned or the possibility of which has been discussed with medical personnel? Yes No
4. Has anyone to be covered been to see a member of the medical profession about a medical condition that has yet to be diagnosed? Yes No

5. Has anyone to be covered, within the last five years: been convicted of a felony; been charged two or more times with operating a vehicle while under the influence of alcohol or drugs; been charged three or more times with a moving violation; or is currently on parole or incarcerated in a correctional institution? Yes No

6. Does anyone to be covered currently have or in the last 12 months, has anyone to be covered been diagnosed with or treated for any of the following conditions or had any of the following procedures: Yes No

- | | |
|------------------------|---|
| AIDS | regional enteritis |
| HIV-positive diagnosis | ulcerative colitis |
| Systemic lupus | ulcerative proctitis |
| muscular dystrophy | vascular insufficiency (circulatory problems) |
| Parkinson's Disease | diabetes (Type II) diagnosed prior to age 30 |
| cystic fibrosis | any sort of back, neck, or joint disorder |
| pulmonary hypertension | carpal tunnel syndrome |
| renal hypertension | psoriatic arthritis |
| Crohn's disease | rheumatoid arthritis |
| Ileitis | sciatica |

7. Within the last 5 years, has anyone to be covered been diagnosed with or treated for any of the following conditions or had any of the following procedures: Yes No

- | | |
|---|---|
| heart attack | diabetes treated with insulin |
| cardiomyopathy | diabetes with complications to include nephropathy; |
| bypass/stents/angioplasty | neuropathy; or retinopathy |
| atrial fibrillation | kidney disease or disorder (not including stones) |
| implant of pacemaker/defibrillator | liver disease or disorder (excluding Hepatitis A) |
| heart surgery (including valve replacement or correction) | fibromyalgia |
| congestive heart failure | chronic fatigue syndrome |
| stroke/TIA | sarcoidosis |
| chronic obstructive pulmonary disease (COPD) | multiple sclerosis |
| emphysema | alcohol or drug abuse |
| pulmonary fibrosis | internal cancer (to include myelodysplastic blood disorder and myeloproliferative blood disorder) |
| diabetes and used tobacco after diagnosis | melanoma (Clark's Level III or higher, or a Breslow Level greater than 1.5 mm) |

If you answered Yes to any question 1 - 7, you are not eligible for any disability coverage; therefore, do not submit this application.

PLEASE COMPLETE THE FOLLOWING QUESTIONS FOR REINSTATEMENT OF MORE THAN 20 UNITS OF COVERAGE OR A BENEFIT PERIOD GREATER THAN 12 MONTHS.
Additional underwriting may be required.

8. During the last 6 months, have you received any medical treatment, including injections, or been prescribed or taken medications (other than prescription contraceptives)? Yes No
 If yes, please provide descriptive information below.

Medical Conditions/Treatments	Onset (mo/yr)	Surgery Performed? (If yes, provide the type of procedure and date)	Date Last Treated	Released by Physician	For Hypertension and Diabetes, List the Average Reading (for the last three months)
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	

				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	

Medication Name	Dosage	Date First Prescribed	Medical Condition

9. Has anyone to be covered used tobacco products or products containing nicotine of any type in the last 12 months? Yes No
10. a. Do you have any individual disability income coverage in force? Yes No
b. Do you have any group disability income coverage in force? Yes No
- If yes to 10a or 10b, please list your monthly benefit amounts/percentages: _____, your benefit period: _____, and your Elimination Period: _____.

PLEASE COMPLETE THE FOLLOWING QUESTION FOR REINSTATEMENT OF THE ON-THE-JOB INJURY RIDER.

11. Are you covered by worker's compensation or a similar law in your full-time job? Yes No
Similar laws include but are not limited to the following:
Railroad Retirement Act
Jones Act
Maritime Doctrine of Maintenance
Wages or Cure
Longshoremen's and Harbor Worker's Acts

If you answered Yes, you are not eligible for On-the-Job Injury Rider coverage; and therefore, this rider will not be reinstated.

SUPPLEMENTAL NOTIFICATION
COMPLETE IF YOU ARE REPLACING/TERMINATING EXISTING AFLAC DISABILITY COVERAGE.

I, _____, am applying for Aflac's short-term disability policy. I currently have disability benefits under Aflac accident/disability Policy Number _____. I understand that I must cancel existing Aflac disability coverage to purchase this short-term disability policy.

Please cancel the disability riders attached to my accident policy, but keep my accident policy in force.
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"Information" means facts or opinions relating to my past, present, or future physical or mental health or condition (excluding psychotherapy notes), employment, other insurance coverage, driving record, or any other medical or nonmedical facts that Aflac deems appropriate to determine eligibility for insurance or to evaluate a claim for benefits during the time this authorization is valid. I also authorize Aflac to give information to MIB, Inc.

I understand that any disclosure of health information to Aflac for the purpose of determining eligibility for coverage other than health plan coverage means the information may no longer be protected by federal privacy regulations. I further understand, however, that such information may be redisclosed only in accordance with other applicable laws or regulations.

I understand that this information will be used by Aflac for enrollment or to determine eligibility for insurance or for underwriting or risk rating (where applicable) purposes and, should coverage be issued, the information may be used to contest a claim for benefits or the issuance of the policy itself during the contestability period provided in the policy.

I understand that Aflac is conditioning the issuance of coverage on the provision of this authorization, and that, while I may refuse to sign this authorization, my refusal to do so could result in coverage not being issued.

I understand that I may revoke this authorization at any time, except to the extent that (1) Aflac has taken action in reliance on this authorization or (2) other law provides Aflac with the right to contest a claim under the policy or the policy itself. My revocation must be submitted in writing to Aflac, [Attn: Policy Service, 1932 Wynnton Road, Columbus, GA 31999].

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

I agree that a copy of this authorization is as valid as the original.

I, the undersigned Policyholder, agree that by signing below I am submitting an application to Aflac for the reinstatement of my policy. The reinstated policy will cover only loss resulting from a condition that begins on or after the date of reinstatement.

I have read, or had read to me, the completed application, and I realize policy reinstatement is based upon statements and answers provided herein, and they are complete and true. I understand, for the purposes of the Time Limit on Certain Defenses provision of the policy, that the Effective Date of the policy shall now be the reinstatement date. I also understand that Aflac and I will have the same rights as provided under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed on or attached to the policy in connection with the reinstatement. I further understand that coverage under the reinstated policy is subject to the terms set forth in my policy Reinstatement Provision.

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.

Signature (X) _____

Signed and Dated at _____ on _____
City and State Date

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

MAKE CHECK OR MONEY ORDER PAYABLE TO AFLAC.
[FOR INFORMATION, CALL TOLL-FREE 1-800-99-AFLAC (1-800-992-3522).
VISIT OUR WEB SITE AT AFLAC.COM.]

SHORT-TERM DISABILITY POLICY

THIS IS A LIMITED BENEFIT HEALTH POLICY

NOTICE TO BUYER: This policy pays benefits for short-term Disability caused by Sickness or Off-the-Job Injury. Read it carefully with the Outline of Coverage, if applicable.

The Named Insured shown in the Policy Schedule will be referred to as "you," "your," or "yours." 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 statements made in your application and the payment of the premium shown in the Policy Schedule. A copy of your application is attached and is a part of this policy. The following paragraphs set forth the definitions of terms, the limitations and exclusions, the insurance benefits, and other provisions.

YOUR RIGHT TO EXAMINE THIS POLICY

It is important to us that you are satisfied with this policy. If you are not satisfied, you may return it within 30 days after you receive it. Send it to your associate (duly licensed agent) or to Aflac [Worldwide Headquarters, 1932 Wynnton Road, Columbus, Georgia 31999]. You will receive a full refund of all premiums paid, and your policy will be void from its Effective Date. If you return this policy, please note in writing: "This policy is returned for cancellation and refund of premium."

IMPORTANT NOTICE

Please read your application attached to this policy. This policy is issued on the basis that the information shown on the application is correct and complete. Statements made in the application are deemed representations and not warranties. Carefully check the application. Write to us within 30 days of the date you receive this policy if any information on the application is not correct or complete. Incorrect or incomplete information may result in the denial of claims or voiding of the policy. No associate (duly licensed agent) may change this policy or waive any of its provisions.

THIS POLICY IS GUARANTEED-RENEWABLE TO AGE 70, SUBJECT TO AFLAC'S RIGHT TO CHANGE PREMIUMS BY CLASS UPON ANY RENEWAL DATE.

We agree that this policy will never be restricted by the addition of any rider without your consent, nor will renewal be refused because of any change in your health or physical condition. You are guaranteed the right to renew this policy until the policy anniversary date following your 70th birthday by the timely payment of premiums at the rate in effect at the beginning of each term. **Your coverage will terminate on the policy anniversary date following your 70th birthday.**

Aflac may change the established premium rate, but only if the rate is changed for all policies of this class. While this policy is in force, no change will be made in your class because of age, sex, or physical condition. "Class" means all policies of this form number and premium classification in your state that are then in force. If the established premium rate changes, Aflac will notify you in writing at your last known address, as shown in our records, at least 30 days before the change becomes effective.

PRE-EXISTING CONDITION LIMITATIONS

A Pre-existing Condition is an illness, disease, infection, disorder, or injury for which, within the 12-month period before the Effective Date of coverage, medical advice, consultation, or treatment was recommended or received, or for which symptoms existed that would ordinarily cause a prudent person to seek diagnosis, care, or treatment. Disability caused by a Pre-existing Condition or reinjuries to a Pre-existing Condition will not be covered unless it begins more than 12 months after the Effective Date of coverage.

AMERICAN FAMILY LIFE ASSURANCE COMPANY OF COLUMBUS (AFLAC) CLIENT SERVICES AND ADMINISTRATION

[WORLDWIDE HEADQUARTERS • 1932 WYNNTON ROAD • COLUMBUS, GEORGIA 31999
FOR ASSISTANCE OR INFORMATION ABOUT THIS POLICY, CALL 1-800-99-AFLAC (1-800-992-3522).
FOR CLAIM FORMS, VISIT OUR WEB SITE AT AFLAC.COM.]

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.

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Policy Schedule

NAMED INSURED: John A. Doe POLICY NUMBER: 111-2222

TYPE OF COVERAGE: Individual Only COVERAGE: XXXXXX
AAABBB

MODE OF PAYMENT: Monthly

ELIMINATION PERIODS: Policy, On-the-Job Rider & Additional Disability Rider: Injury: 0, 7 Days Sickness: 7, 14 Days
BENEFIT PERIODS: Policy: 3 Months On-the-Job Rider: 3 Months Additional Disability Rider: 3 Months

EFFECTIVE DATES Policy: XX/XX/XXXX On-the-Job Rider: XX/XX/XXXX Additional Units Rider: XX/XX/XXXX Additional Units Rider: XX/XX/XXXX Additional Units Rider: XX/XX/XXXX
PREMIUMS Policy: \$XX.xx Rider: \$XX.xx Additional Units Rider: \$XX.xx Additional Units Rider: \$XX.xx Additional Units Rider: \$XX.xx

Short-Term Disability Benefit: \$100 (units) Monthly Disability Benefit Payable \$
RIDERS On-the-Job Injury Disability Benefit Rider: \$100 (units) \$ Additional Units Disability Benefit Rider: \$100 (units) \$

In witness whereof, Aflac's president and secretary signed this policy in Columbus, Georgia, as of the policy Effective Date shown in the Policy Schedule.

[Handwritten signature of Paul S. Amos II]

Paul S. Amos II, President

Handwritten signature of Joey M. Loudermilk

Joey M. Loudermilk, Secretary]

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

**Part 1
DEFINITIONS**

- A. BASE PAY EARNINGS:** your gross salary or wages for your Full-Time Job. This does not include variable pay such as overtime (unless contractual), bonuses, or other incentives. If you are self-employed, the term “Base Pay Earnings” means your business’s gross income minus the allowable business deductions from that business. (For tax purposes, Base Pay Earnings is referred to as “net earnings.”)
- B. BENEFIT PERIOD:** the maximum number of days after the Elimination Period, if any, for which you can be paid benefits for any one or Successive Periods of Disability. Each new Benefit Period is subject to a new Elimination Period. See the Policy Schedule for the Benefit Period you selected. For the purposes of this calculation, a “month” is defined as 30 days for which benefits are paid. See definition of “Successive Periods of Disability.”
- C. COMPLICATIONS OF PREGNANCY:** (1) conditions requiring medical treatment prior to or subsequent to the termination of a pregnancy whose diagnoses are distinct from pregnancy but that are adversely affected by pregnancy or caused by pregnancy, such as acute nephritis; nephrosis; cardiac decompensation; missed abortion; disease of the vascular, hemopoietic, nervous, or endocrine systems; and similar medical and surgical conditions of comparable severity; (2) non-elective cesarean deliveries, hyperemesis gravidarum and pre-eclampsia requiring hospital confinement, ectopic pregnancy that is terminated, and spontaneous termination of pregnancy that occurs during a period of gestation in which a viable birth is not possible.

Complications of Pregnancy do not include premature delivery without incidence, multiple gestation pregnancy, false labor, occasional spotting, prescribed rest during pregnancy, morning sickness and similar conditions associated with the management of a difficult pregnancy not constituting a classifiably distinct pregnancy complication. Elective cesarean deliveries are not considered Complications of Pregnancy.

- D. DAILY DISABILITY BENEFIT:** one-thirtieth of the applicable monthly Disability Benefit shown in the Policy Schedule.
- E. DISABILITY:**
1. **TOTAL DISABILITY:** being under the care and attendance of a Physician due to a condition that causes you to be unable to perform the material and substantial duties of your Full-Time Job and not working at any job.
 2. **PARTIAL DISABILITY:** being under the care and attendance of a Physician due to a condition that causes you to be unable to perform the material and substantial duties of your Full-Time Job, but able to work at any job earning less than 80 percent of your Base Pay Earnings of your Full-Time Job at the time you became disabled.
 3. **TRANSITIONAL DISABILITY:** being under the care and attendance of a Physician due to a condition that causes you to be unable to perform the material and substantial duties of any job.

- F. EFFECTIVE DATE:** the date(s) coverage begins as shown in the Policy Schedule. The Effective Date of this policy **is not** the date you signed the application for coverage.
- G. ELIMINATION PERIOD:** the number of consecutive days at the beginning of your period of Disability for which no benefits are payable. See the Policy Schedule for the Elimination Period you selected. Each new Benefit Period is subject to a new Elimination Period.
- H. FULL-TIME JOB:** your primary job at which you work 19 or more hours per week for pay or benefits.
- I. IMMEDIATE FAMILY:** anyone related to you in the following manner: spouse; brothers or sisters (includes stepbrothers and stepsisters); children (includes stepchildren); parents (includes stepparents); grandchildren; father- or mother-in-law; brother- or sister-in-law; and spouses, as applicable, of any of these.
- J. INJURY:** a bodily injury caused directly by an accident, independent of Sickness, disease, bodily infirmity, or any other cause, occurring on or after the Effective Date of coverage and while coverage is in force.
- K. MEDICALLY NECESSARY:** treatment, services, or supplies necessary and appropriate for the diagnosis or treatment of a Sickness or an Injury based upon generally accepted medical practice.
- L. OFF-THE-JOB INJURY:** an Injury that occurs while you are not working at any job for pay or benefits.
- M. ON-THE-JOB INJURY:** an Injury that occurs while you are working at any job for pay or benefits.
- N. PHYSICIAN:** a person legally qualified to practice medicine, other than you or a member of your Immediate Family, who is licensed as a Physician by the state where treatment is received to treat the type of condition for which a claim is made.
- O. SICKNESS:** an illness, disease, infection, or any other abnormal physical condition, independent of Injury, occurring on or after the Effective Date of coverage and while coverage is in force.
- P. SUCCESSIVE PERIODS OF DISABILITY:** separate periods of Disability, if caused by the **same or a related condition** and not separated by 180 days or more, are considered a continuation of the prior Disability. Once the maximum Benefit Period has been paid, you will not be eligible for a new Benefit Period or any Disability benefits due to the same or a related condition unless you have been released by a Physician from the prior Disability and are no longer qualified to receive Disability benefits for a period of 180 days. Separate periods of Disability resulting from **unrelated causes** are considered a continuation of the prior Disability unless they are separated by your returning to work at a Full-Time Job for 14 working days, during which you are performing the material and substantial duties of such job and are no longer qualified to receive Disability benefits. Periods of Disability meeting either of these separation requirements will begin a new Benefit Period, subject to a new Elimination Period.

Part 2
LIMITATIONS AND EXCLUSIONS

- A. Disability caused by a Pre-existing Condition or reinjuries to a Pre-existing Condition will not be covered unless it begins more than 12 months after the Effective Date of coverage.
- B. Aflac will not pay benefits for a Disability that is being treated outside the territorial limits of the United States.
- C. Aflac will not pay benefits whenever coverage provided by this policy is in violation of any U.S. economic or trade sanctions. If the coverage violates U.S. economic or trade sanctions, such coverage shall be null and void.
- D. Aflac will not pay benefits for a Disability that is caused by or occurs as a result of any bacterial, viral, or microorganism infection or infestation or any condition resulting from insect, arachnid, or other arthropod bites or stings as a Disability due to an Injury; such disability will be covered to the same extent as a Disability due to Sickness.
- E. **Aflac will not pay benefits for a disability that is caused by or occurs as a result of your:**
 - 1. Pregnancy or childbirth within the first ten months of the Effective Date of coverage. (Complications of Pregnancy will be covered to the same extent as a Sickness);
 - 2. Using any drug, narcotic, hallucinogen, or chemical substance (unless administered by a Physician and taken according to the Physician's instructions), or voluntarily taking any kind of poison or inhaling any kind of gas or fumes;
 - 3. Participating in any activity or event, including the operation of a vehicle, while under the influence of a controlled substance (unless administered by a Physician and taken according to the Physician's instructions) or while intoxicated ("intoxicated" means that condition as defined by the law of the jurisdiction in which the accident occurred);
 - 4. Participating in, or attempting to participate in, an illegal activity that is defined as a felony, whether charged or not ("felony" is as defined by the law of the jurisdiction in which the activity takes place); or being incarcerated in any type penal institution;
 - 5. Intentionally self-inflicting a bodily injury or committing or attempting suicide, while sane or insane;
 - 6. Having cosmetic surgery or other elective procedures that are not Medically Necessary;
 - 7. Having dental treatment except as a result of Injury;
 - 8. Being exposed to war or any act of war, declared or undeclared;
 - 9. Actively serving in any of the armed forces, or units auxiliary thereto, including the National Guard or Reserve;
 - 10. Donating an organ within the first 12 months of the Effective Date of this policy; or

11. Mental or emotional disorders, including but not limited to the following: bipolar affective disorder (manic-depressive syndrome), delusional (paranoid) disorders, psychotic disorders, somatoform disorders (psychosomatic illness), eating disorders, schizophrenia, anxiety disorders, depression, stress or post-partum depression. This policy will pay, however, for covered disabilities resulting from Alzheimer's disease, or similar forms of senility or senile dementia, first manifested while coverage is in force.

Benefits will be paid for only one Disability at a time even if the Disability is caused by more than one Sickness, more than one Injury, or a Sickness and an Injury.

Part 3 **UNIFORM PROVISIONS**

- A. ENTIRE CONTRACT; CHANGES:** This policy, together with the application, endorsements, benefit agreements, riders, and attached papers, if any, constitutes the entire contract of insurance. No change in this policy is valid until approved in writing by the president and secretary of Aflac at our worldwide headquarters. Any such change must be noted hereon 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:** After two years from the Effective Date of this policy, no misstatements, except fraudulent misstatements, made by you in the application shall be used to void this policy or to deny a claim for Disability commencing after the expiration of such two-year period. No claim for loss incurred or Disability commencing after 12 months from the Effective Date of coverage shall be reduced on the grounds that a sickness or physical condition, not excluded from coverage by name or specific description, had existed prior to the Effective Date of coverage. Coverage for Pre-existing Conditions will not be reduced or denied after the policy has been in force 12 months.
- C. TERM:** You are guaranteed the right to renew this policy until the policy anniversary date following your 70th birthday by the timely payment of premiums at the rate in effect at the beginning of each term. Your coverage will terminate on the policy anniversary date following your 70th birthday. 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 will maintain this policy in force for 12 months, semiannual for six months, quarterly for three months, and monthly for one month. Premium for a term is due on the first day of that term. **If you fail to pay your premium by the end of the grace period, coverage under this policy will terminate.** If you are receiving short-term Disability benefits on the date coverage would otherwise terminate, coverage under this policy will be extended to the earlier of the date you are no longer qualified to receive Disability benefits or to the end of the Benefit Period, whichever occurs first.
- D. 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 will continue in force.
- E. MISSTATEMENT OF AGE:** If your age has been misstated on the application, the benefits will be those the premium paid would have purchased at the correct age. Aflac 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.

- F. REINSTATEMENT:** You may request reinstatement of your policy from your 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 will 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 your application is received at our worldwide headquarters, your policy will be deemed reinstated. The reinstated policy will cover only loss resulting from a condition that begins on or after the date of reinstatement. In all other respects, you and Aflac will 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 be applied to a period for which premium was due, but not to any period more than 60 days prior to the date of reinstatement.
- G. MISSTATEMENT OF OCCUPATION OR INCOME:** If your occupation has been misstated, the benefits will be those that the premiums paid would have purchased for your correct occupation. If your income has been misstated, the benefit payable will be that which would have been allowed for your true income level and any overpayment of premium will be refunded.
- H. 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 Aflac at our worldwide headquarters, [1932 Wynnton Rd, Columbus, GA 31999], or to your associate (duly licensed agent). The notice of claim should include the name of the covered person and the policy number.
- I. CLAIM FORMS:** When we receive a notice of claim, we will send you forms for filing proof of loss. If the forms are not sent to you within ten working days after the giving of such notice, you will meet the proof-of-loss requirements by giving us a written statement of the nature and extent of the loss within the time limit stated in the Proof of Loss provision.
- J. PROOF OF LOSS:** Written proof of loss must be furnished to Aflac at our worldwide headquarters within 90 days after the date of such loss. Failure to furnish such proof within the time required will not invalidate or 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 15 months from the time proof is otherwise required.
- K. TIME OF PAYMENT OF CLAIMS:** All benefits payable under this policy will be paid immediately upon receipt of due written proof of loss.
- L. PAYMENT OF CLAIMS:** All benefits will be payable to you unless assigned by you or by operation of law. Any accrued benefits unpaid at your death will be paid to your estate.
- M. LEGAL ACTIONS:** No legal action may 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. No such action may be brought after three years from the time written proof of loss is required to be furnished.
- N. CONFORMITY WITH STATE AND FEDERAL STATUTES:** Any provision of this policy that, on its Effective Date, is in conflict with the statutes of the state in which it was issued or with

any federal statute is hereby amended to conform to the minimum requirements of such statutes.

- O. PHYSICAL EXAMINATIONS AND AUTOPSY:** Aflac, at its own expense, will have the right and opportunity to examine a covered person when and as often as it may be reasonably required during the pendency of a claim hereunder, and to make an autopsy in the case of death where autopsy is not forbidden by law.
- P. ASSIGNMENT:** Aflac 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 receive notice at our worldwide headquarters that you have specifically assigned the benefits of your Aflac policy.
- Q. OTHER INSURANCE WITH AFLAC:** If you are covered under more than one Aflac policy with disability benefits, only one disability benefit chosen by you or your estate, as the case may be, will be effective. Aflac will return all premiums paid for the canceled benefits from the date of duplication, less any benefits paid under these policies from such date.
- R. REFUND OF UNEARNED PREMIUMS:** That portion of the premium paid for a period beyond the end of 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 Aflac.

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.

Part 4 **BENEFITS**

Aflac will pay the following benefits, as applicable, if your Disability is caused by a covered Sickness or covered Off-the-Job Injury and occurs while this coverage is in force. All benefits are subject to the Limitations and Exclusions, Pre-existing Condition Limitations, and other policy terms.

Disability due to pregnancy and childbirth is payable to the same extent as a covered Sickness. Disability benefits for childbirth will only be payable after this policy has been in force ten months. The maximum Benefit Period allowed for childbirth is six weeks for noncesarean delivery and eight weeks for cesarean delivery, less the Elimination Period, unless you furnish proof that your Disability continues beyond these time frames.

Benefits will be paid for only one Disability at a time even if the Disability is caused by more than one Sickness, more than one Injury, or a Sickness and an Injury. **We reserve the right to meet with you during the pendency of a claim or to use an independent consultant and Physician's statement to determine whether you are qualified to receive Disability benefits. You must be under the care and attendance of a Physician for these benefits to be payable. Benefits will cease on the date of your death.**

- A. TOTAL DISABILITY BENEFIT:** If you have a Full-Time Job at the time of your Sickness or Off-the-Job Injury, we will insure you as follows while coverage is in force:

If your covered Sickness or covered Off-the-Job Injury causes your Total Disability within 90 days of your last treatment for your covered Sickness or covered Off-the-Job Injury, we will pay you the Daily Disability Benefit for each day of your Disability or your Successive Periods of Disability. This benefit is payable up to the Benefit Period you selected and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled "Term", and the definitions of "Benefit Period" and "Successive Periods of Disability."

You will no longer be qualified to receive this benefit upon the earlier of your: (1) being released by your Physician to perform the material and substantial duties of your Full-Time Job or (2) working at any job.

B. PARTIAL DISABILITY BENEFIT: If you have a Full-Time Job at the time of your Sickness or Off-the-Job Injury, we will insure you as follows while coverage is in force:

If your covered Sickness or covered Off-the-Job Injury causes your Partial Disability within 90 days of your last treatment for your covered Sickness or covered Off-the-Job Injury, we will pay you the Daily Disability Benefit for each day of your Disability or your Successive Periods of Disability. This benefit is payable up to the Benefit Period you selected and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled "Term", and the definitions of "Benefit Period" and "Successive Periods of Disability."

You will no longer be qualified to receive this benefit upon the earlier of your: (1) being released by your Physician to perform the material and substantial duties of your Full-Time Job or (2) working at any job earning 80 percent or more of your pre-Disability Base Pay Earnings.

C. TRANSITIONAL DISABILITY BENEFIT: If you do not have a Full-Time Job at the time of your Sickness or Off-the-Job Injury, we will insure you as follows while coverage is in force:

If your covered Sickness or covered Off-the-Job Injury causes your Transitional Disability within 15 days of your last treatment for your covered Sickness or covered Off-the-Job Injury, we will pay you one-half of the Daily Disability Benefit for each day you remain unable to work at any job. This benefit is payable for a maximum period of three months of Disability or Successive Periods of Disability and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled "Term", and the definition of "Successive Periods of Disability."

You will no longer be qualified to receive this benefit upon the earlier of your: (1) being released by your Physician to perform the material and substantial duties of any job or (2) working at any job. **This benefit is limited to a lifetime maximum period of a total of three months, regardless of the number of Disabilities or the duration of any Disability.**

**THIS IS A LIMITED BENEFIT HEALTH POLICY
IF YOU HAVE ANY OTHER DISABILITY BENEFIT IN FORCE WITH US, ONLY ONE
DISABILITY BENEFIT IS PAYABLE.**

American Family Life Assurance Company of Columbus (Aflac)
[Worldwide Headquarters, 1932 Wynnton Road
Columbus, Georgia 31999
TOLL-FREE 1-800-99-AFLAC (1-800-992-3522)]

SHORT-TERM DISABILITY COVERAGE
Outline of Coverage for Policy Series A57500

THIS IS NOT A MEDICARE SUPPLEMENT POLICY.

If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from Aflac.

- 1. Read Your Policy Carefully.** This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and Aflac. It is, therefore, important that you **READ YOUR POLICY CAREFULLY!**
- 2. Short-Term Disability Coverage** is designed to provide, to persons insured, coverage for disabilities resulting from a covered accident or sickness, subject to any limitations set forth in the policy. Coverage is not provided for basic hospital, basic medical-surgical or major medical expenses.
- 3. Benefits.** The following benefits are a part of the policy.

Aflac will pay the following benefits, as applicable, if your Disability is caused by a covered Sickness or covered Off-the-Job Injury and occurs while this coverage is in force. All benefits are subject to the Limitations and Exclusions, Pre-existing Condition Limitations, and other policy terms.

Disability due to pregnancy and childbirth is payable to the same extent as a covered Sickness. Disability benefits for childbirth will only be payable after this policy has been in force ten months. The maximum Benefit Period allowed for childbirth is six weeks for noncesarean delivery and eight weeks for cesarean delivery, less the Elimination Period, unless you furnish proof that your Disability continues beyond these time frames.

Benefits will be paid for only one Disability at a time even if the Disability is caused by more than one Sickness, more than one Injury, or a Sickness and an Injury. **We reserve the right to meet with you during the pendency of a claim or to use an independent consultant and Physician's statement to determine whether you are qualified to receive Disability benefits. You must be under the care and attendance of a Physician for these benefits to be payable. Benefits will cease on the date of your death.**

- A. TOTAL DISABILITY BENEFIT:** If you have a Full-Time Job at the time of your Sickness or Off-the-Job Injury, we will insure you as follows while coverage is in force:

If your covered Sickness or covered Off-the-Job Injury causes your Total Disability within 90 days of your last treatment for your covered Sickness or covered Off-the-Job Injury, we will pay you the Daily Disability Benefit for each day of your Disability or your Successive Periods of Disability. This benefit is payable up to the Benefit Period you selected and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled "Term", and the definitions of "Benefit Period" and "Successive Periods of Disability."

You will no longer be qualified to receive this benefit upon the earlier of your: (1) being released by your Physician to perform the material and substantial duties of your Full-Time Job or (2) working at any job.

B. PARTIAL DISABILITY BENEFIT: If you have a Full-Time Job at the time of your Sickness or Off-the-Job Injury, we will insure you as follows while coverage is in force:

If your covered Sickness or covered Off-the-Job Injury causes your Partial Disability within 90 days of your last treatment for your covered Sickness or covered Off-the-Job Injury, we will pay you the Daily Disability Benefit for each day of your Disability or your Successive Periods of Disability. This benefit is payable up to the Benefit Period you selected and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled "Term", and the definitions of "Benefit Period" and "Successive Periods of Disability."

You will no longer be qualified to receive this benefit upon the earlier of your: (1) being released by your Physician to perform the material and substantial duties of your Full-Time Job or (2) working at any job earning 80 percent or more of your pre-Disability Base Pay Earnings.

C. TRANSITIONAL DISABILITY BENEFIT: If you do not have a Full-Time Job at the time of your Sickness or Off-the-Job Injury, we will insure you as follows while coverage is in force:

If your covered Sickness or covered Off-the-Job Injury causes your Transitional Disability within 15 days of your last treatment for your covered Sickness or covered Off-the-Job Injury, we will pay you one-half of the Daily Disability Benefit for each day you remain unable to work at any job. This benefit is payable for a maximum period of three months of Disability or Successive Periods of Disability and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled "Term", and the definition of "Successive Periods of Disability."

You will no longer be qualified to receive this benefit upon the earlier of your: (1) being released by your Physician to perform the material and substantial duties of any job or (2) working at any job. **This benefit is limited to a lifetime maximum period of a total of three months, regardless of the number of Disabilities or the duration of any Disability.**

IF YOU HAVE ANY OTHER DISABILITY BENEFIT IN FORCE WITH US, ONLY ONE DISABILITY BENEFIT IS PAYABLE.

PRE-EXISTING CONDITION LIMITATIONS: A Pre-existing Condition is an illness, disease, infection, disorder, or injury for which, within the 12-month period before the Effective Date of coverage, medical advice, consultation, or treatment was recommended or received, or for which symptoms existed that would ordinarily cause a prudent person to seek diagnosis, care, or treatment. Disability caused by a Pre-existing Condition or reinjuries to a Pre-existing Condition will not be covered unless it begins more than 12 months after the Effective Date of coverage.

4. OPTIONAL BENEFITS:

Disability Benefit for On-the-Job Injury Rider: (Series A57550) Applied For: Yes No

Aflac will pay the following benefits, as applicable, if your Disability is caused by a covered On-the-Job Injury and occurs while this coverage is in force. All benefits are subject to the Limitations and Exclusions, Pre-existing Condition Limitations, and other policy terms.

Benefits will be paid for only one Disability at a time even if the Disability is caused by more than one Injury. **We reserve the right to meet with you during the pendency of a claim or to use an**

independent consultant and Physician's statement to determine whether you are qualified to receive Disability benefits. You must be under the care and attendance of a Physician for these benefits to be payable. Benefits will cease on the date of your death.

- A. TOTAL DISABILITY BENEFIT:** If you have a Full-Time Job at the time of your On-the-Job Injury, we will insure you as follows while coverage is in force:

If your covered On-the-Job Injury causes your Total Disability within 90 days of your last treatment for your covered On-the-Job Injury, we will pay you the Daily Disability Benefit for the On-the-Job Injury Disability Rider for each day of your Disability or your Successive Periods of Disability. This benefit is payable up to the Benefit Period you selected and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled "Term", and the definitions of "Benefit Period" and "Successive Periods of Disability."

You will no longer be qualified to receive this benefit upon the earlier of your: (1) being released by your Physician to perform the material and substantial duties of your Full-Time Job or (2) working at any job.

- B. PARTIAL DISABILITY BENEFIT:** If you have a Full-Time Job at the time of your On-the-Job Injury, we will insure you as follows while coverage is in force:

If your covered On-the-Job Injury causes your Partial Disability within 90 days of your last treatment for your covered On-the-Job Injury, we will pay you the Daily Disability Benefit for the On-the-Job Injury Disability Rider for each day of your Disability or your Successive Periods of Disability. This benefit is payable up to the Benefit Period you selected and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled "Term", and the definitions of "Benefit Period" and "Successive Periods of Disability."

You will no longer be qualified to receive this benefit upon the earlier of your: (1) being released by your Physician to perform the material and substantial duties of your Full-Time Job or (2) working at any job earning 80 percent or more of your pre-Disability Base Pay Earnings.

- C. TRANSITIONAL DISABILITY BENEFIT:** If you do not have a Full-Time Job at the time of your On-the-Job Injury, we will insure you as follows while coverage is in force:

If your covered On-the-Job Injury causes your Transitional Disability within 15 days of your last treatment for your covered On-the-Job Injury, we will pay you one-half of the Daily Disability Benefit for the On-the-Job Injury Disability Rider for each day you remain unable to work at any job. This benefit is payable for a maximum period of three months of Disability or Successive Periods of Disability and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled "Term", and the definition of "Successive Periods of Disability."

You will no longer be qualified to receive this benefit upon the earlier of your: (1) being released by your Physician to perform the material and substantial duties of any job or (2) working at any job. **This benefit is limited to a lifetime maximum period of a total of three months, regardless of the number of Disabilities or the duration of any Disability.**

IF YOU HAVE ANY OTHER DISABILITY BENEFIT IN FORCE WITH US, ONLY ONE DISABILITY BENEFIT IS PAYABLE.

Additional Units of Disability Benefit Rider: (Series A57551) Applied For: Yes No

Aflac will pay the following benefits, as applicable, if your Disability is caused by a covered Sickness or covered Off-the-Job Injury and occurs while this coverage is in force. All benefits are subject to the Limitations and Exclusions, Pre-existing Condition Limitations, and other policy terms.

Disability due to pregnancy and childbirth is payable to the same extent as a covered Sickness. Disability benefits for childbirth will only be payable after this rider has been in force ten months. The maximum Benefit Period allowed for childbirth is six weeks for noncesarean delivery and eight weeks for cesarean delivery, less the Elimination Period, unless you furnish proof that your Disability continues beyond these time frames.

Benefits will be paid for only one Disability at a time even if the Disability is caused by more than one Sickness, more than one Injury, or a Sickness and an Injury. **We reserve the right to meet with you during the pendency of a claim or to use an independent consultant and Physician's statement to determine whether you are qualified to receive Disability benefits. You must be under the care and attendance of a Physician for these benefits to be payable. Benefits will cease on the date of your death.**

This benefit will be paid under the same terms as the applicable Total Disability Benefit, Partial Disability Benefit, or Transitional Disability Benefit as described in your policy. The additional units of coverage will only be payable for a Disability that begins after the Effective Date of this rider.

A. TOTAL DISABILITY BENEFIT: If you have a Full-Time Job at the time of your Sickness or Off-the-Job Injury, we will insure you as follows while coverage is in force:

If your covered Sickness or covered Off-the-Job Injury causes your Total Disability within 90 days of your last treatment for your covered Sickness or covered Off-the-Job Injury, we will pay you the Daily Disability Benefit for the Additional Units of Disability Benefit Rider for each day of your Disability or your Successive Periods of Disability. This benefit is payable up to the Benefit Period you selected and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled "Term", and the definitions of "Benefit Period" and "Successive Periods of Disability."

You will no longer be qualified to receive this benefit upon the earlier of your: (1) being released by your Physician to perform the material and substantial duties of your Full-Time Job or (2) working at any job.

B. PARTIAL DISABILITY BENEFIT: If you have a Full-Time Job at the time of your Sickness or Off-the-Job Injury, we will insure you as follows while coverage is in force:

If your covered Sickness or covered Off-the-Job Injury causes your Partial Disability within 90 days of your last treatment for your covered Sickness or covered Off-the-Job Injury, we will pay you the Daily Disability Benefit for the Additional Units of Disability Benefit Rider for each day of your Disability or your Successive Periods of Disability. This benefit is payable up to the Benefit Period you selected and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled "Term", and the definitions of "Benefit Period" and "Successive Periods of Disability."

You will no longer be qualified to receive this benefit upon the earlier of your: (1) being released by your Physician to perform the material and substantial duties of your Full-Time Job or (2) working at any job earning 80 percent or more of your pre-Disability Base Pay Earnings.

C. TRANSITIONAL DISABILITY BENEFIT: If you do not have a Full-Time Job at the time of your Sickness or Off-the-Job Injury, we will insure you as follows while coverage is in force:

If your covered Sickness or covered Off-the-Job Injury causes your Transitional Disability within 15 days of your last treatment for your covered Sickness or covered Off-the-Job Injury, we will pay you one-half of the Daily Disability Benefit for the Additional Units of Disability Benefit Rider for each day you remain unable to work at any job. This benefit is payable for a maximum period of three months of Disability or Successive Periods of Disability and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled "Term", and the definition of "Successive Periods of Disability."

You will no longer be qualified to receive this benefit upon the earlier of your: (1) being released by your Physician to perform the material and substantial duties of any job or (2) working at any job. **This benefit is limited to a lifetime maximum period of a total of three months, regardless of the number of Disabilities or the duration of any Disability.**

IMPORTANT PROVISIONS OF YOUR POLICY

LIMITATIONS AND EXCLUSIONS.

- A. Disability caused by a Pre-existing Condition or reinjuries to a Pre-existing Condition will not be covered unless it begins more than 12 months after the Effective Date of coverage.
- B. Aflac will not pay benefits for a Disability that is being treated outside the territorial limits of the United States.
- C. Aflac will not pay benefits whenever coverage provided by this policy is in violation of any U.S. economic or trade sanctions. If the coverage violates U.S. economic or trade sanctions, such coverage shall be null and void.
- D. Aflac will not pay benefits for a Disability that is caused by or occurs as a result of any bacterial, viral, or microorganism infection or infestation or any condition resulting from insect, arachnid, or other arthropod bites or stings as a Disability due to an Injury; such disability will be covered to the same extent as a Disability due to Sickness.
- E. **Aflac will not pay benefits for a disability that is caused by or occurs as a result of your:**
 - 1. Pregnancy or childbirth within the first ten months of the Effective Date of coverage. (Complications of Pregnancy will be covered to the same extent as a Sickness);
 - 2. Using any drug, narcotic, hallucinogen, or chemical substance (unless administered by a Physician and taken according to the Physician's instructions), or voluntarily taking any kind of poison or inhaling any kind of gas or fumes;
 - 3. Participating in any activity or event, including the operation of a vehicle, while under the influence of a controlled substance (unless administered by a Physician and taken according to the Physician's instructions) or while intoxicated ("intoxicated" means that condition as defined by the law of the jurisdiction in which the accident occurred);
 - 4. Participating in, or attempting to participate in, an illegal activity that is defined as a felony, whether charged or not ("felony" is as defined by the law of the jurisdiction in which the activity takes place); or being incarcerated in any type penal institution;

5. Intentionally self-inflicting a bodily injury or committing or attempting suicide, while sane or insane;
6. Having cosmetic surgery or other elective procedures that are not Medically Necessary;
7. Having dental treatment except as a result of Injury;
8. Being exposed to war or any act of war, declared or undeclared;
9. Actively serving in any of the armed forces, or units auxiliary thereto, including the National Guard or Reserve;
10. Donating an organ within the first 12 months of the Effective Date of this policy; or
11. Mental or emotional disorders, including but not limited to the following: bipolar affective disorder (manic-depressive syndrome), delusional (paranoid) disorders, psychotic disorders, somatoform disorders (psychosomatic illness), eating disorders, schizophrenia, anxiety disorders, depression, stress or post-partum depression. This policy will pay, however, for covered disabilities resulting from Alzheimer's disease, or similar forms of senility or senile dementia, first manifested while coverage is in force.

Benefits will be paid for only one Disability at a time even if the Disability is caused by more than one Sickness, more than one Injury, or a Sickness and an Injury.

Renewability. The Policy is guaranteed renewable to age 70 by payment of the premium in effect at the beginning of each renewal period. Premium rates may be changed only if changed on all policies of the same form number and class in force in your state.

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

American Family Life Assurance Company of Columbus (Aflac)
[Worldwide Headquarters, 1932 Wynnton Road
Columbus, Georgia 31999
TOLL-FREE 1-800-99-AFLAC (1-800-992-3522)]

LIMITED BENEFIT HEALTH COVERAGE

SHORT-TERM DISABILITY COVERAGE
Outline of Coverage for Policy Series A57500LB

THIS IS NOT A MEDICARE SUPPLEMENT POLICY.

If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from Aflac.

- 1. Read Your Policy Carefully.** This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and Aflac. It is, therefore, important that you **READ YOUR POLICY CAREFULLY!**
- 2. Limited Benefit Health Coverage.** Policies of this category are designed to provide, to persons insured, limited or supplemental insurance coverage, subject to any limitations, deductibles or copayment requirements set forth in the policy.
- 3. Short-Term Disability Coverage** is designed to provide, to persons insured, coverage for disabilities resulting from a covered accident or sickness, subject to any limitations set forth in the policy. Coverage is not provided for basic hospital, basic medical-surgical or major medical expenses.
- 4. Benefits.** The following benefits are a part of the policy.

Aflac will pay the following benefits, as applicable, if your Disability is caused by a covered Sickness or covered Off-the-Job Injury and occurs while this coverage is in force. All benefits are subject to the Limitations and Exclusions, Pre-existing Condition Limitations, and other policy terms.

Disability due to pregnancy and childbirth is payable to the same extent as a covered Sickness. Disability benefits for childbirth will only be payable after this policy has been in force ten months. The maximum Benefit Period allowed for childbirth is six weeks for noncesarean delivery and eight weeks for cesarean delivery, less the Elimination Period, unless you furnish proof that your Disability continues beyond these time frames.

Benefits will be paid for only one Disability at a time even if the Disability is caused by more than one Sickness, more than one Injury, or a Sickness and an Injury. **We reserve the right to meet with you during the pendency of a claim or to use an independent consultant and Physician's statement to determine whether you are qualified to receive Disability benefits. You must be under the care and attendance of a Physician for these benefits to be payable. Benefits will cease on the date of your death.**

A. TOTAL DISABILITY BENEFIT: If you have a Full-Time Job at the time of your Sickness or Off-the-Job Injury, we will insure you as follows while coverage is in force:

If your covered Sickness or covered Off-the-Job Injury causes your Total Disability within 90 days of your last treatment for your covered Sickness or covered Off-the-Job Injury, we will pay you the Daily

Disability Benefit for each day of your Disability or your Successive Periods of Disability. This benefit is payable up to the Benefit Period you selected and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled "Term", and the definitions of "Benefit Period" and "Successive Periods of Disability."

You will no longer be qualified to receive this benefit upon the earlier of your: (1) being released by your Physician to perform the material and substantial duties of your Full-Time Job or (2) working at any job.

B. PARTIAL DISABILITY BENEFIT: If you have a Full-Time Job at the time of your Sickness or Off-the-Job Injury, we will insure you as follows while coverage is in force:

If your covered Sickness or covered Off-the-Job Injury causes your Partial Disability within 90 days of your last treatment for your covered Sickness or covered Off-the-Job Injury, we will pay you the Daily Disability Benefit for each day of your Disability or your Successive Periods of Disability. This benefit is payable up to the Benefit Period you selected and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled "Term", and the definitions of "Benefit Period" and "Successive Periods of Disability."

You will no longer be qualified to receive this benefit upon the earlier of your: (1) being released by your Physician to perform the material and substantial duties of your Full-Time Job or (2) working at any job earning 80 percent or more of your pre-Disability Base Pay Earnings.

C. TRANSITIONAL DISABILITY BENEFIT: If you do not have a Full-Time Job at the time of your Sickness or Off-the-Job Injury, we will insure you as follows while coverage is in force:

If your covered Sickness or covered Off-the-Job Injury causes your Transitional Disability within 15 days of your last treatment for your covered Sickness or covered Off-the-Job Injury, we will pay you one-half of the Daily Disability Benefit for each day you remain unable to work at any job. This benefit is payable for a maximum period of three months of Disability or Successive Periods of Disability and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled "Term", and the definition of "Successive Periods of Disability."

You will no longer be qualified to receive this benefit upon the earlier of your: (1) being released by your Physician to perform the material and substantial duties of any job or (2) working at any job. **This benefit is limited to a lifetime maximum period of a total of three months, regardless of the number of Disabilities or the duration of any Disability.**

IF YOU HAVE ANY OTHER DISABILITY BENEFIT IN FORCE WITH US, ONLY ONE DISABILITY BENEFIT IS PAYABLE.

PRE-EXISTING CONDITION LIMITATIONS: A Pre-existing Condition is an illness, disease, infection, disorder, or injury for which, within the 12-month period before the Effective Date of coverage, medical advice, consultation, or treatment was recommended or received, or for which symptoms existed that would ordinarily cause a prudent person to seek diagnosis, care, or treatment. Disability caused by a Pre-existing Condition or reinjuries to a Pre-existing Condition will not be covered unless it begins more than 12 months after the Effective Date of coverage.

5. OPTIONAL BENEFITS:

Disability Benefit for On-the-Job Injury Rider: (Series A57550) Applied For: Yes No

Aflac will pay the following benefits, as applicable, if your Disability is caused by a covered On-the-Job Injury and occurs while this coverage is in force. All benefits are subject to the Limitations and Exclusions, Pre-existing Condition Limitations, and other policy terms.

Benefits will be paid for only one Disability at a time even if the Disability is caused by more than one Injury. **We reserve the right to meet with you during the pendency of a claim or to use an independent consultant and Physician's statement to determine whether you are qualified to receive Disability benefits. You must be under the care and attendance of a Physician for these benefits to be payable. Benefits will cease on the date of your death.**

A. TOTAL DISABILITY BENEFIT: If you have a Full-Time Job at the time of your On-the-Job Injury, we will insure you as follows while coverage is in force:

If your covered On-the-Job Injury causes your Total Disability within 90 days of your last treatment for your covered On-the-Job Injury, we will pay you the Daily Disability Benefit for the On-the-Job Injury Disability Rider for each day of your Disability or your Successive Periods of Disability. This benefit is payable up to the Benefit Period you selected and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled "Term", and the definitions of "Benefit Period" and "Successive Periods of Disability."

You will no longer be qualified to receive this benefit upon the earlier of your: (1) being released by your Physician to perform the material and substantial duties of your Full-Time Job or (2) working at any job.

B. PARTIAL DISABILITY BENEFIT: If you have a Full-Time Job at the time of your On-the-Job Injury, we will insure you as follows while coverage is in force:

If your covered On-the-Job Injury causes your Partial Disability within 90 days of your last treatment for your covered On-the-Job Injury, we will pay you the Daily Disability Benefit for the On-the-Job Injury Disability Rider for each day of your Disability or your Successive Periods of Disability. This benefit is payable up to the Benefit Period you selected and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled "Term", and the definitions of "Benefit Period" and "Successive Periods of Disability."

You will no longer be qualified to receive this benefit upon the earlier of your: (1) being released by your Physician to perform the material and substantial duties of your Full-Time Job or (2) working at any job earning 80 percent or more of your pre-Disability Base Pay Earnings.

C. TRANSITIONAL DISABILITY BENEFIT: If you do not have a Full-Time Job at the time of your On-the-Job Injury, we will insure you as follows while coverage is in force:

If your covered On-the-Job Injury causes your Transitional Disability within 15 days of your last treatment for your covered On-the-Job Injury, we will pay you one-half of the Daily Disability Benefit for the On-the-Job Injury Disability Rider for each day you remain unable to work at any job. This benefit is payable for a maximum period of three months of Disability or Successive Periods of Disability and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled "Term", and the definition of "Successive Periods of Disability."

You will no longer be qualified to receive this benefit upon the earlier of your: (1) being released by your Physician to perform the material and substantial duties of any job or (2) working at any job. **This benefit is limited to a lifetime maximum period of a total of three months, regardless of the number of Disabilities or the duration of any Disability.**

IF YOU HAVE ANY OTHER DISABILITY BENEFIT IN FORCE WITH US, ONLY ONE DISABILITY BENEFIT IS PAYABLE.

Additional Units of Disability Benefit Rider: (Series A57551) Applied For: Yes No

Aflac will pay the following benefits, as applicable, if your Disability is caused by a covered Sickness or covered Off-the-Job Injury and occurs while this coverage is in force. All benefits are subject to the Limitations and Exclusions, Pre-existing Condition Limitations, and other policy terms.

Disability due to pregnancy and childbirth is payable to the same extent as a covered Sickness. Disability benefits for childbirth will only be payable after this rider has been in force ten months. The maximum Benefit Period allowed for childbirth is six weeks for noncesarean delivery and eight weeks for cesarean delivery, less the Elimination Period, unless you furnish proof that your Disability continues beyond these time frames.

Benefits will be paid for only one Disability at a time even if the Disability is caused by more than one Sickness, more than one Injury, or a Sickness and an Injury. **We reserve the right to meet with you during the pendency of a claim or to use an independent consultant and Physician's statement to determine whether you are qualified to receive Disability benefits. You must be under the care and attendance of a Physician for these benefits to be payable. Benefits will cease on the date of your death.**

This benefit will be paid under the same terms as the applicable Total Disability Benefit, Partial Disability Benefit, or Transitional Disability Benefit as described in your policy. The additional units of coverage will only be payable for a Disability that begins after the Effective Date of this rider.

A. TOTAL DISABILITY BENEFIT: If you have a Full-Time Job at the time of your Sickness or Off-the-Job Injury, we will insure you as follows while coverage is in force:

If your covered Sickness or covered Off-the-Job Injury causes your Total Disability within 90 days of your last treatment for your covered Sickness or covered Off-the-Job Injury, we will pay you the Daily Disability Benefit for the Additional Units of Disability Benefit Rider for each day of your Disability or your Successive Periods of Disability. This benefit is payable up to the Benefit Period you selected and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled "Term", and the definitions of "Benefit Period" and "Successive Periods of Disability."

You will no longer be qualified to receive this benefit upon the earlier of your: (1) being released by your Physician to perform the material and substantial duties of your Full-Time Job or (2) working at any job.

B. PARTIAL DISABILITY BENEFIT: If you have a Full-Time Job at the time of your Sickness or Off-the-Job Injury, we will insure you as follows while coverage is in force:

If your covered Sickness or covered Off-the-Job Injury causes your Partial Disability within 90 days of your last treatment for your covered Sickness or covered Off-the-Job Injury, we will pay you the Daily Disability Benefit for the Additional Units of Disability Benefit Rider for each day of your Disability or your Successive Periods of Disability. This benefit is payable up to the Benefit Period you selected

and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled "Term", and the definitions of "Benefit Period" and "Successive Periods of Disability."

You will no longer be qualified to receive this benefit upon the earlier of your: (1) being released by your Physician to perform the material and substantial duties of your Full-Time Job or (2) working at any job earning 80 percent or more of your pre-Disability Base Pay Earnings.

C. TRANSITIONAL DISABILITY BENEFIT: If you do not have a Full-Time Job at the time of your Sickness or Off-the-Job Injury, we will insure you as follows while coverage is in force:

If your covered Sickness or covered Off-the-Job Injury causes your Transitional Disability within 15 days of your last treatment for your covered Sickness or covered Off-the-Job Injury, we will pay you one-half of the Daily Disability Benefit for the Additional Units of Disability Benefit Rider for each day you remain unable to work at any job. This benefit is payable for a maximum period of three months of Disability or Successive Periods of Disability and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled "Term", and the definition of "Successive Periods of Disability."

You will no longer be qualified to receive this benefit upon the earlier of your: (1) being released by your Physician to perform the material and substantial duties of any job or (2) working at any job. **This benefit is limited to a lifetime maximum period of a total of three months, regardless of the number of Disabilities or the duration of any Disability.**

IMPORTANT PROVISIONS OF YOUR POLICY

LIMITATIONS AND EXCLUSIONS.

- A. Disability caused by a Pre-existing Condition or reinjuries to a Pre-existing Condition will not be covered unless it begins more than 12 months after the Effective Date of coverage.
- B. Aflac will not pay benefits for a Disability that is being treated outside the territorial limits of the United States.
- C. Aflac will not pay benefits whenever coverage provided by this policy is in violation of any U.S. economic or trade sanctions. If the coverage violates U.S. economic or trade sanctions, such coverage shall be null and void.
- D. Aflac will not pay benefits for a Disability that is caused by or occurs as a result of any bacterial, viral, or microorganism infection or infestation or any condition resulting from insect, arachnid, or other arthropod bites or stings as a Disability due to an Injury; such disability will be covered to the same extent as a Disability due to Sickness.
- E. **Aflac will not pay benefits for a disability that is caused by or occurs as a result of your:**
 - 1. Pregnancy or childbirth within the first ten months of the Effective Date of coverage. (Complications of Pregnancy will be covered to the same extent as a Sickness);
 - 2. Using any drug, narcotic, hallucinogen, or chemical substance (unless administered by a Physician and taken according to the Physician's instructions), or voluntarily taking any kind of poison or inhaling any kind of gas or fumes;

3. Participating in any activity or event, including the operation of a vehicle, while under the influence of a controlled substance (unless administered by a Physician and taken according to the Physician's instructions) or while intoxicated ("intoxicated" means that condition as defined by the law of the jurisdiction in which the accident occurred);
4. Participating in, or attempting to participate in, an illegal activity that is defined as a felony, whether charged or not ("felony" is as defined by the law of the jurisdiction in which the activity takes place); or being incarcerated in any type penal institution;
5. Intentionally self-inflicting a bodily injury or committing or attempting suicide, while sane or insane;
6. Having cosmetic surgery or other elective procedures that are not Medically Necessary;
7. Having dental treatment except as a result of Injury;
8. Being exposed to war or any act of war, declared or undeclared;
9. Actively serving in any of the armed forces, or units auxiliary thereto, including the National Guard or Reserve;
10. Donating an organ within the first 12 months of the Effective Date of this policy; or
11. Mental or emotional disorders, including but not limited to the following: bipolar affective disorder (manic-depressive syndrome), delusional (paranoid) disorders, psychotic disorders, somatoform disorders (psychosomatic illness), eating disorders, schizophrenia, anxiety disorders, depression, stress or post-partum depression. This policy will pay, however, for covered disabilities resulting from Alzheimer's disease, or similar forms of senility or senile dementia, first manifested while coverage is in force.

Benefits will be paid for only one Disability at a time even if the Disability is caused by more than one Sickness, more than one Injury, or a Sickness and an Injury.

Renewability. The Policy is guaranteed renewable to age 70 by payment of the premium in effect at the beginning of each renewal period. Premium rates may be changed only if changed on all policies of the same form number and class in force in your state.

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

I, the undersigned Proposed Insured/Employee, agree that by signing below I am submitting an application to Aflac for the following insurance policy(ies).

- | | | |
|--|---|---|
| <input type="checkbox"/> Lump Sum Critical Illness | <input type="checkbox"/> Dental | <input type="checkbox"/> Vision |
| <input type="checkbox"/> Lump Sum Cancer | <input type="checkbox"/> Hospital Confinement | <input type="checkbox"/> Specified Disease/Cancer |
| <input type="checkbox"/> Short Term Disability | <input type="checkbox"/> Specified Health Event | <input type="checkbox"/> Hospital Intensive Care |
| <input type="checkbox"/> Accident | | |

- This is an electronic application. It has been completed and signed by me electronically without the presence of an associate/agent.
- I verify that the unique identifier used to sign this application is mine and that by clicking the "Accept" button I am signing the application(s) electronically. I further understand, agree, and authorize my employer to deduct the premiums for this policy(ies) from my paycheck.
- I would prefer to receive an electronic copy of my policy(ies) instead of paper. Yes No

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.

Signed and Dated at _____ on _____
City and State Date

Proposed Insured's/Employee's Signature _____

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,
[WORLDWIDE HEADQUARTERS • 1932 WYNNTON ROAD • COLUMBUS, GEORGIA 31999.]**

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.**

**MAKE CHECK OR MONEY ORDER PAYABLE TO AFLAC.
[FOR INFORMATION, CALL TOLL-FREE 1-800-99-AFLAC (1-800-992-3522).
VISIT OUR WEB SITE AT AFLAC.COM.]**

American Family Life Assurance Company of Columbus (Aflac)
[Worldwide Headquarters: Columbus, Georgia 31999]

I, the undersigned Proposed Insured/Employee, agree that by signing below I am submitting an application to Aflac for the following insurance policy(ies).

- | | | |
|--|---|---|
| <input type="checkbox"/> Lump Sum Critical Illness | <input type="checkbox"/> Dental | <input type="checkbox"/> Vision |
| <input type="checkbox"/> Lump Sum Cancer | <input type="checkbox"/> Hospital Confinement | <input type="checkbox"/> Specified Disease/Cancer |
| <input type="checkbox"/> Short Term Disability | <input type="checkbox"/> Specified Health Event | <input type="checkbox"/> Hospital Intensive Care |
| <input type="checkbox"/> Accident | | |

I would prefer to receive an electronic copy of my policy(ies) instead of paper. Yes No

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.

Signed and Dated at _____ on _____
City and State Date

Proposed Insured's/Employee's Signature _____

I certify that I personally saw the Proposed Insured/Employee when the application was written, and each question was asked of the Proposed Insured/Employee and answered as recorded. All answers above are correct to the best of my knowledge.

Associate's/Agent's Signature _____ Date _____
Licensed Resident Associate/Agent

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,
[WORLDWIDE HEADQUARTERS • 1932 WYNNTON ROAD • COLUMBUS, GEORGIA 31999.]**

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.**

**MAKE CHECK OR MONEY ORDER PAYABLE TO AFLAC.
[FOR INFORMATION, CALL TOLL-FREE 1-800-99-AFLAC (1-800-992-3522).
VISIT OUR WEB SITE AT AFLAC.COM.]**

SERFF Tracking Number: AFLA-125900873 State: Arkansas
Filing Company: American Family Life Assurance Company of Columbus State Tracking Number: 41904
Company Tracking Number: A57500
TOI: H111 Individual Health - Disability Income Sub-TOI: H111.004 Other
Product Name: Short Term Disability
Project Name/Number: Short Term Disability/

Supporting Document Schedules

Satisfied -Name: Certification/Notice **Review Status:** Approved-Closed 02/10/2009

Comments:

The filing letter includes Rule & Regulation 19, Rule & Regulation 49, and the required Flesch Certification along with the required officer signature.

Page two: Rule & Regulation 19, Rule & Regulation 49, and the required Flesch Certification

Page three: officer signature

Attachment:

57500LB DTG letterhead2.pdf

Satisfied -Name: Application **Review Status:** Approved-Closed 02/10/2009

Comments:

Application forms are attached below.

Attachments:

A575PAPP.pdf

A575UAPP.pdf

A57503AR.pdf

Satisfied -Name: Outline of Coverage **Review Status:** Approved-Closed 02/10/2009

Comments:

Outline of Coverage forms are attached below.

Attachments:

A57525.pdf

A57525LB.pdf

Satisfied -Name: Filing Fee Certification **Review Status:** Approved-Closed 02/10/2009

Comments:

Filing fee certification is attached below.

SERFF Tracking Number: AFLA-125900873 *State:* Arkansas
Filing Company: American Family Life Assurance Company of Columbus *State Tracking Number:* 41904
Company Tracking Number: A57500
TOI: H111 Individual Health - Disability Income *Sub-TOI:* H111.004 Other
Product Name: Short Term Disability
Project Name/Number: Short Term Disability/

Per Rosalind Minor ok to submit with note regarding filing fees.

Please note there are not any fees submitted via EFT with this filing as fees were overpaid in the amount of \$430.00 on

SERFF Tr Num: AFLA-125856287

State Tr Num: 40777 (H071 Individual Health - Specified Disease - Limited Benefit).

Attachment:

57500 FEECERT.pdf



Deborah T. Grantham
AIRC, HIA, ACS
Second Vice President
Compliance Department

January 28, 2009

Mr. Joe Musgrove
Arkansas Insurance Department
1200 West Third Street
Little Rock, AR 72201-1904

NAIC# 60380

RE: Short-Term Disability Policy Form A57500AR, Disability Benefit for On-the-Job Injury Rider Form A57550, Additional Units of Disability Rider Form A57551, Payroll Application Form A575PAPP, Union Application Form A575UAPP, Underwriting Application Auwall, Signature Forms AassignAR and AassignAR, Outline of Coverage Form A57525, and Application for Reinstatement Form A57503AR.

Limited Benefit Short-Term Disability Policy Form A57500LBAR and Outline of Coverage Form A57525LB.

Dear Mr. Musgrove:

Referenced forms are submitted for your review and approval. Nebraska, our state of domicile, has approved similar versions of the A57500 series on September 29, 2008. Limited Benefit Short-Term Disability Policy Series A57500LB was not filed in Nebraska as same was not required by the state.

Short-Term Disability Policy Form A57500AR pays disability benefits when the insured is disabled due to a covered sickness or covered off-the-job injury. The policy will pay for total or partial disability. We have included a new benefit titled Transitional Benefit. This benefit will pay the insured who doesn't work full-time at time of disability due to their covered sickness or off-the-job injury. There are five occupational classes.

Short-Term Disability Policy Form A57500LBAR pays disability benefits when the insured is disabled due to a covered sickness or covered off-the-job injury and only provides for a three month benefit period option. The policy will pay for total or partial disability. We have included a new benefit titled Transitional Benefit. This benefit will pay the insured who doesn't work full-time at time of disability due to their covered sickness or off-the-job injury. There are four occupational classes

The policies are available in unit values with the applicant having the option of choosing the unit amounts best suited for their individual needs. The policies will be marketed through payroll deduction and on a union basis to applicants age 18 through 64.

Our payroll deduction billing is for the individual market only and does not imply that this is a true group. All policies sold are sold on an individual basis and each insured is issued an individual policy.

Disability Benefit for On-the-Job Injury Rider Form A57550 pays benefits for disabilities occurring On-the-Job only.

Additional Units of Disability Benefit Rider Form A57551 pays additional amounts of benefits for Sickness or On-the-Job Injury. The additional amounts will reflect the same elimination and benefit periods as those for the policy.

Payroll Application Form A575PAPP will be used to make application for the policies and the optional rider forms on a payroll deduction basis.

Union Application Form A575UAPP will be used to make application for the policies and the optional rider forms on a union basis.

Brackets are included around the "Check Coverage Desired" section in Application Forms A575PAPP and A575UAPP to allow us to change the coverage offered if needed. For example, if one of our accounts requests a specific "coverage package" we would be able to adjust the coverage desired section to accommodate their requests.

Forms A575PAPP and A575UAPP, Auwall, and AsigncAR or AsignAR will be used in conjunction with each other to apply for the policies. Forms A575PAPP and A575UAPP will be used to collect the personal information and select the type of coverage desired. Form Auwall will be used to answer the underwriting questions. Since this form will be used with multiple products, additional underwriting may be added as Aflac develops new products. When the application prints and is attached to the policy at the time of issue, only the underwriting questions for the desired coverage will print. We will not change any of the underwriting questions without refiling the form. Form AsigncAR or AsignAR will be used to collect the applicant's and agent's signature. These forms differ in that Form AsigncAR contains an agent's certification statement. Form AsignAR does NOT contain the agent's certification statement and will be used in situations where the associate/agent is unable to be present at the time of application.

Reinstatement Application Form A57503AR will be used to apply for reinstatement of policies that have lapsed for non-payment of premium.

Replacement Notice Form A-57015, previously approved with Policy Form A-57000-AR on August 2, 1994, will be used with Policy Form A57500AR and Policy Form A57500LBAR. This form will be completed in duplicate if the applicant intends to replace existing insurance with our policy. The duplicate will be left with the applicant and the original returned to us with the application.

Outline of Coverage Forms A57525 or A57525LB will be given to the applicant at the time of application and are self-explanatory. Outline of Coverage Form A57525 will be used with Policy Form A57500AR and Outline of Coverage Form A57525LB will be used with Policy Form A57500LBAR.

I certify that the forms submitted herewith meet the applicable provisions of Rule and Regulation 18 of the Arkansas Insurance Department Regulations as well as meeting the applicable requirements of Arkansas Insurance Department.

I certify the following form complies with the requirements of Rule and Regulation 49 of the Arkansas Insurance Department Regulations, Life and Disability Guaranty Fund Notices.

I certify the following forms comply with the requirements of Arkansas Statute Annotated Sections 23-80-201 through 23-80-208, cited as the Life and Disability Insurance Policy Language Simplification Act.

I certify that the enclosed forms meet the minimum reading ease score for the FLESCH test. I further certify the scores for each form are as follows:

	<u>FLESCH Score</u>	<u>Grade Level</u>
Short Term Disability Policy Form A57500AR	50.044	10
Limited Benefit Short-Term Disability Policy Form A57500LBAR	50.044	10
On-the-Job Disability Benefit Rider Form A57550	87.725	3
Additional Units Disability Benefit Rider Form A57551	84.766	4
Payroll Application Form A575PAPP	103.815	1
Signature Form AsignAR	66.891	7
Signature Form AsigncAR	74.25	4
Union Application Form A575UAPP	61.768	7
Reinstatement Application Form A57503AR	72.013	5
Underwriting Application Form Auwall	85.648	2
Outline of Coverage Form A57525	50.495	10
Outline of Coverage Form A57525LB	53.853	10

An actuarial memorandum and rate sheets are enclosed for your review and approval. The appropriate filing fee and/or certification form are also included.

Aflac reserves the right to alter the format of the forms without refiling due to future technology changes, i.e. paper size, font, font type, line ending or page ending changes. Be assured that any minimum font-size requirements will be met. Any changes to wording or content would be filed for prior approval. We have included brackets in all forms around the address, telephone number, web site, and officer signatures in the event these change in the future. We also reserve the right to use these forms in an electronic format, but Aflac certifies we will retain the filed final print format.

This filing has been prepared by Connie Gates. Should you have any questions or comments concerning this submission, please do not hesitate to call her collect at (706) 596-5048, by fax at (706) 660-7080 or email at cgates@aflac.com.

Sincerely,



Deborah T. Grantham
DTG/CG/cg
Enclosures

CHECK COVERAGE DESIRED: [Class: A B C E

Benefit Periods:	<input type="checkbox"/> 3 Months <input type="checkbox"/> 12 Months <input type="checkbox"/> 24 Months (maximum of 30 units) <input type="checkbox"/> 6 Months <input type="checkbox"/> 18 Months (maximum of 30 units)
Elimination Periods: Injury/Sickness	<input type="checkbox"/> 0/7 Days <input type="checkbox"/> 0/14 Days <input type="checkbox"/> 7/14 Days <input type="checkbox"/> 14/14 Days <input type="checkbox"/> 0/30 Days* <input type="checkbox"/> 30/30 Days* (*not available with 3-month Benefit Period) <input type="checkbox"/> 60/60 Days** <input type="checkbox"/> 90/90 Days** <input type="checkbox"/> 180/180 Days** (**not available with 3- or 6-month Benefit Period)

	No. of Units Purchased for this Application	Premium	<input type="checkbox"/> Pre-Tax or <input type="checkbox"/> After-Tax
<input type="checkbox"/> Base Policy Series A57500			
<input type="checkbox"/> On-the-Job Injury Rider Series A57550			
<input type="checkbox"/> Additional Units of Disability Benefit Rider Series A57551 (applies to base policy only) Current Units: _____ (includes any additional units previously purchased) (must match policy elimination and benefit periods)			
NOTE: Each unit is equal to a \$100 monthly benefit.	Total Premium]		

TO BE COMPLETED BY PROPOSED INSURED/EMPLOYEE

- Do you work fewer than [19] hours per week in your primary job at which you work for pay or benefits and which is considered full time employment by your employer listed on the first page of this application? Yes No
- Do you have disability coverage that you purchased that will remain in force, which combined with this applied for coverage, will exceed 70 percent of your gross monthly income? Yes No
- If your Industry Class is E, have you been employed for less than 12 months with the employer listed on the front page of this application? Yes No N/A
- I certify that my gross annual income (without overtime, unless contractual; bonuses; or other incentives) for my full-time job is \$_____. If you are self-employed, your gross annual income is your net earnings. I understand that this information will be verified at the time of claim. **Annual income must be [\$15,000] or greater for coverage to be issued.**

If you answered Yes to any Question 1–3, a policy will not be issued; therefore, do not submit this application.

- Do you have any of Aflac's accident policies with disability benefits? Yes No
If yes, please complete the Supplemental Notification section at the end of this application and be aware that you cannot have this policy without canceling those disability benefits with Aflac.

APPLICANT'S STATEMENTS AND AGREEMENTS

- I understand that the Effective Date of the policy will be the date recorded in the Policy Schedule by Aflac Worldwide Headquarters. It is not the date this application was signed by me.
- I understand that coverage is not provided for an illness, disease, infection, disorder, or injury for which, within the 12-month period before the Effective Date of coverage, medical advice, consultation, or treatment was recommended or received, or for which symptoms existed that would ordinarily cause a prudent person to seek diagnosis, care, or treatment. Disability caused by a Pre-existing Condition or reinjuries to a Pre-existing Condition will not be covered unless it begins more than 12 months after the Effective Date of coverage.
- I acknowledge receipt of, if applicable:

<input type="checkbox"/> Replacement Notice	<input type="checkbox"/> <i>Guide to Health Insurance for People With Medicare</i>
<input type="checkbox"/> Outline of Coverage	<input type="checkbox"/> Fair Credit Reporting Notice

- I understand that (1) the policy of insurance I am now applying for will be issued based upon the written answers to the questions and information asked for in this application and any other pertinent information Aflac may require for proper underwriting; (2) the policy, together with this application, endorsements, benefit agreements, riders, and attached papers, if any, constitutes the entire contract of insurance; and (3) no change to the policy will be valid until approved by Aflac's president and secretary, and noted in or attached to the policy.
- I understand that (1) Aflac is not bound by any statement made by me, or any associate/agent of Aflac, unless written herein and (2) the associate/agent cannot change the provisions of the policy or waive any of its provisions either orally or in writing.
- I understand that the premium amount listed on this application represents the premium amount that my employer will remit to Aflac on my behalf. I further understand that this amount, because of my employer's billing/payroll practices, may differ from the amount being deducted from my paycheck or the premium amount quoted to me on an online enrollment system, if applicable.
- If I am applying to replace existing Aflac coverage with this policy, I acknowledge that the policies may have different benefits and that I should make a comparison to personally determine which is best for me. I understand and agree that I am terminating my current Aflac policy and its benefits for the benefits provided in this Aflac policy.
- I have reviewed the statements and answers I have provided on this application. I understand that this policy is to be issued based upon these statements and answers, and any other pertinent information Aflac may require for proper underwriting. The answers are complete and true. I understand that all statements made in this application are deemed representations and not warranties but that material misrepresentations herein may result in loss of coverage under this policy. I further understand that I am signing this application one time even though I may have used it to apply for more than one policy.

SUPPLEMENTAL NOTIFICATION

COMPLETE IF YOU ARE REPLACING/TERMINATING EXISTING AFLAC DISABILITY COVERAGE.

I, _____, am applying for Aflac's short-term disability policy. I currently have disability benefits under Aflac accident/disability Policy Number _____. I understand that I must cancel existing Aflac disability coverage to purchase this short-term disability policy.

- Please cancel the disability riders attached to my accident policy, but keep my accident policy in force.
- I wish to retain my spouse disability rider. I may retain the spouse disability rider **ONLY** if the accident policy remains in force.
- Please cancel my entire accident policy (with Disability Benefits) number _____. I understand that I will be terminating benefits provided for in my current accident policy that are not provided for in the new short-term disability policy.

NOTICE OF INFORMATION PRACTICES

To issue an insurance policy, Aflac may need to obtain additional information about you and any other persons proposed for insurance. Some information will come from you and some may come from other sources. That information and any other subsequent information collected by Aflac may in some circumstances be disclosed to third parties without your specific consent. You have the right to access and correct the information collected about you, except information that relates to a claim or to a civil or criminal proceeding. If you wish to have a more detailed explanation of our information practices, please submit a written request to our worldwide headquarters. This notice applies only in Arizona, California, Connecticut, Georgia, Illinois, Maine, Massachusetts, Minnesota, Nevada, New Jersey, North Carolina, Ohio, Oregon, and Virginia.

INFORMATION REGARDING THE MEDICAL INFORMATION BUREAU (MIB)

PRENOTICE

Information regarding your insurability will be treated as confidential. Aflac may, however, make a brief report thereon to MIB, Inc., formerly known as the Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file. Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB toll-free at [1-866-692-6901 (TTY 1-866-346-3642)]. If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is [50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734].

Aflac may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its web site at www.mib.com.

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

I authorize the following to give information (as defined below) to American Family Life Assurance Company of Columbus (Aflac) or any person or entity acting on its part: any medical professional, medical care institution, insurer (including Aflac, with respect to other Aflac coverages), reinsurer, government agency (including departments of public safety and motor vehicle departments), MIB, Inc., formerly known as the Medical Information Bureau, consumer reporting agency, or employer.

“Information” means facts or opinions relating to my past, present, or future physical or mental health or condition (excluding psychotherapy notes), employment, other insurance coverage, driving record, or any other medical or nonmedical facts that Aflac deems appropriate to determine eligibility for insurance or to evaluate a claim for benefits during the time this authorization is valid. I also authorize Aflac to give information to MIB, Inc.

I understand that any disclosure of health information to Aflac for the purpose of determining eligibility for coverage other than health plan coverage means the information may no longer be protected by federal privacy regulations. I further understand, however, that such information may be redisclosed only in accordance with other applicable laws or regulations.

I understand that this information will be used by Aflac for enrollment or to determine eligibility for insurance or for underwriting or risk rating (where applicable) purposes and, should coverage be issued, the information may be used to contest a claim for benefits or the issuance of the policy itself during the contestability period provided in the policy.

I understand that Aflac is conditioning the issuance of coverage on the provision of this authorization, and that, while I may refuse to sign this authorization, my refusal to do so could result in coverage not being issued.

I understand that I may revoke this authorization at any time, except to the extent that (1) Aflac has taken action in reliance on this authorization or (2) other law provides Aflac with the right to contest a claim under the policy or the policy itself. My revocation must be submitted in writing to Aflac, [Attn: Policy Service, 1932 Wynnton Road, Columbus, GA 31999].

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

I agree that a copy of this authorization is as valid as the original.

CHECK COVERAGE DESIRED: Class: A B C E

Benefit Periods:	<input type="checkbox"/> 3 Months	<input type="checkbox"/> 6 Months	<input type="checkbox"/> 12 Months	<input type="checkbox"/> 18 Months	<input type="checkbox"/> 24 Months
Elimination Periods: Injury/Sickness	<input type="checkbox"/> 0/7 Days	<input type="checkbox"/> 0/14 Days	<input type="checkbox"/> 7/14 Days	<input type="checkbox"/> 14/14 Days	
	<input type="checkbox"/> 0/30 Days*	<input type="checkbox"/> 30/30 Days* (*not available with 3-month Benefit Period)			
	<input type="checkbox"/> 60/60 Days**	<input type="checkbox"/> 90/90 Days**	<input type="checkbox"/> 180/180 Days** (**not available with 3- or 6-month Benefit Period)		

	No. of Units Purchased for this Application	Premium	
<input type="checkbox"/> Base Policy Series A57500			<input checked="" type="checkbox"/> After-Tax Only
<input type="checkbox"/> On-the-Job Injury Rider Series A57550			
<input type="checkbox"/> Additional Units of Disability Benefit Rider Series A57551 (applies to base policy only)			
Current Units: _____ (includes any additional units previously purchased) (must match policy elimination and benefit periods)			
NOTE: Each unit is equal to a \$100 monthly benefit.	Total Premium]		

TO BE COMPLETED BY PROPOSED INSURED

- Do you work fewer than [19] hours per week in your primary job at which you work for pay or benefits and which is considered full time employment by your employer listed on the first page of this application? Yes No
- Do you have disability coverage that will remain in force, which combined with this applied for coverage, will exceed 55 percent of your gross monthly income? Yes No
- If your Industry Class is E, have you been employed for less than 12 months with the employer listed on the front page of this application? Yes No N/A
- I certify that my gross annual income (without overtime, unless contractual; bonuses; or other incentives) for my full-time job is \$ _____. If you are self-employed, your gross annual income is your net earnings. I understand that this information will be verified at the time of claim. **Annual income must be [\$15,000] or greater for coverage to be issued.**

If you answered Yes to any Question 1–3, a policy will not be issued; therefore, do not submit this application.

- Do you have any of Aflac's accident policies with disability benefits? Yes No
If yes, please complete the Supplemental Notification section at the end of this application and be aware that you cannot have this policy without canceling those disability benefits with Aflac.

APPLICANT'S STATEMENTS AND AGREEMENTS

- I understand that the Effective Date of the policy will be the date recorded in the Policy Schedule by Aflac Worldwide Headquarters. It is not the date this application was signed by me.
- I understand that coverage is not provided for an illness, disease, infection, disorder, or injury for which, within the 12-month period before the Effective Date of coverage, medical advice, consultation, or treatment was recommended or received, or for which symptoms existed that would ordinarily cause a prudent person to seek diagnosis, care, or treatment. Disability caused by a Pre-existing Condition or reinjuries to a Pre-existing Condition will not be covered unless it begins more than 12 months after the Effective Date of coverage.
- I acknowledge receipt of, if applicable:
 - Replacement Notice *Guide to Health Insurance for People With Medicare*
 - Outline of Coverage Fair Credit Reporting Notice
- I understand that (1) the policy of insurance I am now applying for will be issued based upon the written answers to the questions and information asked for in this application and any other pertinent information Aflac may require for

proper underwriting; (2) the policy, together with this application, endorsements, benefit agreements, riders, and attached papers, if any, constitutes the entire contract of insurance; and (3) no change to the policy will be valid until approved by Aflac's president and secretary, and noted in or attached to the policy.

- I understand that (1) Aflac is not bound by any statement made by me, or any associate/agent of Aflac, unless written herein and (2) the associate/agent cannot change the provisions of the policy or waive any of its provisions either orally or in writing.
- I understand that the premium amount listed on this application represents the premium amount that my employer will remit to Aflac on my behalf. I further understand that this amount, because of my employer's billing/payroll practices, may differ from the amount being deducted from my paycheck or the premium amount quoted to me on an online enrollment system, if applicable.
- If I am applying to replace existing Aflac coverage with this policy, I acknowledge that the policies may have different benefits and that I should make a comparison to personally determine which is best for me. I understand and agree that I am terminating my current Aflac policy and its benefits for the benefits provided in this Aflac policy.
- I have reviewed the statements and answers I have provided on this application. I understand that this policy is to be issued based upon these statements and answers, and any other pertinent information Aflac may require for proper underwriting. The answers are complete and true. I understand that all statements made in this application are deemed representations and not warranties but that material misrepresentations herein may result in loss of coverage under this policy. I further understand that I am signing this application one time even though I may have used it to apply for more than one policy.

SUPPLEMENTAL NOTIFICATION

COMPLETE IF YOU ARE REPLACING/TERMINATING EXISTING AFLAC DISABILITY COVERAGE.

I, _____, am applying for Aflac's short-term disability policy. I currently have disability benefits under Aflac accident/disability Policy Number _____. I understand that I must cancel existing Aflac disability coverage to purchase this short-term disability policy.

- Please cancel the disability riders attached to my accident policy, but keep my accident policy in force.
- I wish to retain my spouse disability rider. I may retain the spouse disability rider **ONLY** if the accident policy remains in force.
- Please cancel my entire accident policy (with Disability Benefits) number _____. I understand that I will be terminating benefits provided for in my current accident policy that are not provided for in the new short-term disability policy.

NOTICE OF INFORMATION PRACTICES

To issue an insurance policy, Aflac may need to obtain additional information about you and any other persons proposed for insurance. Some information will come from you and some may come from other sources. That information and any other subsequent information collected by Aflac may in some circumstances be disclosed to third parties without your specific consent. You have the right to access and correct the information collected about you, except information that relates to a claim or to a civil or criminal proceeding. If you wish to have a more detailed explanation of our information practices, please submit a written request to our worldwide headquarters. This notice applies only in Arizona, California, Connecticut, Georgia, Illinois, Maine, Massachusetts, Minnesota, Nevada, New Jersey, North Carolina, Ohio, Oregon, and Virginia.

INFORMATION REGARDING THE MEDICAL INFORMATION BUREAU (MIB) PRENOTICE

Information regarding your insurability will be treated as confidential. Aflac may, however, make a brief report thereon to MIB, Inc., formerly known as the Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file. Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB toll-free at [1-866-692-6901 (TTY 1-866-346-3642)]. If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is [50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734].

Aflac may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its web site at www.mib.com.

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

I authorize the following to give information (as defined below) to American Family Life Assurance Company of Columbus (Aflac) or any person or entity acting on its part: any medical professional, medical care institution, insurer (including Aflac, with respect to other Aflac coverages), reinsurer, government agency (including departments of public safety and motor vehicle departments), MIB, Inc., formerly known as the Medical Information Bureau, consumer reporting agency, or employer.

"Information" means facts or opinions relating to my past, present, or future physical or mental health or condition (excluding psychotherapy notes), employment, other insurance coverage, driving record, or any other medical or nonmedical facts that Aflac deems appropriate to determine eligibility for insurance or to evaluate a claim for benefits during the time this authorization is valid. I also authorize Aflac to give information to MIB, Inc.

I understand that any disclosure of health information to Aflac for the purpose of determining eligibility for coverage other than health plan coverage means the information may no longer be protected by federal privacy regulations. I further understand, however, that such information may be redisclosed only in accordance with other applicable laws or regulations.

I understand that this information will be used by Aflac for enrollment or to determine eligibility for insurance or for underwriting or risk rating (where applicable) purposes and, should coverage be issued, the information may be used to contest a claim for benefits or the issuance of the policy itself during the contestability period provided in the policy.

I understand that Aflac is conditioning the issuance of coverage on the provision of this authorization, and that, while I may refuse to sign this authorization, my refusal to do so could result in coverage not being issued.

I understand that I may revoke this authorization at any time, except to the extent that (1) Aflac has taken action in reliance on this authorization or (2) other law provides Aflac with the right to contest a claim under the policy or the policy itself. My revocation must be submitted in writing to Aflac, [Attn: Policy Service, 1932 Wynnton Road, Columbus, GA 31999].

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

I agree that a copy of this authorization is as valid as the original.

APPLICATION FOR REINSTATEMENT
SHORT-TERM DISABILITY INSURANCE FOR A57500 SERIES
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 _____		SSN _____	
Policy Number _____	Date of Birth _____		
Current Address of Policyholder _____			
City _____	State _____	ZIP _____	Telephone No. _____
Former Address of Policyholder _____			
City _____	State _____	ZIP _____	
Name of Employer _____			

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

PLEASE MAKE THE FOLLOWING CHANGES TO MY POLICY:

<input type="checkbox"/> OCCUPATION CLASS CHANGE ONLY - Please note that all occupation class changes are subject to review and approval.
[Class: <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> E]
Type of Business _____
Job Duties _____
Job Title _____

TO BE COMPLETED IF APPLYING FOR REINSTATEMENT OR AN OCCUPATION CLASS CHANGE ON PAYROLL SALES ONLY.

1. Do you work fewer than [19] hours per week in your primary job at which you work for pay or benefits and which is considered full time employment by your employer listed on the first page of this application? Yes No

2. Do you have disability coverage that you purchased that will remain in force, which combined with this applied for coverage, will exceed 70 percent of your gross monthly income? Yes No

3. If your Industry Class is E, have you been employed for less than 12 months with the employer listed on the front page of this application? Yes No
 N/A

4. I certify that my gross annual income (without overtime, unless contractual; bonuses; or other incentives) for my full-time job is \$_____. If you are self-employed, your gross annual income is your net earnings. I understand that this information will be verified at the time of claim. **Annual income must be [\$15,000] or greater for coverage to be issued.**

If you answered Yes to any Question 1–3, a policy will not be reinstated. If applying for an occupation class change and you answered Yes to any Question 1-3, an occupation class change will not be allowed.

**TO BE COMPLETED IF APPLYING FOR REINSTATEMENT
OR AN OCCUPATION CLASS CHANGE ON UNION SALES ONLY.**

1. Do you work fewer than [19] hours per week in your primary job at which you work for pay or benefits and which is considered full time employment by your employer listed on the first page of this application? Yes No
2. Do you have disability coverage that will remain in force, which combined with this applied for coverage, will exceed 55 percent of your gross monthly income? Yes No
3. If your Industry Class is E, have you been employed for less than 12 months with the employer listed on the front page of this application? Yes No
 N/A
4. I certify that my gross annual income (without overtime, unless contractual; bonuses; or other incentives) for my full-time job is \$_____. If you are self-employed, your gross annual income is your net earnings. I understand that this information will be verified at the time of claim. **Annual income must be [\$15,000] or greater for coverage to be issued.**

If you answered Yes to any Question 1–3, a policy will not be reinstated. If applying for an occupation class change and you answered Yes to any Question 1-3, an occupation class change will not be allowed.

**TO BE COMPLETED IF APPLYING FOR REINSTATEMENT
OR AN OCCUPATION CLASS CHANGE ON PAYROLL OR UNION SALES.**

1. Do you have any of Aflac's accident policies with disability benefits? Yes No
If yes, please complete the Supplemental Notification section at the end of this application and be aware that you cannot have this policy without canceling those disability benefits with Aflac.

**PLEASE COMPLETE THE FOLLOWING QUESTIONS FOR
REINSTATEMENT OF THE SHORT-TERM DISABILITY POLICY.**

**THIS POLICY PROVIDES INDIVIDUAL COVERAGE ON THE POLICYHOLDER ONLY;
THEREFORE, THE FOLLOWING QUESTIONS ONLY APPLY TO THE POLICYHOLDER.**

1. Is anyone to be covered currently disabled due to sickness or injury, or has anyone to be covered been out of work or disabled due to sickness or injury more than 5 consecutive days within the last 12 months (excluding routine childbirth)? Yes No
2. Has anyone to be covered been hospitalized more than 24 hours within the last 12 months for reasons other than routine childbirth? Yes No
3. Does anyone to be covered have any condition for which any medical procedure (including but not limited to surgery, child delivery, organ or bone marrow transplant) has been planned or the possibility of which has been discussed with medical personnel? Yes No
4. Has anyone to be covered been to see a member of the medical profession about a medical condition that has yet to be diagnosed? Yes No

5. Has anyone to be covered, within the last five years: been convicted of a felony; been charged two or more times with operating a vehicle while under the influence of alcohol or drugs; been charged three or more times with a moving violation; or is currently on parole or incarcerated in a correctional institution? Yes No

6. Does anyone to be covered currently have or in the last 12 months, has anyone to be covered been diagnosed with or treated for any of the following conditions or had any of the following procedures: Yes No

- | | |
|------------------------|---|
| AIDS | regional enteritis |
| HIV-positive diagnosis | ulcerative colitis |
| Systemic lupus | ulcerative proctitis |
| muscular dystrophy | vascular insufficiency (circulatory problems) |
| Parkinson's Disease | diabetes (Type II) diagnosed prior to age 30 |
| cystic fibrosis | any sort of back, neck, or joint disorder |
| pulmonary hypertension | carpal tunnel syndrome |
| renal hypertension | psoriatic arthritis |
| Crohn's disease | rheumatoid arthritis |
| Ileitis | sciatica |

7. Within the last 5 years, has anyone to be covered been diagnosed with or treated for any of the following conditions or had any of the following procedures: Yes No

- | | |
|---|---|
| heart attack | diabetes treated with insulin |
| cardiomyopathy | diabetes with complications to include nephropathy; |
| bypass/stents/angioplasty | neuropathy; or retinopathy |
| atrial fibrillation | kidney disease or disorder (not including stones) |
| implant of pacemaker/defibrillator | liver disease or disorder (excluding Hepatitis A) |
| heart surgery (including valve replacement or correction) | fibromyalgia |
| congestive heart failure | chronic fatigue syndrome |
| stroke/TIA | sarcoidosis |
| chronic obstructive pulmonary disease (COPD) | multiple sclerosis |
| emphysema | alcohol or drug abuse |
| pulmonary fibrosis | internal cancer (to include myelodysplastic blood disorder and myeloproliferative blood disorder) |
| diabetes and used tobacco after diagnosis | melanoma (Clark's Level III or higher, or a Breslow Level greater than 1.5 mm) |

If you answered Yes to any question 1 - 7, you are not eligible for any disability coverage; therefore, do not submit this application.

PLEASE COMPLETE THE FOLLOWING QUESTIONS FOR REINSTATEMENT OF MORE THAN 20 UNITS OF COVERAGE OR A BENEFIT PERIOD GREATER THAN 12 MONTHS.
Additional underwriting may be required.

8. During the last 6 months, have you received any medical treatment, including injections, or been prescribed or taken medications (other than prescription contraceptives)? Yes No
 If yes, please provide descriptive information below.

Medical Conditions/Treatments	Onset (mo/yr)	Surgery Performed? (If yes, provide the type of procedure and date)	Date Last Treated	Released by Physician	For Hypertension and Diabetes, List the Average Reading (for the last three months)
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	

				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	

Medication Name	Dosage	Date First Prescribed	Medical Condition

9. Has anyone to be covered used tobacco products or products containing nicotine of any type in the last 12 months? Yes No
10. a. Do you have any individual disability income coverage in force? Yes No
b. Do you have any group disability income coverage in force? Yes No
- If yes to 10a or 10b, please list your monthly benefit amounts/percentages: _____, your benefit period: _____, and your Elimination Period: _____.

PLEASE COMPLETE THE FOLLOWING QUESTION FOR REINSTATEMENT OF THE ON-THE-JOB INJURY RIDER.

11. Are you covered by worker's compensation or a similar law in your full-time job? Yes No
Similar laws include but are not limited to the following:
Railroad Retirement Act
Jones Act
Maritime Doctrine of Maintenance
Wages or Cure
Longshoremen's and Harbor Worker's Acts

If you answered Yes, you are not eligible for On-the-Job Injury Rider coverage; and therefore, this rider will not be reinstated.

SUPPLEMENTAL NOTIFICATION

COMPLETE IF YOU ARE REPLACING/TERMINATING EXISTING AFLAC DISABILITY COVERAGE.

I, _____, am applying for Aflac's short-term disability policy. I currently have disability benefits under Aflac accident/disability Policy Number _____. I understand that I must cancel existing Aflac disability coverage to purchase this short-term disability policy.

Please cancel the disability riders attached to my accident policy, but keep my accident policy in force.

I wish to retain my spouse disability rider. I may retain the spouse disability rider **ONLY** if the accident policy remains in force.

Please cancel my entire accident policy (with Disability Benefits) number _____. I understand that I will be terminating benefits provided for in my current accident policy that are not provided for in the new short-term disability policy.

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

I authorize the following to give information (as defined below) to American Family Life Assurance Company of Columbus (Aflac) or any person or entity acting on its part: any medical professional, medical care institution, insurer (including Aflac, with respect to other Aflac coverages), reinsurer, government agency (including departments of public safety and motor vehicle departments), MIB, Inc., formerly known as the Medical Information Bureau, consumer reporting agency, or employer.

"Information" means facts or opinions relating to my past, present, or future physical or mental health or condition (excluding psychotherapy notes), employment, other insurance coverage, driving record, or any other medical or nonmedical facts that Aflac deems appropriate to determine eligibility for insurance or to evaluate a claim for benefits during the time this authorization is valid. I also authorize Aflac to give information to MIB, Inc.

I understand that any disclosure of health information to Aflac for the purpose of determining eligibility for coverage other than health plan coverage means the information may no longer be protected by federal privacy regulations. I further understand, however, that such information may be redisclosed only in accordance with other applicable laws or regulations.

I understand that this information will be used by Aflac for enrollment or to determine eligibility for insurance or for underwriting or risk rating (where applicable) purposes and, should coverage be issued, the information may be used to contest a claim for benefits or the issuance of the policy itself during the contestability period provided in the policy.

I understand that Aflac is conditioning the issuance of coverage on the provision of this authorization, and that, while I may refuse to sign this authorization, my refusal to do so could result in coverage not being issued.

I understand that I may revoke this authorization at any time, except to the extent that (1) Aflac has taken action in reliance on this authorization or (2) other law provides Aflac with the right to contest a claim under the policy or the policy itself. My revocation must be submitted in writing to Aflac, [Attn: Policy Service, 1932 Wynnton Road, Columbus, GA 31999].

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

I agree that a copy of this authorization is as valid as the original.

I, the undersigned Policyholder, agree that by signing below I am submitting an application to Aflac for the reinstatement of my policy. The reinstated policy will cover only loss resulting from a condition that begins on or after the date of reinstatement.

I have read, or had read to me, the completed application, and I realize policy reinstatement is based upon statements and answers provided herein, and they are complete and true. I understand, for the purposes of the Time Limit on Certain Defenses provision of the policy, that the Effective Date of the policy shall now be the reinstatement date. I also understand that Aflac and I will have the same rights as provided under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed on or attached to the policy in connection with the reinstatement. I further understand that coverage under the reinstated policy is subject to the terms set forth in my policy Reinstatement Provision.

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.

Signature (X) _____

Signed and Dated at _____ on _____
City and State Date

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

MAKE CHECK OR MONEY ORDER PAYABLE TO AFLAC.
[FOR INFORMATION, CALL TOLL-FREE 1-800-99-AFLAC (1-800-992-3522).
VISIT OUR WEB SITE AT AFLAC.COM.]

American Family Life Assurance Company of Columbus (Aflac)
[Worldwide Headquarters, 1932 Wynnton Road
Columbus, Georgia 31999
TOLL-FREE 1-800-99-AFLAC (1-800-992-3522)]

SHORT-TERM DISABILITY COVERAGE
Outline of Coverage for Policy Series A57500

THIS IS NOT A MEDICARE SUPPLEMENT POLICY.

If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from Aflac.

- 1. Read Your Policy Carefully.** This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and Aflac. It is, therefore, important that you **READ YOUR POLICY CAREFULLY!**
- 2. Short-Term Disability Coverage** is designed to provide, to persons insured, coverage for disabilities resulting from a covered accident or sickness, subject to any limitations set forth in the policy. Coverage is not provided for basic hospital, basic medical-surgical or major medical expenses.
- 3. Benefits.** The following benefits are a part of the policy.

Aflac will pay the following benefits, as applicable, if your Disability is caused by a covered Sickness or covered Off-the-Job Injury and occurs while this coverage is in force. All benefits are subject to the Limitations and Exclusions, Pre-existing Condition Limitations, and other policy terms.

Disability due to pregnancy and childbirth is payable to the same extent as a covered Sickness. Disability benefits for childbirth will only be payable after this policy has been in force ten months. The maximum Benefit Period allowed for childbirth is six weeks for noncesarean delivery and eight weeks for cesarean delivery, less the Elimination Period, unless you furnish proof that your Disability continues beyond these time frames.

Benefits will be paid for only one Disability at a time even if the Disability is caused by more than one Sickness, more than one Injury, or a Sickness and an Injury. **We reserve the right to meet with you during the pendency of a claim or to use an independent consultant and Physician's statement to determine whether you are qualified to receive Disability benefits. You must be under the care and attendance of a Physician for these benefits to be payable. Benefits will cease on the date of your death.**

- A. TOTAL DISABILITY BENEFIT:** If you have a Full-Time Job at the time of your Sickness or Off-the-Job Injury, we will insure you as follows while coverage is in force:

If your covered Sickness or covered Off-the-Job Injury causes your Total Disability within 90 days of your last treatment for your covered Sickness or covered Off-the-Job Injury, we will pay you the Daily Disability Benefit for each day of your Disability or your Successive Periods of Disability. This benefit is payable up to the Benefit Period you selected and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled "Term", and the definitions of "Benefit Period" and "Successive Periods of Disability."

You will no longer be qualified to receive this benefit upon the earlier of your: (1) being released by your Physician to perform the material and substantial duties of your Full-Time Job or (2) working at any job.

B. PARTIAL DISABILITY BENEFIT: If you have a Full-Time Job at the time of your Sickness or Off-the-Job Injury, we will insure you as follows while coverage is in force:

If your covered Sickness or covered Off-the-Job Injury causes your Partial Disability within 90 days of your last treatment for your covered Sickness or covered Off-the-Job Injury, we will pay you the Daily Disability Benefit for each day of your Disability or your Successive Periods of Disability. This benefit is payable up to the Benefit Period you selected and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled "Term", and the definitions of "Benefit Period" and "Successive Periods of Disability."

You will no longer be qualified to receive this benefit upon the earlier of your: (1) being released by your Physician to perform the material and substantial duties of your Full-Time Job or (2) working at any job earning 80 percent or more of your pre-Disability Base Pay Earnings.

C. TRANSITIONAL DISABILITY BENEFIT: If you do not have a Full-Time Job at the time of your Sickness or Off-the-Job Injury, we will insure you as follows while coverage is in force:

If your covered Sickness or covered Off-the-Job Injury causes your Transitional Disability within 15 days of your last treatment for your covered Sickness or covered Off-the-Job Injury, we will pay you one-half of the Daily Disability Benefit for each day you remain unable to work at any job. This benefit is payable for a maximum period of three months of Disability or Successive Periods of Disability and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled "Term", and the definition of "Successive Periods of Disability."

You will no longer be qualified to receive this benefit upon the earlier of your: (1) being released by your Physician to perform the material and substantial duties of any job or (2) working at any job. **This benefit is limited to a lifetime maximum period of a total of three months, regardless of the number of Disabilities or the duration of any Disability.**

IF YOU HAVE ANY OTHER DISABILITY BENEFIT IN FORCE WITH US, ONLY ONE DISABILITY BENEFIT IS PAYABLE.

PRE-EXISTING CONDITION LIMITATIONS: A Pre-existing Condition is an illness, disease, infection, disorder, or injury for which, within the 12-month period before the Effective Date of coverage, medical advice, consultation, or treatment was recommended or received, or for which symptoms existed that would ordinarily cause a prudent person to seek diagnosis, care, or treatment. Disability caused by a Pre-existing Condition or reinjuries to a Pre-existing Condition will not be covered unless it begins more than 12 months after the Effective Date of coverage.

4. OPTIONAL BENEFITS:

Disability Benefit for On-the-Job Injury Rider: (Series A57550) Applied For: Yes No

Aflac will pay the following benefits, as applicable, if your Disability is caused by a covered On-the-Job Injury and occurs while this coverage is in force. All benefits are subject to the Limitations and Exclusions, Pre-existing Condition Limitations, and other policy terms.

Benefits will be paid for only one Disability at a time even if the Disability is caused by more than one Injury. **We reserve the right to meet with you during the pendency of a claim or to use an**

independent consultant and Physician's statement to determine whether you are qualified to receive Disability benefits. You must be under the care and attendance of a Physician for these benefits to be payable. Benefits will cease on the date of your death.

- A. TOTAL DISABILITY BENEFIT:** If you have a Full-Time Job at the time of your On-the-Job Injury, we will insure you as follows while coverage is in force:

If your covered On-the-Job Injury causes your Total Disability within 90 days of your last treatment for your covered On-the-Job Injury, we will pay you the Daily Disability Benefit for the On-the-Job Injury Disability Rider for each day of your Disability or your Successive Periods of Disability. This benefit is payable up to the Benefit Period you selected and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled "Term", and the definitions of "Benefit Period" and "Successive Periods of Disability."

You will no longer be qualified to receive this benefit upon the earlier of your: (1) being released by your Physician to perform the material and substantial duties of your Full-Time Job or (2) working at any job.

- B. PARTIAL DISABILITY BENEFIT:** If you have a Full-Time Job at the time of your On-the-Job Injury, we will insure you as follows while coverage is in force:

If your covered On-the-Job Injury causes your Partial Disability within 90 days of your last treatment for your covered On-the-Job Injury, we will pay you the Daily Disability Benefit for the On-the-Job Injury Disability Rider for each day of your Disability or your Successive Periods of Disability. This benefit is payable up to the Benefit Period you selected and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled "Term", and the definitions of "Benefit Period" and "Successive Periods of Disability."

You will no longer be qualified to receive this benefit upon the earlier of your: (1) being released by your Physician to perform the material and substantial duties of your Full-Time Job or (2) working at any job earning 80 percent or more of your pre-Disability Base Pay Earnings.

- C. TRANSITIONAL DISABILITY BENEFIT:** If you do not have a Full-Time Job at the time of your On-the-Job Injury, we will insure you as follows while coverage is in force:

If your covered On-the-Job Injury causes your Transitional Disability within 15 days of your last treatment for your covered On-the-Job Injury, we will pay you one-half of the Daily Disability Benefit for the On-the-Job Injury Disability Rider for each day you remain unable to work at any job. This benefit is payable for a maximum period of three months of Disability or Successive Periods of Disability and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled "Term", and the definition of "Successive Periods of Disability."

You will no longer be qualified to receive this benefit upon the earlier of your: (1) being released by your Physician to perform the material and substantial duties of any job or (2) working at any job. **This benefit is limited to a lifetime maximum period of a total of three months, regardless of the number of Disabilities or the duration of any Disability.**

IF YOU HAVE ANY OTHER DISABILITY BENEFIT IN FORCE WITH US, ONLY ONE DISABILITY BENEFIT IS PAYABLE.

Additional Units of Disability Benefit Rider: (Series A57551) Applied For: Yes No

Aflac will pay the following benefits, as applicable, if your Disability is caused by a covered Sickness or covered Off-the-Job Injury and occurs while this coverage is in force. All benefits are subject to the Limitations and Exclusions, Pre-existing Condition Limitations, and other policy terms.

Disability due to pregnancy and childbirth is payable to the same extent as a covered Sickness. Disability benefits for childbirth will only be payable after this rider has been in force ten months. The maximum Benefit Period allowed for childbirth is six weeks for noncesarean delivery and eight weeks for cesarean delivery, less the Elimination Period, unless you furnish proof that your Disability continues beyond these time frames.

Benefits will be paid for only one Disability at a time even if the Disability is caused by more than one Sickness, more than one Injury, or a Sickness and an Injury. **We reserve the right to meet with you during the pendency of a claim or to use an independent consultant and Physician's statement to determine whether you are qualified to receive Disability benefits. You must be under the care and attendance of a Physician for these benefits to be payable. Benefits will cease on the date of your death.**

This benefit will be paid under the same terms as the applicable Total Disability Benefit, Partial Disability Benefit, or Transitional Disability Benefit as described in your policy. The additional units of coverage will only be payable for a Disability that begins after the Effective Date of this rider.

A. TOTAL DISABILITY BENEFIT: If you have a Full-Time Job at the time of your Sickness or Off-the-Job Injury, we will insure you as follows while coverage is in force:

If your covered Sickness or covered Off-the-Job Injury causes your Total Disability within 90 days of your last treatment for your covered Sickness or covered Off-the-Job Injury, we will pay you the Daily Disability Benefit for the Additional Units of Disability Benefit Rider for each day of your Disability or your Successive Periods of Disability. This benefit is payable up to the Benefit Period you selected and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled "Term", and the definitions of "Benefit Period" and "Successive Periods of Disability."

You will no longer be qualified to receive this benefit upon the earlier of your: (1) being released by your Physician to perform the material and substantial duties of your Full-Time Job or (2) working at any job.

B. PARTIAL DISABILITY BENEFIT: If you have a Full-Time Job at the time of your Sickness or Off-the-Job Injury, we will insure you as follows while coverage is in force:

If your covered Sickness or covered Off-the-Job Injury causes your Partial Disability within 90 days of your last treatment for your covered Sickness or covered Off-the-Job Injury, we will pay you the Daily Disability Benefit for the Additional Units of Disability Benefit Rider for each day of your Disability or your Successive Periods of Disability. This benefit is payable up to the Benefit Period you selected and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled "Term", and the definitions of "Benefit Period" and "Successive Periods of Disability."

You will no longer be qualified to receive this benefit upon the earlier of your: (1) being released by your Physician to perform the material and substantial duties of your Full-Time Job or (2) working at any job earning 80 percent or more of your pre-Disability Base Pay Earnings.

C. TRANSITIONAL DISABILITY BENEFIT: If you do not have a Full-Time Job at the time of your Sickness or Off-the-Job Injury, we will insure you as follows while coverage is in force:

If your covered Sickness or covered Off-the-Job Injury causes your Transitional Disability within 15 days of your last treatment for your covered Sickness or covered Off-the-Job Injury, we will pay you one-half of the Daily Disability Benefit for the Additional Units of Disability Benefit Rider for each day you remain unable to work at any job. This benefit is payable for a maximum period of three months of Disability or Successive Periods of Disability and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled "Term", and the definition of "Successive Periods of Disability."

You will no longer be qualified to receive this benefit upon the earlier of your: (1) being released by your Physician to perform the material and substantial duties of any job or (2) working at any job. **This benefit is limited to a lifetime maximum period of a total of three months, regardless of the number of Disabilities or the duration of any Disability.**

IMPORTANT PROVISIONS OF YOUR POLICY

LIMITATIONS AND EXCLUSIONS.

- A. Disability caused by a Pre-existing Condition or reinjuries to a Pre-existing Condition will not be covered unless it begins more than 12 months after the Effective Date of coverage.
- B. Aflac will not pay benefits for a Disability that is being treated outside the territorial limits of the United States.
- C. Aflac will not pay benefits whenever coverage provided by this policy is in violation of any U.S. economic or trade sanctions. If the coverage violates U.S. economic or trade sanctions, such coverage shall be null and void.
- D. Aflac will not pay benefits for a Disability that is caused by or occurs as a result of any bacterial, viral, or microorganism infection or infestation or any condition resulting from insect, arachnid, or other arthropod bites or stings as a Disability due to an Injury; such disability will be covered to the same extent as a Disability due to Sickness.
- E. **Aflac will not pay benefits for a disability that is caused by or occurs as a result of your:**
 - 1. Pregnancy or childbirth within the first ten months of the Effective Date of coverage. (Complications of Pregnancy will be covered to the same extent as a Sickness);
 - 2. Using any drug, narcotic, hallucinogen, or chemical substance (unless administered by a Physician and taken according to the Physician's instructions), or voluntarily taking any kind of poison or inhaling any kind of gas or fumes;
 - 3. Participating in any activity or event, including the operation of a vehicle, while under the influence of a controlled substance (unless administered by a Physician and taken according to the Physician's instructions) or while intoxicated ("intoxicated" means that condition as defined by the law of the jurisdiction in which the accident occurred);
 - 4. Participating in, or attempting to participate in, an illegal activity that is defined as a felony, whether charged or not ("felony" is as defined by the law of the jurisdiction in which the activity takes place); or being incarcerated in any type penal institution;

5. Intentionally self-inflicting a bodily injury or committing or attempting suicide, while sane or insane;
6. Having cosmetic surgery or other elective procedures that are not Medically Necessary;
7. Having dental treatment except as a result of Injury;
8. Being exposed to war or any act of war, declared or undeclared;
9. Actively serving in any of the armed forces, or units auxiliary thereto, including the National Guard or Reserve;
10. Donating an organ within the first 12 months of the Effective Date of this policy; or
11. Mental or emotional disorders, including but not limited to the following: bipolar affective disorder (manic-depressive syndrome), delusional (paranoid) disorders, psychotic disorders, somatoform disorders (psychosomatic illness), eating disorders, schizophrenia, anxiety disorders, depression, stress or post-partum depression. This policy will pay, however, for covered disabilities resulting from Alzheimer's disease, or similar forms of senility or senile dementia, first manifested while coverage is in force.

Benefits will be paid for only one Disability at a time even if the Disability is caused by more than one Sickness, more than one Injury, or a Sickness and an Injury.

Renewability. The Policy is guaranteed renewable to age 70 by payment of the premium in effect at the beginning of each renewal period. Premium rates may be changed only if changed on all policies of the same form number and class in force in your state.

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

American Family Life Assurance Company of Columbus (Aflac)
[Worldwide Headquarters, 1932 Wynnton Road
Columbus, Georgia 31999
TOLL-FREE 1-800-99-AFLAC (1-800-992-3522)]

LIMITED BENEFIT HEALTH COVERAGE

SHORT-TERM DISABILITY COVERAGE
Outline of Coverage for Policy Series A57500LB

THIS IS NOT A MEDICARE SUPPLEMENT POLICY.

If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from Aflac.

- 1. Read Your Policy Carefully.** This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and Aflac. It is, therefore, important that you **READ YOUR POLICY CAREFULLY!**
- 2. Limited Benefit Health Coverage.** Policies of this category are designed to provide, to persons insured, limited or supplemental insurance coverage, subject to any limitations, deductibles or copayment requirements set forth in the policy.
- 3. Short-Term Disability Coverage** is designed to provide, to persons insured, coverage for disabilities resulting from a covered accident or sickness, subject to any limitations set forth in the policy. Coverage is not provided for basic hospital, basic medical-surgical or major medical expenses.
- 4. Benefits.** The following benefits are a part of the policy.

Aflac will pay the following benefits, as applicable, if your Disability is caused by a covered Sickness or covered Off-the-Job Injury and occurs while this coverage is in force. All benefits are subject to the Limitations and Exclusions, Pre-existing Condition Limitations, and other policy terms.

Disability due to pregnancy and childbirth is payable to the same extent as a covered Sickness. Disability benefits for childbirth will only be payable after this policy has been in force ten months. The maximum Benefit Period allowed for childbirth is six weeks for noncesarean delivery and eight weeks for cesarean delivery, less the Elimination Period, unless you furnish proof that your Disability continues beyond these time frames.

Benefits will be paid for only one Disability at a time even if the Disability is caused by more than one Sickness, more than one Injury, or a Sickness and an Injury. **We reserve the right to meet with you during the pendency of a claim or to use an independent consultant and Physician's statement to determine whether you are qualified to receive Disability benefits. You must be under the care and attendance of a Physician for these benefits to be payable. Benefits will cease on the date of your death.**

A. TOTAL DISABILITY BENEFIT: If you have a Full-Time Job at the time of your Sickness or Off-the-Job Injury, we will insure you as follows while coverage is in force:

If your covered Sickness or covered Off-the-Job Injury causes your Total Disability within 90 days of your last treatment for your covered Sickness or covered Off-the-Job Injury, we will pay you the Daily

Disability Benefit for each day of your Disability or your Successive Periods of Disability. This benefit is payable up to the Benefit Period you selected and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled "Term", and the definitions of "Benefit Period" and "Successive Periods of Disability."

You will no longer be qualified to receive this benefit upon the earlier of your: (1) being released by your Physician to perform the material and substantial duties of your Full-Time Job or (2) working at any job.

B. PARTIAL DISABILITY BENEFIT: If you have a Full-Time Job at the time of your Sickness or Off-the-Job Injury, we will insure you as follows while coverage is in force:

If your covered Sickness or covered Off-the-Job Injury causes your Partial Disability within 90 days of your last treatment for your covered Sickness or covered Off-the-Job Injury, we will pay you the Daily Disability Benefit for each day of your Disability or your Successive Periods of Disability. This benefit is payable up to the Benefit Period you selected and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled "Term", and the definitions of "Benefit Period" and "Successive Periods of Disability."

You will no longer be qualified to receive this benefit upon the earlier of your: (1) being released by your Physician to perform the material and substantial duties of your Full-Time Job or (2) working at any job earning 80 percent or more of your pre-Disability Base Pay Earnings.

C. TRANSITIONAL DISABILITY BENEFIT: If you do not have a Full-Time Job at the time of your Sickness or Off-the-Job Injury, we will insure you as follows while coverage is in force:

If your covered Sickness or covered Off-the-Job Injury causes your Transitional Disability within 15 days of your last treatment for your covered Sickness or covered Off-the-Job Injury, we will pay you one-half of the Daily Disability Benefit for each day you remain unable to work at any job. This benefit is payable for a maximum period of three months of Disability or Successive Periods of Disability and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled "Term", and the definition of "Successive Periods of Disability."

You will no longer be qualified to receive this benefit upon the earlier of your: (1) being released by your Physician to perform the material and substantial duties of any job or (2) working at any job. **This benefit is limited to a lifetime maximum period of a total of three months, regardless of the number of Disabilities or the duration of any Disability.**

IF YOU HAVE ANY OTHER DISABILITY BENEFIT IN FORCE WITH US, ONLY ONE DISABILITY BENEFIT IS PAYABLE.

PRE-EXISTING CONDITION LIMITATIONS: A Pre-existing Condition is an illness, disease, infection, disorder, or injury for which, within the 12-month period before the Effective Date of coverage, medical advice, consultation, or treatment was recommended or received, or for which symptoms existed that would ordinarily cause a prudent person to seek diagnosis, care, or treatment. Disability caused by a Pre-existing Condition or reinjuries to a Pre-existing Condition will not be covered unless it begins more than 12 months after the Effective Date of coverage.

5. OPTIONAL BENEFITS:

Disability Benefit for On-the-Job Injury Rider: (Series A57550) Applied For: Yes No

Aflac will pay the following benefits, as applicable, if your Disability is caused by a covered On-the-Job Injury and occurs while this coverage is in force. All benefits are subject to the Limitations and Exclusions, Pre-existing Condition Limitations, and other policy terms.

Benefits will be paid for only one Disability at a time even if the Disability is caused by more than one Injury. **We reserve the right to meet with you during the pendency of a claim or to use an independent consultant and Physician's statement to determine whether you are qualified to receive Disability benefits. You must be under the care and attendance of a Physician for these benefits to be payable. Benefits will cease on the date of your death.**

A. TOTAL DISABILITY BENEFIT: If you have a Full-Time Job at the time of your On-the-Job Injury, we will insure you as follows while coverage is in force:

If your covered On-the-Job Injury causes your Total Disability within 90 days of your last treatment for your covered On-the-Job Injury, we will pay you the Daily Disability Benefit for the On-the-Job Injury Disability Rider for each day of your Disability or your Successive Periods of Disability. This benefit is payable up to the Benefit Period you selected and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled "Term", and the definitions of "Benefit Period" and "Successive Periods of Disability."

You will no longer be qualified to receive this benefit upon the earlier of your: (1) being released by your Physician to perform the material and substantial duties of your Full-Time Job or (2) working at any job.

B. PARTIAL DISABILITY BENEFIT: If you have a Full-Time Job at the time of your On-the-Job Injury, we will insure you as follows while coverage is in force:

If your covered On-the-Job Injury causes your Partial Disability within 90 days of your last treatment for your covered On-the-Job Injury, we will pay you the Daily Disability Benefit for the On-the-Job Injury Disability Rider for each day of your Disability or your Successive Periods of Disability. This benefit is payable up to the Benefit Period you selected and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled "Term", and the definitions of "Benefit Period" and "Successive Periods of Disability."

You will no longer be qualified to receive this benefit upon the earlier of your: (1) being released by your Physician to perform the material and substantial duties of your Full-Time Job or (2) working at any job earning 80 percent or more of your pre-Disability Base Pay Earnings.

C. TRANSITIONAL DISABILITY BENEFIT: If you do not have a Full-Time Job at the time of your On-the-Job Injury, we will insure you as follows while coverage is in force:

If your covered On-the-Job Injury causes your Transitional Disability within 15 days of your last treatment for your covered On-the-Job Injury, we will pay you one-half of the Daily Disability Benefit for the On-the-Job Injury Disability Rider for each day you remain unable to work at any job. This benefit is payable for a maximum period of three months of Disability or Successive Periods of Disability and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled "Term", and the definition of "Successive Periods of Disability."

You will no longer be qualified to receive this benefit upon the earlier of your: (1) being released by your Physician to perform the material and substantial duties of any job or (2) working at any job. **This benefit is limited to a lifetime maximum period of a total of three months, regardless of the number of Disabilities or the duration of any Disability.**

IF YOU HAVE ANY OTHER DISABILITY BENEFIT IN FORCE WITH US, ONLY ONE DISABILITY BENEFIT IS PAYABLE.

Additional Units of Disability Benefit Rider: (Series A57551) Applied For: Yes No

Aflac will pay the following benefits, as applicable, if your Disability is caused by a covered Sickness or covered Off-the-Job Injury and occurs while this coverage is in force. All benefits are subject to the Limitations and Exclusions, Pre-existing Condition Limitations, and other policy terms.

Disability due to pregnancy and childbirth is payable to the same extent as a covered Sickness. Disability benefits for childbirth will only be payable after this rider has been in force ten months. The maximum Benefit Period allowed for childbirth is six weeks for noncesarean delivery and eight weeks for cesarean delivery, less the Elimination Period, unless you furnish proof that your Disability continues beyond these time frames.

Benefits will be paid for only one Disability at a time even if the Disability is caused by more than one Sickness, more than one Injury, or a Sickness and an Injury. **We reserve the right to meet with you during the pendency of a claim or to use an independent consultant and Physician's statement to determine whether you are qualified to receive Disability benefits. You must be under the care and attendance of a Physician for these benefits to be payable. Benefits will cease on the date of your death.**

This benefit will be paid under the same terms as the applicable Total Disability Benefit, Partial Disability Benefit, or Transitional Disability Benefit as described in your policy. The additional units of coverage will only be payable for a Disability that begins after the Effective Date of this rider.

A. TOTAL DISABILITY BENEFIT: If you have a Full-Time Job at the time of your Sickness or Off-the-Job Injury, we will insure you as follows while coverage is in force:

If your covered Sickness or covered Off-the-Job Injury causes your Total Disability within 90 days of your last treatment for your covered Sickness or covered Off-the-Job Injury, we will pay you the Daily Disability Benefit for the Additional Units of Disability Benefit Rider for each day of your Disability or your Successive Periods of Disability. This benefit is payable up to the Benefit Period you selected and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled "Term", and the definitions of "Benefit Period" and "Successive Periods of Disability."

You will no longer be qualified to receive this benefit upon the earlier of your: (1) being released by your Physician to perform the material and substantial duties of your Full-Time Job or (2) working at any job.

B. PARTIAL DISABILITY BENEFIT: If you have a Full-Time Job at the time of your Sickness or Off-the-Job Injury, we will insure you as follows while coverage is in force:

If your covered Sickness or covered Off-the-Job Injury causes your Partial Disability within 90 days of your last treatment for your covered Sickness or covered Off-the-Job Injury, we will pay you the Daily Disability Benefit for the Additional Units of Disability Benefit Rider for each day of your Disability or your Successive Periods of Disability. This benefit is payable up to the Benefit Period you selected

and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled "Term", and the definitions of "Benefit Period" and "Successive Periods of Disability."

You will no longer be qualified to receive this benefit upon the earlier of your: (1) being released by your Physician to perform the material and substantial duties of your Full-Time Job or (2) working at any job earning 80 percent or more of your pre-Disability Base Pay Earnings.

C. TRANSITIONAL DISABILITY BENEFIT: If you do not have a Full-Time Job at the time of your Sickness or Off-the-Job Injury, we will insure you as follows while coverage is in force:

If your covered Sickness or covered Off-the-Job Injury causes your Transitional Disability within 15 days of your last treatment for your covered Sickness or covered Off-the-Job Injury, we will pay you one-half of the Daily Disability Benefit for the Additional Units of Disability Benefit Rider for each day you remain unable to work at any job. This benefit is payable for a maximum period of three months of Disability or Successive Periods of Disability and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled "Term", and the definition of "Successive Periods of Disability."

You will no longer be qualified to receive this benefit upon the earlier of your: (1) being released by your Physician to perform the material and substantial duties of any job or (2) working at any job. **This benefit is limited to a lifetime maximum period of a total of three months, regardless of the number of Disabilities or the duration of any Disability.**

IMPORTANT PROVISIONS OF YOUR POLICY

LIMITATIONS AND EXCLUSIONS.

- A. Disability caused by a Pre-existing Condition or reinjuries to a Pre-existing Condition will not be covered unless it begins more than 12 months after the Effective Date of coverage.
- B. Aflac will not pay benefits for a Disability that is being treated outside the territorial limits of the United States.
- C. Aflac will not pay benefits whenever coverage provided by this policy is in violation of any U.S. economic or trade sanctions. If the coverage violates U.S. economic or trade sanctions, such coverage shall be null and void.
- D. Aflac will not pay benefits for a Disability that is caused by or occurs as a result of any bacterial, viral, or microorganism infection or infestation or any condition resulting from insect, arachnid, or other arthropod bites or stings as a Disability due to an Injury; such disability will be covered to the same extent as a Disability due to Sickness.
- E. **Aflac will not pay benefits for a disability that is caused by or occurs as a result of your:**
 - 1. Pregnancy or childbirth within the first ten months of the Effective Date of coverage. (Complications of Pregnancy will be covered to the same extent as a Sickness);
 - 2. Using any drug, narcotic, hallucinogen, or chemical substance (unless administered by a Physician and taken according to the Physician's instructions), or voluntarily taking any kind of poison or inhaling any kind of gas or fumes;

3. Participating in any activity or event, including the operation of a vehicle, while under the influence of a controlled substance (unless administered by a Physician and taken according to the Physician's instructions) or while intoxicated ("intoxicated" means that condition as defined by the law of the jurisdiction in which the accident occurred);
4. Participating in, or attempting to participate in, an illegal activity that is defined as a felony, whether charged or not ("felony" is as defined by the law of the jurisdiction in which the activity takes place); or being incarcerated in any type penal institution;
5. Intentionally self-inflicting a bodily injury or committing or attempting suicide, while sane or insane;
6. Having cosmetic surgery or other elective procedures that are not Medically Necessary;
7. Having dental treatment except as a result of Injury;
8. Being exposed to war or any act of war, declared or undeclared;
9. Actively serving in any of the armed forces, or units auxiliary thereto, including the National Guard or Reserve;
10. Donating an organ within the first 12 months of the Effective Date of this policy; or
11. Mental or emotional disorders, including but not limited to the following: bipolar affective disorder (manic-depressive syndrome), delusional (paranoid) disorders, psychotic disorders, somatoform disorders (psychosomatic illness), eating disorders, schizophrenia, anxiety disorders, depression, stress or post-partum depression. This policy will pay, however, for covered disabilities resulting from Alzheimer's disease, or similar forms of senility or senile dementia, first manifested while coverage is in force.

Benefits will be paid for only one Disability at a time even if the Disability is caused by more than one Sickness, more than one Injury, or a Sickness and an Injury.

Renewability. The Policy is guaranteed renewable to age 70 by payment of the premium in effect at the beginning of each renewal period. Premium rates may be changed only if changed on all policies of the same form number and class in force in your state.

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

**ARKANSAS
INSURANCE
DEPARTMENT**

400 University Tower Building
1123 South University Avenue
Little Rock, Arkansas 72204

501-686-2900

ATTN: LIFE & HEALTH DIVISION, ARKANSAS INSURANCE DEPARTMENT

Company Name: AMERICAN FAMILY LIFE ASSURANCE COMPANY OF COLUMBUS (Aflac)

Company NAIC Code: 60380

Company Contact Person & Telephone # Connie Gates (706) 596-5048

ALL FEES ARE PER EACH INSURER, PER ANNUAL STATEMENT LINE OF BUSINESS, UNLESS OTHERWISE INDICATED.

FEE SCHEDULE FOR ADMITTED INSURERS

RATE/FORM FILINGS

Life and/or disability policy form filing and review, per each policy, contract, annuity form, per each insurer, per each filing. * 2 x \$50 = \$100
** Retaliatory

Life and/or Disability – Filing and review of each rate filing or loss ration guarantee filing, per each insurer. * _____ x \$50 = _____
** Retaliatory

Life and/or Disability Policy, Contract or annuity Forms: Filing and review of each certificate, rider, endorsement or application if each is filed separately from the basic form. * _____ x \$20 = _____
** Retaliatory

Policy and contract forms, all lines, filing corrections in previously filed policy and contract forms. * _____ x \$20 = _____
** Retaliatory

Life and/or Disability: Filing and review of insurer's advertisements, per advertisement, per each insurer. * _____ x \$25 = _____
** Retaliatory

AMEND CERTIFICATE OF AUTHORITY

Review and processing of information to amend an Insurer's Certificate of Authority * _____ x \$400 = _____

Filing to amend Certificate of Authority *** _____ x \$100 = _____

* THESE FEES ARE PAYABLE UNDER THE OLD FEE SCHEDULE AS OUTLINED UNDER ARK. CODE ANN. 23-63-102, RETALIATORY TAX.

*** THESE FEES ARE PAYABLE AS REQUIRED IN ARK. ANN. § 23-61-401.

SERFF Tracking Number: AFLA-125900873 State: Arkansas
 Filing Company: American Family Life Assurance Company of Columbus State Tracking Number: 41904
 Company Tracking Number: A57500
 TOI: H111 Individual Health - Disability Income Sub-TOI: H111.004 Other
 Product Name: Short Term Disability
 Project Name/Number: Short Term Disability/

Superseded Attachments

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Original Date:	Schedule	Document Name	Replaced Date	Attach Document
No original date	Form	Signature Page	01/27/2009	AsignAR.pdf
No original date	Supporting Document	Certification/Notice	11/12/2008	57500LB DTG letterhead.pdf
No original date	Supporting Document	Outline of Coverage	11/12/2008	A57525AR.pdf A57525LBAR.pdf
No original date	Form	Limited Benefit Outline of Coverage	01/27/2009	A57525LBAR.pdf
No original date	Form	Outline of Coverage	01/27/2009	A57525AR.pdf

I, the undersigned Proposed Insured/Employee, agree that by signing below I am submitting an application to Aflac for the following insurance policy(ies).

- | | | |
|--|---|---|
| <input type="checkbox"/> Lump Sum Critical Illness | <input type="checkbox"/> Dental | <input type="checkbox"/> Vision |
| <input type="checkbox"/> Lump Sum Cancer | <input type="checkbox"/> Hospital Confinement | <input type="checkbox"/> Specified Disease/Cancer |
| <input type="checkbox"/> Short Term Disability | <input type="checkbox"/> Specified Health Event | <input type="checkbox"/> Hospital Intensive Care |
| <input type="checkbox"/> Accident | | |

- This is an electronic application. It has been completed and signed by me electronically without the presence of an associate/agent.
- I verify that the unique identifier used to sign this application is mine and that by clicking the "Accept" button I am signing the application(s) electronically. I further understand, agree, and authorize my employer to deduct the premiums for this policy(ies) from my paycheck.
- I would prefer to receive an electronic copy of my policy(ies) instead of paper. Yes No

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.

Signed and Dated at _____ on _____
City and State Date

Proposed Insured's/Employee's Signature _____

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,
[WORLDWIDE HEADQUARTERS • 1932 WYNNTON ROAD • COLUMBUS, GEORGIA 31999.]**

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.**

**MAKE CHECK OR MONEY ORDER PAYABLE TO AFLAC.
[FOR INFORMATION, CALL TOLL-FREE 1-800-99-AFLAC (1-800-992-3522).
VISIT OUR WEB SITE AT AFLAC.COM.]**

American Family Life Assurance Company of Columbus (Aflac)
[Worldwide Headquarters, 1932 Wynnton Road
Columbus, Georgia 31999
TOLL-FREE 1-800-99-AFLAC (1-800-992-3522)]

LIMITED BENEFIT HEALTH COVERAGE

SHORT-TERM DISABILITY COVERAGE
Outline of Coverage for Policy Series A57500LB

THIS IS NOT A MEDICARE SUPPLEMENT POLICY.

If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from Aflac.

- 1. Read Your Policy Carefully.** This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and Aflac. It is, therefore, important that you **READ YOUR POLICY CAREFULLY!**
- 2. Limited Benefit Health Coverage.** Policies of this category are designed to provide, to persons insured, limited or supplemental insurance coverage, subject to any limitations, deductibles or copayment requirements set forth in the policy.
- 3. Short-Term Disability Coverage** is designed to provide, to persons insured, coverage for disabilities resulting from a covered accident or sickness, subject to any limitations set forth in the policy. Coverage is not provided for basic hospital, basic medical-surgical or major medical expenses.
- 4. Benefits.** The following benefits are a part of the policy.

Aflac will pay the following benefits, as applicable, if your Disability is caused by a covered Sickness or covered Off-the-Job Injury and occurs while this coverage is in force. All benefits are subject to the Limitations and Exclusions, Pre-existing Condition Limitations, and other policy terms.

Disability due to pregnancy and childbirth is payable to the same extent as a covered Sickness. Disability benefits for childbirth will only be payable after this policy has been in force ten months. The maximum Benefit Period allowed for childbirth is six weeks for noncesarean delivery and eight weeks for cesarean delivery, less the Elimination Period, unless you furnish proof that your Disability continues beyond these time frames.

Benefits will be paid for only one Disability at a time even if the Disability is caused by more than one Sickness, more than one Injury, or a Sickness and an Injury. **We reserve the right to meet with you during the pendency of a claim or to use an independent consultant and Physician's statement to determine whether you are qualified to receive Disability benefits. You must be under the care and attendance of a Physician for these benefits to be payable. Benefits will cease on the date of your death.**

A. TOTAL DISABILITY BENEFIT: If you have a Full-Time Job at the time of your Sickness or Off-the-Job Injury, we will insure you as follows while coverage is in force:

If your covered Sickness or covered Off-the-Job Injury causes your Total Disability within 90 days of your last treatment for your covered Sickness or covered Off-the-Job Injury, we will pay you the

Daily Disability Benefit for each day of your Disability or your Successive Periods of Disability. This benefit is payable up to the Benefit Period you selected and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled "Term", and the definitions of "Benefit Period" and "Successive Periods of Disability."

You will no longer be qualified to receive this benefit upon the earlier of your: (1) being released by your Physician to perform the material and substantial duties of your Full-Time Job or (2) working at any job.

- B. PARTIAL DISABILITY BENEFIT:** If you have a Full-Time Job at the time of your Sickness or Off-the-Job Injury, we will insure you as follows while coverage is in force:

If your covered Sickness or covered Off-the-Job Injury causes your Partial Disability within 90 days of your last treatment for your covered Sickness or covered Off-the-Job Injury, we will pay you the Daily Disability Benefit for each day of your Disability or your Successive Periods of Disability. This benefit is payable up to the Benefit Period you selected and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled "Term", and the definitions of "Benefit Period" and "Successive Periods of Disability."

You will no longer be qualified to receive this benefit upon the earlier of your: (1) being released by your Physician to perform the material and substantial duties of your Full-Time Job or (2) working at any job earning 80 percent or more of your pre-Disability Base Pay Earnings.

- C. TRANSITIONAL DISABILITY BENEFIT:** If you do not have a Full-Time Job at the time of your Sickness or Off-the-Job Injury, we will insure you as follows while coverage is in force:

If your covered Sickness or covered Off-the-Job Injury causes your Transitional Disability within 15 days of your last treatment for your covered Sickness or covered Off-the-Job Injury, we will pay you one-half of the Daily Disability Benefit for each day you remain unable to work at any job. This benefit is payable for a maximum period of three months of Disability or Successive Periods of Disability and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled "Term", and the definition of "Successive Periods of Disability."

You will no longer be qualified to receive this benefit upon the earlier of your: (1) being released by your Physician to perform the material and substantial duties of any job or (2) working at any job. **This benefit is limited to a lifetime maximum period of a total of three months, regardless of the number of Disabilities or the duration of any Disability.**

IF YOU HAVE ANY OTHER DISABILITY BENEFIT IN FORCE WITH US, ONLY ONE DISABILITY BENEFIT IS PAYABLE.

PRE-EXISTING CONDITION LIMITATIONS: A Pre-existing Condition is an illness, disease, infection, disorder, or injury for which, within the 12-month period before the Effective Date of coverage, medical advice, consultation, or treatment was recommended or received, or for which symptoms existed that would ordinarily cause a prudent person to seek diagnosis, care, or treatment. Disability caused by a Pre-existing Condition or reinjuries to a Pre-existing Condition will not be covered unless it begins more than 12 months after the Effective Date of coverage.

5. OPTIONAL BENEFITS:

Disability Benefit for On-the-Job Injury Rider: (Series A57550) Applied For: Yes No

Aflac will pay the following benefits, as applicable, if your Disability is caused by a covered On-the-Job Injury and occurs while this coverage is in force. All benefits are subject to the Limitations and Exclusions, Pre-existing Condition Limitations, and other policy terms.

Benefits will be paid for only one Disability at a time even if the Disability is caused by more than one Injury. **We reserve the right to meet with you during the pendency of a claim or to use an independent consultant and Physician's statement to determine whether you are qualified to receive Disability benefits. You must be under the care and attendance of a Physician for these benefits to be payable. Benefits will cease on the date of your death.**

A. TOTAL DISABILITY BENEFIT: If you have a Full-Time Job at the time of your On-the-Job Injury, we will insure you as follows while coverage is in force:

If your covered On-the-Job Injury causes your Total Disability within 90 days of your last treatment for your covered On-the-Job Injury, we will pay you the Daily Disability Benefit for the On-the-Job Injury Disability Rider for each day of your Disability or your Successive Periods of Disability. This benefit is payable up to the Benefit Period you selected and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled "Term", and the definitions of "Benefit Period" and "Successive Periods of Disability."

You will no longer be qualified to receive this benefit upon the earlier of your: (1) being released by your Physician to perform the material and substantial duties of your Full-Time Job or (2) working at any job.

B. PARTIAL DISABILITY BENEFIT: If you have a Full-Time Job at the time of your On-the-Job Injury, we will insure you as follows while coverage is in force:

If your covered On-the-Job Injury causes your Partial Disability within 90 days of your last treatment for your covered On-the-Job Injury, we will pay you the Daily Disability Benefit for the On-the-Job Injury Disability Rider for each day of your Disability or your Successive Periods of Disability. This benefit is payable up to the Benefit Period you selected and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled "Term", and the definitions of "Benefit Period" and "Successive Periods of Disability."

You will no longer be qualified to receive this benefit upon the earlier of your: (1) being released by your Physician to perform the material and substantial duties of your Full-Time Job or (2) working at any job earning 80 percent or more of your pre-Disability Base Pay Earnings.

C. TRANSITIONAL DISABILITY BENEFIT: If you do not have a Full-Time Job at the time of your On-the-Job Injury, we will insure you as follows while coverage is in force:

If your covered On-the-Job Injury causes your Transitional Disability within 15 days of your last treatment for your covered On-the-Job Injury, we will pay you one-half of the Daily Disability Benefit for the On-the-Job Injury Disability Rider for each day you remain unable to work at any job. This benefit is payable for a maximum period of three months of Disability or Successive Periods of Disability and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled "Term", and the definition of "Successive Periods of Disability."

You will no longer be qualified to receive this benefit upon the earlier of your: (1) being released by your Physician to perform the material and substantial duties of any job or (2) working at any job. **This benefit is limited to a lifetime maximum period of a total of three months, regardless of the number of Disabilities or the duration of any Disability.**

IF YOU HAVE ANY OTHER DISABILITY BENEFIT IN FORCE WITH US, ONLY ONE DISABILITY BENEFIT IS PAYABLE.

Additional Units of Disability Benefit Rider: (Series A57551) Applied For: Yes No

Aflac will pay the following benefits, as applicable, if your Disability is caused by a covered Sickness or covered Off-the-Job Injury and occurs while this coverage is in force. All benefits are subject to the Limitations and Exclusions, Pre-existing Condition Limitations, and other policy terms.

Disability due to pregnancy and childbirth is payable to the same extent as a covered Sickness. Disability benefits for childbirth will only be payable after this rider has been in force ten months. The maximum Benefit Period allowed for childbirth is six weeks for noncesarean delivery and eight weeks for cesarean delivery, less the Elimination Period, unless you furnish proof that your Disability continues beyond these time frames.

Benefits will be paid for only one Disability at a time even if the Disability is caused by more than one Sickness, more than one Injury, or a Sickness and an Injury. **We reserve the right to meet with you during the pendency of a claim or to use an independent consultant and Physician's statement to determine whether you are qualified to receive Disability benefits. You must be under the care and attendance of a Physician for these benefits to be payable. Benefits will cease on the date of your death.**

This benefit will be paid under the same terms as the applicable Total Disability Benefit, Partial Disability Benefit, or Transitional Disability Benefit as described in your policy. The additional units of coverage will only be payable for a Disability that begins after the Effective Date of this rider.

A. TOTAL DISABILITY BENEFIT: If you have a Full-Time Job at the time of your Sickness or Off-the-Job Injury, we will insure you as follows while coverage is in force:

If your covered Sickness or covered Off-the-Job Injury causes your Total Disability within 90 days of your last treatment for your covered Sickness or covered Off-the-Job Injury, we will pay you the Daily Disability Benefit for the Additional Units of Disability Benefit Rider for each day of your Disability or your Successive Periods of Disability. This benefit is payable up to the Benefit Period you selected and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled "Term", and the definitions of "Benefit Period" and "Successive Periods of Disability."

You will no longer be qualified to receive this benefit upon the earlier of your: (1) being released by your Physician to perform the material and substantial duties of your Full-Time Job or (2) working at any job.

B. PARTIAL DISABILITY BENEFIT: If you have a Full-Time Job at the time of your Sickness or Off-the-Job Injury, we will insure you as follows while coverage is in force:

If your covered Sickness or covered Off-the-Job Injury causes your Partial Disability within 90 days of your last treatment for your covered Sickness or covered Off-the-Job Injury, we will pay you the Daily Disability Benefit for the Additional Units of Disability Benefit Rider for each day of your Disability or your Successive Periods of Disability. This benefit is payable up to the Benefit Period

you selected and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled "Term", and the definitions of "Benefit Period" and "Successive Periods of Disability."

You will no longer be qualified to receive this benefit upon the earlier of your: (1) being released by your Physician to perform the material and substantial duties of your Full-Time Job or (2) working at any job earning 80 percent or more of your pre-Disability Base Pay Earnings.

- C. TRANSITIONAL DISABILITY BENEFIT:** If you do not have a Full-Time Job at the time of your Sickness or Off-the-Job Injury, we will insure you as follows while coverage is in force:

If your covered Sickness or covered Off-the-Job Injury causes your Transitional Disability within 15 days of your last treatment for your covered Sickness or covered Off-the-Job Injury, we will pay you one-half of the Daily Disability Benefit for the Additional Units of Disability Benefit Rider for each day you remain unable to work at any job. This benefit is payable for a maximum period of three months of Disability or Successive Periods of Disability and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled "Term", and the definition of "Successive Periods of Disability."

You will no longer be qualified to receive this benefit upon the earlier of your: (1) being released by your Physician to perform the material and substantial duties of any job or (2) working at any job. **This benefit is limited to a lifetime maximum period of a total of three months, regardless of the number of Disabilities or the duration of any Disability.**

IMPORTANT PROVISIONS OF YOUR POLICY

LIMITATIONS AND EXCLUSIONS.

- A. Disability caused by a Pre-existing Condition or reinjuries to a Pre-existing Condition will not be covered unless it begins more than 12 months after the Effective Date of coverage.
- B. Aflac will not pay benefits for a Disability that is being treated outside the territorial limits of the United States.
- C. Aflac will not pay benefits whenever coverage provided by this policy is in violation of any U.S. economic or trade sanctions. If the coverage violates U.S. economic or trade sanctions, such coverage shall be null and void.
- D. Aflac will not pay benefits for a Disability that is caused by or occurs as a result of any bacterial, viral, or microorganism infection or infestation or any condition resulting from insect, arachnid, or other arthropod bites or stings as a Disability due to an Injury; such disability will be covered to the same extent as a Disability due to Sickness.
- E. **Aflac will not pay benefits for a disability that is caused by or occurs as a result of your:**
 - 1. Pregnancy or childbirth within the first ten months of the Effective Date of coverage. (Complications of Pregnancy will be covered to the same extent as a Sickness);
 - 2. Using any drug, narcotic, hallucinogen, or chemical substance (unless administered by a Physician and taken according to the Physician's instructions), or voluntarily taking any kind of poison or inhaling any kind of gas or fumes;

3. Participating in any activity or event, including the operation of a vehicle, while under the influence of a controlled substance (unless administered by a Physician and taken according to the Physician's instructions) or while intoxicated ("intoxicated" means that condition as defined by the law of the jurisdiction in which the accident occurred);
4. Participating in, or attempting to participate in, an illegal activity that is defined as a felony, whether charged or not ("felony" is as defined by the law of the jurisdiction in which the activity takes place); or being incarcerated in any type penal institution;
5. Intentionally self-inflicting a bodily injury or committing or attempting suicide, while sane or insane;
6. Having cosmetic surgery or other elective procedures that are not Medically Necessary;
7. Having dental treatment except as a result of Injury;
8. Being exposed to war or any act of war, declared or undeclared;
9. Actively serving in any of the armed forces, or units auxiliary thereto, including the National Guard or Reserve;
10. Donating an organ within the first 12 months of the Effective Date of this policy; or
11. Mental or emotional disorders, including but not limited to the following: bipolar affective disorder (manic-depressive syndrome), delusional (paranoid) disorders, psychotic disorders, somatoform disorders (psychosomatic illness), eating disorders, schizophrenia, anxiety disorders, depression, stress or post-partum depression. This policy will pay, however, for covered disabilities resulting from Alzheimer's disease, or similar forms of senility or senile dementia, first manifested while coverage is in force.

Benefits will be paid for only one Disability at a time even if the Disability is caused by more than one Sickness, more than one Injury, or a Sickness and an Injury.

Renewability. The Policy is guaranteed renewable to age 70 by payment of the premium in effect at the beginning of each renewal period. Premium rates may be changed only if changed on all policies of the same form number and class in force in your state.

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

American Family Life Assurance Company of Columbus (Aflac)
[Worldwide Headquarters, 1932 Wynnton Road
Columbus, Georgia 31999
TOLL-FREE 1-800-99-AFLAC (1-800-992-3522)]

SHORT-TERM DISABILITY COVERAGE
Outline of Coverage for Policy Series A57500

THIS IS NOT A MEDICARE SUPPLEMENT POLICY.

If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from Aflac.

- 1. Read Your Policy Carefully.** This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and Aflac. It is, therefore, important that you **READ YOUR POLICY CAREFULLY!**
- 2. Short-Term Disability Coverage** is designed to provide, to persons insured, coverage for disabilities resulting from a covered accident or sickness, subject to any limitations set forth in the policy. Coverage is not provided for basic hospital, basic medical-surgical or major medical expenses.
- 3. Benefits.** The following benefits are a part of the policy.

Aflac will pay the following benefits, as applicable, if your Disability is caused by a covered Sickness or covered Off-the-Job Injury and occurs while this coverage is in force. All benefits are subject to the Limitations and Exclusions, Pre-existing Condition Limitations, and other policy terms.

Disability due to pregnancy and childbirth is payable to the same extent as a covered Sickness. Disability benefits for childbirth will only be payable after this policy has been in force ten months. The maximum Benefit Period allowed for childbirth is six weeks for noncesarean delivery and eight weeks for cesarean delivery, less the Elimination Period, unless you furnish proof that your Disability continues beyond these time frames.

Benefits will be paid for only one Disability at a time even if the Disability is caused by more than one Sickness, more than one Injury, or a Sickness and an Injury. **We reserve the right to meet with you during the pendency of a claim or to use an independent consultant and Physician's statement to determine whether you are qualified to receive Disability benefits. You must be under the care and attendance of a Physician for these benefits to be payable. Benefits will cease on the date of your death.**

- A. TOTAL DISABILITY BENEFIT:** If you have a Full-Time Job at the time of your Sickness or Off-the-Job Injury, we will insure you as follows while coverage is in force:

If your covered Sickness or covered Off-the-Job Injury causes your Total Disability within 90 days of your last treatment for your covered Sickness or covered Off-the-Job Injury, we will pay you the Daily Disability Benefit for each day of your Disability or your Successive Periods of Disability. This benefit is payable up to the Benefit Period you selected and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled "Term", and the definitions of "Benefit Period" and "Successive Periods of Disability."

You will no longer be qualified to receive this benefit upon the earlier of your: (1) being released by your Physician to perform the material and substantial duties of your Full-Time Job or (2) working at any job.

B. PARTIAL DISABILITY BENEFIT: If you have a Full-Time Job at the time of your Sickness or Off-the-Job Injury, we will insure you as follows while coverage is in force:

If your covered Sickness or covered Off-the-Job Injury causes your Partial Disability within 90 days of your last treatment for your covered Sickness or covered Off-the-Job Injury, we will pay you the Daily Disability Benefit for each day of your Disability or your Successive Periods of Disability. This benefit is payable up to the Benefit Period you selected and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled "Term", and the definitions of "Benefit Period" and "Successive Periods of Disability."

You will no longer be qualified to receive this benefit upon the earlier of your: (1) being released by your Physician to perform the material and substantial duties of your Full-Time Job or (2) working at any job earning 80 percent or more of your pre-Disability Base Pay Earnings.

C. TRANSITIONAL DISABILITY BENEFIT: If you do not have a Full-Time Job at the time of your Sickness or Off-the-Job Injury, we will insure you as follows while coverage is in force:

If your covered Sickness or covered Off-the-Job Injury causes your Transitional Disability within 15 days of your last treatment for your covered Sickness or covered Off-the-Job Injury, we will pay you one-half of the Daily Disability Benefit for each day you remain unable to work at any job. This benefit is payable for a maximum period of three months of Disability or Successive Periods of Disability and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled "Term", and the definition of "Successive Periods of Disability."

You will no longer be qualified to receive this benefit upon the earlier of your: (1) being released by your Physician to perform the material and substantial duties of any job or (2) working at any job. **This benefit is limited to a lifetime maximum period of a total of three months, regardless of the number of Disabilities or the duration of any Disability.**

IF YOU HAVE ANY OTHER DISABILITY BENEFIT IN FORCE WITH US, ONLY ONE DISABILITY BENEFIT IS PAYABLE.

PRE-EXISTING CONDITION LIMITATIONS: A Pre-existing Condition is an illness, disease, infection, disorder, or injury for which, within the 12-month period before the Effective Date of coverage, medical advice, consultation, or treatment was recommended or received, or for which symptoms existed that would ordinarily cause a prudent person to seek diagnosis, care, or treatment. Disability caused by a Pre-existing Condition or reinjuries to a Pre-existing Condition will not be covered unless it begins more than 12 months after the Effective Date of coverage.

4. OPTIONAL BENEFITS:

Disability Benefit for On-the-Job Injury Rider: (Series A57550) Applied For: Yes No

Aflac will pay the following benefits, as applicable, if your Disability is caused by a covered On-the-Job Injury and occurs while this coverage is in force. All benefits are subject to the Limitations and Exclusions, Pre-existing Condition Limitations, and other policy terms.

Benefits will be paid for only one Disability at a time even if the Disability is caused by more than one Injury. **We reserve the right to meet with you during the pendency of a claim or to use an independent consultant and Physician's statement to determine whether you are qualified to receive Disability benefits. You must be under the care and attendance of a Physician for these benefits to be payable. Benefits will cease on the date of your death.**

A. TOTAL DISABILITY BENEFIT: If you have a Full-Time Job at the time of your On-the-Job Injury, we will insure you as follows while coverage is in force:

If your covered On-the-Job Injury causes your Total Disability within 90 days of your last treatment for your covered On-the-Job Injury, we will pay you the Daily Disability Benefit for the On-the-Job Injury Disability Rider for each day of your Disability or your Successive Periods of Disability. This benefit is payable up to the Benefit Period you selected and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled "Term", and the definitions of "Benefit Period" and "Successive Periods of Disability."

You will no longer be qualified to receive this benefit upon the earlier of your: (1) being released by your Physician to perform the material and substantial duties of your Full-Time Job or (2) working at any job.

B. PARTIAL DISABILITY BENEFIT: If you have a Full-Time Job at the time of your On-the-Job Injury, we will insure you as follows while coverage is in force:

If your covered On-the-Job Injury causes your Partial Disability within 90 days of your last treatment for your covered On-the-Job Injury, we will pay you the Daily Disability Benefit for the On-the-Job Injury Disability Rider for each day of your Disability or your Successive Periods of Disability. This benefit is payable up to the Benefit Period you selected and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled "Term", and the definitions of "Benefit Period" and "Successive Periods of Disability."

You will no longer be qualified to receive this benefit upon the earlier of your: (1) being released by your Physician to perform the material and substantial duties of your Full-Time Job or (2) working at any job earning 80 percent or more of your pre-Disability Base Pay Earnings.

C. TRANSITIONAL DISABILITY BENEFIT: If you do not have a Full-Time Job at the time of your On-the-Job Injury, we will insure you as follows while coverage is in force:

If your covered On-the-Job Injury causes your Transitional Disability within 15 days of your last treatment for your covered On-the-Job Injury, we will pay you one-half of the Daily Disability Benefit for the On-the-Job Injury Disability Rider for each day you remain unable to work at any job. This benefit is payable for a maximum period of three months of Disability or Successive Periods of Disability and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled "Term", and the definition of "Successive Periods of Disability."

You will no longer be qualified to receive this benefit upon the earlier of your: (1) being released by your Physician to perform the material and substantial duties of any job or (2) working at any job. **This benefit is limited to a lifetime maximum period of a total of three months, regardless of the number of Disabilities or the duration of any Disability.**

IF YOU HAVE ANY OTHER DISABILITY BENEFIT IN FORCE WITH US, ONLY ONE DISABILITY BENEFIT IS PAYABLE.

Additional Units of Disability Benefit Rider: (Series A57551) Applied For: Yes No

Aflac will pay the following benefits, as applicable, if your Disability is caused by a covered Sickness or covered Off-the-Job Injury and occurs while this coverage is in force. All benefits are subject to the Limitations and Exclusions, Pre-existing Condition Limitations, and other policy terms.

Disability due to pregnancy and childbirth is payable to the same extent as a covered Sickness. Disability benefits for childbirth will only be payable after this rider has been in force ten months. The maximum Benefit Period allowed for childbirth is six weeks for noncesarean delivery and eight weeks for cesarean delivery, less the Elimination Period, unless you furnish proof that your Disability continues beyond these time frames.

Benefits will be paid for only one Disability at a time even if the Disability is caused by more than one Sickness, more than one Injury, or a Sickness and an Injury. **We reserve the right to meet with you during the pendency of a claim or to use an independent consultant and Physician's statement to determine whether you are qualified to receive Disability benefits. You must be under the care and attendance of a Physician for these benefits to be payable. Benefits will cease on the date of your death.**

This benefit will be paid under the same terms as the applicable Total Disability Benefit, Partial Disability Benefit, or Transitional Disability Benefit as described in your policy. The additional units of coverage will only be payable for a Disability that begins after the Effective Date of this rider.

A. TOTAL DISABILITY BENEFIT: If you have a Full-Time Job at the time of your Sickness or Off-the-Job Injury, we will insure you as follows while coverage is in force:

If your covered Sickness or covered Off-the-Job Injury causes your Total Disability within 90 days of your last treatment for your covered Sickness or covered Off-the-Job Injury, we will pay you the Daily Disability Benefit for the Additional Units of Disability Benefit Rider for each day of your Disability or your Successive Periods of Disability. This benefit is payable up to the Benefit Period you selected and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled "Term", and the definitions of "Benefit Period" and "Successive Periods of Disability."

You will no longer be qualified to receive this benefit upon the earlier of your: (1) being released by your Physician to perform the material and substantial duties of your Full-Time Job or (2) working at any job.

B. PARTIAL DISABILITY BENEFIT: If you have a Full-Time Job at the time of your Sickness or Off-the-Job Injury, we will insure you as follows while coverage is in force:

If your covered Sickness or covered Off-the-Job Injury causes your Partial Disability within 90 days of your last treatment for your covered Sickness or covered Off-the-Job Injury, we will pay you the Daily Disability Benefit for the Additional Units of Disability Benefit Rider for each day of your Disability or your Successive Periods of Disability. This benefit is payable up to the Benefit Period you selected and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled "Term", and the definitions of "Benefit Period" and "Successive Periods of Disability."

You will no longer be qualified to receive this benefit upon the earlier of your: (1) being released by your Physician to perform the material and substantial duties of your Full-Time Job or (2) working at any job earning 80 percent or more of your pre-Disability Base Pay Earnings.

- C. TRANSITIONAL DISABILITY BENEFIT:** If you do not have a Full-Time Job at the time of your Sickness or Off-the-Job Injury, we will insure you as follows while coverage is in force:

If your covered Sickness or covered Off-the-Job Injury causes your Transitional Disability within 15 days of your last treatment for your covered Sickness or covered Off-the-Job Injury, we will pay you one-half of the Daily Disability Benefit for the Additional Units of Disability Benefit Rider for each day you remain unable to work at any job. This benefit is payable for a maximum period of three months of Disability or Successive Periods of Disability and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled "Term", and the definition of "Successive Periods of Disability."

You will no longer be qualified to receive this benefit upon the earlier of your: (1) being released by your Physician to perform the material and substantial duties of any job or (2) working at any job. **This benefit is limited to a lifetime maximum period of a total of three months, regardless of the number of Disabilities or the duration of any Disability.**

IMPORTANT PROVISIONS OF YOUR POLICY

LIMITATIONS AND EXCLUSIONS.

- A.** Disability caused by a Pre-existing Condition or reinjuries to a Pre-existing Condition will not be covered unless it begins more than 12 months after the Effective Date of coverage.
- B.** Aflac will not pay benefits for a Disability that is being treated outside the territorial limits of the United States.
- C.** Aflac will not pay benefits whenever coverage provided by this policy is in violation of any U.S. economic or trade sanctions. If the coverage violates U.S. economic or trade sanctions, such coverage shall be null and void.
- D.** Aflac will not pay benefits for a Disability that is caused by or occurs as a result of any bacterial, viral, or microorganism infection or infestation or any condition resulting from insect, arachnid, or other arthropod bites or stings as a Disability due to an Injury; such disability will be covered to the same extent as a Disability due to Sickness.
- E. Aflac will not pay benefits for a disability that is caused by or occurs as a result of your:**
1. Pregnancy or childbirth within the first ten months of the Effective Date of coverage. (Complications of Pregnancy will be covered to the same extent as a Sickness);
 2. Using any drug, narcotic, hallucinogen, or chemical substance (unless administered by a Physician and taken according to the Physician's instructions), or voluntarily taking any kind of poison or inhaling any kind of gas or fumes;
 3. Participating in any activity or event, including the operation of a vehicle, while under the influence of a controlled substance (unless administered by a Physician and taken according to the Physician's instructions) or while intoxicated ("intoxicated" means that condition as defined by the law of the jurisdiction in which the accident occurred);

4. Participating in, or attempting to participate in, an illegal activity that is defined as a felony, whether charged or not (“felony” is as defined by the law of the jurisdiction in which the activity takes place); or being incarcerated in any type penal institution;
5. Intentionally self-inflicting a bodily injury or committing or attempting suicide, while sane or insane;
6. Having cosmetic surgery or other elective procedures that are not Medically Necessary;
7. Having dental treatment except as a result of Injury;
8. Being exposed to war or any act of war, declared or undeclared;
9. Actively serving in any of the armed forces, or units auxiliary thereto, including the National Guard or Reserve;
10. Donating an organ within the first 12 months of the Effective Date of this policy; or
11. Mental or emotional disorders, including but not limited to the following: bipolar affective disorder (manic-depressive syndrome), delusional (paranoid) disorders, psychotic disorders, somatoform disorders (psychosomatic illness), eating disorders, schizophrenia, anxiety disorders, depression, stress or post-partum depression. This policy will pay, however, for covered disabilities resulting from Alzheimer’s disease, or similar forms of senility or senile dementia, first manifested while coverage is in force.

Benefits will be paid for only one Disability at a time even if the Disability is caused by more than one Sickness, more than one Injury, or a Sickness and an Injury.

Renewability. The Policy is guaranteed renewable to age 70 by payment of the premium in effect at the beginning of each renewal period. Premium rates may be changed only if changed on all policies of the same form number and class in force in your state.

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



*Deborah T. Grantham
AIRC, HIA, ACS
Second Vice President
Compliance Department*

January 28, 2009

Mr. Joe Musgrove
Arkansas Insurance Department
1200 West Third Street
Little Rock, AR 72201-1904

NAIC# 60380

RE: Short-Term Disability Policy Form A57500AR, Disability Benefit for On-the-Job Injury Rider Form A57550, Additional Units of Disability Rider Form A57551, Payroll Application Form A575PAPP, Union Application Form A575UAPP, Underwriting Application Auwall, Signature Forms AassignAR and AassignAR, Outline of Coverage Form A57525AR, and Application for Reinstatement Form A57503AR.

Limited Benefit Short-Term Disability Policy Form A57500LBAR and Outline of Coverage Form A57525LBAR.

Dear Mr. Musgrove:

Referenced forms are submitted for your review and approval. Nebraska, our state of domicile, has approved similar versions of the A57500 series on September 29, 2008. Limited Benefit Short-Term Disability Policy Series A57500LB was not filed in Nebraska as same was not required by the state.

Short-Term Disability Policy Form A57500AR pays disability benefits when the insured is disabled due to a covered sickness or covered off-the-job injury. The policy will pay for total or partial disability. We have included a new benefit titled Transitional Benefit. This benefit will pay the insured who doesn't work full-time at time of disability due to their covered sickness or off-the-job injury. There are five occupational classes.

Short-Term Disability Policy Form A57500LBAR pays disability benefits when the insured is disabled due to a covered sickness or covered off-the-job injury and only provides for a three month benefit period option. The policy will pay for total or partial disability. We have included a new benefit titled Transitional Benefit. This benefit will pay the insured who doesn't work full-time at time of disability due to their covered sickness or off-the-job injury. There are four occupational classes

The policies are available in unit values with the applicant having the option of choosing the unit amounts best suited for their individual needs. The policies will be marketed through payroll deduction and on a union basis to applicants age 18 through 64.

Our payroll deduction billing is for the individual market only and does not imply that this is a true group. All policies sold are sold on an individual basis and each insured is issued an individual policy.

Disability Benefit for On-the-Job Injury Rider Form A57550 pays benefits for disabilities occurring On-the-Job only.

Additional Units of Disability Benefit Rider Form A57551 pays additional amounts of benefits for Sickness or On-the-Job Injury. The additional amounts will reflect the same elimination and benefit periods as those for the policy.

Payroll Application Form A575PAPP will be used to make application for the policies and the optional rider forms on a payroll deduction basis.

Union Application Form A575UAPP will be used to make application for the policies and the optional rider forms on a union basis.

Brackets are included around the "Check Coverage Desired" section in Application Forms A575PAPP and A575UAPP to allow us to change the coverage offered if needed. For example, if one of our accounts requests a specific "coverage package" we would be able to adjust the coverage desired section to accommodate their requests.

Forms A575PAPP and A575UAPP, Auwall, and AsigncAR or AsignAR will be used in conjunction with each other to apply for the policies. Forms A575PAPP and A575UAPP will be used to collect the personal information and select the type of coverage desired. Form Auwall will be used to answer the underwriting questions. Since this form will be used with multiple products, additional underwriting may be added as Aflac develops new products. When the application prints and is attached to the policy at the time of issue, only the underwriting questions for the desired coverage will print. We will not change any of the underwriting questions without refiling the form. Form AsigncAR or AsignAR will be used to collect the applicant's and agent's signature. These forms differ in that Form AsigncAR contains an agent's certification statement. Form AsignAR does NOT contain the agent's certification statement and will be used in situations where the associate/agent is unable to be present at the time of application.

Reinstatement Application Form A57503AR will be used to apply for reinstatement of policies that have lapsed for non-payment of premium.

Replacement Notice Form A-57015, previously approved with Policy Form A-57000-AR on August 2, 1994, will be used with Policy Form A57500AR and Policy Form A57500LBAR. This form will be completed in duplicate if the applicant intends to replace existing insurance with our policy. The duplicate will be left with the applicant and the original returned to us with the application.

Outline of Coverage Forms A57525AR or A57525LBAR will be given to the applicant at the time of application and are self-explanatory. Outline of Coverage Form A57525AR will be used with Policy Form A57500AR and Outline of Coverage Form A57525LBAR will be used with Policy Form A57500LBAR.

I certify that the forms submitted herewith meet the applicable provisions of Rule and Regulation 18 of the Arkansas Insurance Department Regulations as well as meeting the applicable requirements of Arkansas Insurance Department.

I certify the following form complies with the requirements of Rule and Regulation 49 of the Arkansas Insurance Department Regulations, Life and Disability Guaranty Fund Notices.

I certify the following forms comply with the requirements of Arkansas Statute Annotated Sections 23-80-201 through 23-80-208, cited as the Life and Disability Insurance Policy Language Simplification Act.

I certify that the enclosed forms meet the minimum reading ease score for the FLESch test. I further certify the scores for each form are as follows:

	<u>FLESch Score</u>	<u>Grade Level</u>
Short Term Disability Policy Form A57500AR	50.044	10
Limited Benefit Short-Term Disability Policy Form A57500LBAR	50.044	10
On-the-Job Disability Benefit Rider Form A57550	87.725	3
Additional Units Disability Benefit Rider Form A57551	84.766	4
Payroll Application Form A575PAPP	103.815	1
Signature Form AssignAR	66.891	7
Signature Form AssigncAR	74.25	4
Union Application Form A575UAPP	61.768	7
Reinstatement Application Form A57503AR	72.013	5
Underwriting Application Form Auwall	85.648	2
Outline of Coverage Form A57525AR	50.495	10
Outline of Coverage Form A57525LBAR	53.853	10

An actuarial memorandum and rate sheets are enclosed for your review and approval. The appropriate filing fee and/or certification form are also included.

Aflac reserves the right to alter the format of the forms without refiling due to future technology changes, i.e. paper size, font, font type, line ending or page ending changes. Be assured that any minimum font-size requirements will be met. Any changes to wording or content would be filed for prior approval. We have included brackets in all forms around the address, telephone number, web site, and officer signatures in the event these change in the future. We also reserve the right to use these forms in an electronic format, but Aflac certifies we will retain the filed final print format.

This filing has been prepared by Connie Gates. Should you have any questions or comments concerning this submission, please do not hesitate to call her collect at (706) 596-5048, by fax at (706) 660-7080 or email at cgates@aflac.com.

Sincerely,



Deborah T. Grantham
DTG/CG/cg
Enclosures

American Family Life Assurance Company of Columbus (Aflac)
[Worldwide Headquarters, 1932 Wynnton Road
Columbus, Georgia 31999
TOLL-FREE 1-800-99-AFLAC (1-800-992-3522)]

SHORT-TERM DISABILITY COVERAGE
Outline of Coverage for Policy Series A57500

THIS IS NOT A MEDICARE SUPPLEMENT POLICY.

If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from Aflac.

- 1. Read Your Policy Carefully.** This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and Aflac. It is, therefore, important that you **READ YOUR POLICY CAREFULLY!**
- 2. Short-Term Disability Coverage** is designed to provide, to persons insured, coverage for disabilities resulting from a covered accident or sickness, subject to any limitations set forth in the policy. Coverage is not provided for basic hospital, basic medical-surgical or major medical expenses.
- 3. Benefits.** The following benefits are a part of the policy.

Aflac will pay the following benefits, as applicable, if your Disability is caused by a covered Sickness or covered Off-the-Job Injury and occurs while this coverage is in force. All benefits are subject to the Limitations and Exclusions, Pre-existing Condition Limitations, and other policy terms.

Disability due to pregnancy and childbirth is payable to the same extent as a covered Sickness. Disability benefits for childbirth will only be payable after this policy has been in force ten months. The maximum Benefit Period allowed for childbirth is six weeks for noncesarean delivery and eight weeks for cesarean delivery, less the Elimination Period, unless you furnish proof that your Disability continues beyond these time frames.

Benefits will be paid for only one Disability at a time even if the Disability is caused by more than one Sickness, more than one Injury, or a Sickness and an Injury. **We reserve the right to meet with you during the pendency of a claim or to use an independent consultant and Physician's statement to determine whether you are qualified to receive Disability benefits. You must be under the care and attendance of a Physician for these benefits to be payable. Benefits will cease on the date of your death.**

- A. TOTAL DISABILITY BENEFIT:** If you have a Full-Time Job at the time of your Sickness or Off-the-Job Injury, we will insure you as follows while coverage is in force:

If your covered Sickness or covered Off-the-Job Injury causes your Total Disability within 90 days of your last treatment for your covered Sickness or covered Off-the-Job Injury, we will pay you the Daily Disability Benefit for each day of your Disability or your Successive Periods of Disability. This benefit is payable up to the Benefit Period you selected and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled "Term", and the definitions of "Benefit Period" and "Successive Periods of Disability."

You will no longer be qualified to receive this benefit upon the earlier of your: (1) being released by your Physician to perform the material and substantial duties of your Full-Time Job or (2) working at any job.

B. PARTIAL DISABILITY BENEFIT: If you have a Full-Time Job at the time of your Sickness or Off-the-Job Injury, we will insure you as follows while coverage is in force:

If your covered Sickness or covered Off-the-Job Injury causes your Partial Disability within 90 days of your last treatment for your covered Sickness or covered Off-the-Job Injury, we will pay you the Daily Disability Benefit for each day of your Disability or your Successive Periods of Disability. This benefit is payable up to the Benefit Period you selected and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled "Term", and the definitions of "Benefit Period" and "Successive Periods of Disability."

You will no longer be qualified to receive this benefit upon the earlier of your: (1) being released by your Physician to perform the material and substantial duties of your Full-Time Job or (2) working at any job earning 80 percent or more of your pre-Disability Base Pay Earnings.

C. TRANSITIONAL DISABILITY BENEFIT: If you do not have a Full-Time Job at the time of your Sickness or Off-the-Job Injury, we will insure you as follows while coverage is in force:

If your covered Sickness or covered Off-the-Job Injury causes your Transitional Disability within 15 days of your last treatment for your covered Sickness or covered Off-the-Job Injury, we will pay you one-half of the Daily Disability Benefit for each day you remain unable to work at any job. This benefit is payable for a maximum period of three months of Disability or Successive Periods of Disability and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled "Term", and the definition of "Successive Periods of Disability."

You will no longer be qualified to receive this benefit upon the earlier of your: (1) being released by your Physician to perform the material and substantial duties of any job or (2) working at any job. **This benefit is limited to a lifetime maximum period of a total of three months, regardless of the number of Disabilities or the duration of any Disability.**

IF YOU HAVE ANY OTHER DISABILITY BENEFIT IN FORCE WITH US, ONLY ONE DISABILITY BENEFIT IS PAYABLE.

PRE-EXISTING CONDITION LIMITATIONS: A Pre-existing Condition is an illness, disease, infection, disorder, or injury for which, within the 12-month period before the Effective Date of coverage, medical advice, consultation, or treatment was recommended or received, or for which symptoms existed that would ordinarily cause a prudent person to seek diagnosis, care, or treatment. Disability caused by a Pre-existing Condition or reinjuries to a Pre-existing Condition will not be covered unless it begins more than 12 months after the Effective Date of coverage.

4. OPTIONAL BENEFITS:

Disability Benefit for On-the-Job Injury Rider: (Series A57550) Applied For: Yes No

Aflac will pay the following benefits, as applicable, if your Disability is caused by a covered On-the-Job Injury and occurs while this coverage is in force. All benefits are subject to the Limitations and Exclusions, Pre-existing Condition Limitations, and other policy terms.

Benefits will be paid for only one Disability at a time even if the Disability is caused by more than one Injury. **We reserve the right to meet with you during the pendency of a claim or to use an independent consultant and Physician's statement to determine whether you are qualified to receive Disability benefits. You must be under the care and attendance of a Physician for these benefits to be payable. Benefits will cease on the date of your death.**

A. TOTAL DISABILITY BENEFIT: If you have a Full-Time Job at the time of your On-the-Job Injury, we will insure you as follows while coverage is in force:

If your covered On-the-Job Injury causes your Total Disability within 90 days of your last treatment for your covered On-the-Job Injury, we will pay you the Daily Disability Benefit for the On-the-Job Injury Disability Rider for each day of your Disability or your Successive Periods of Disability. This benefit is payable up to the Benefit Period you selected and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled "Term", and the definitions of "Benefit Period" and "Successive Periods of Disability."

You will no longer be qualified to receive this benefit upon the earlier of your: (1) being released by your Physician to perform the material and substantial duties of your Full-Time Job or (2) working at any job.

B. PARTIAL DISABILITY BENEFIT: If you have a Full-Time Job at the time of your On-the-Job Injury, we will insure you as follows while coverage is in force:

If your covered On-the-Job Injury causes your Partial Disability within 90 days of your last treatment for your covered On-the-Job Injury, we will pay you the Daily Disability Benefit for the On-the-Job Injury Disability Rider for each day of your Disability or your Successive Periods of Disability. This benefit is payable up to the Benefit Period you selected and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled "Term", and the definitions of "Benefit Period" and "Successive Periods of Disability."

You will no longer be qualified to receive this benefit upon the earlier of your: (1) being released by your Physician to perform the material and substantial duties of your Full-Time Job or (2) working at any job earning 80 percent or more of your pre-Disability Base Pay Earnings.

C. TRANSITIONAL DISABILITY BENEFIT: If you do not have a Full-Time Job at the time of your On-the-Job Injury, we will insure you as follows while coverage is in force:

If your covered On-the-Job Injury causes your Transitional Disability within 15 days of your last treatment for your covered On-the-Job Injury, we will pay you one-half of the Daily Disability Benefit for the On-the-Job Injury Disability Rider for each day you remain unable to work at any job. This benefit is payable for a maximum period of three months of Disability or Successive Periods of Disability and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled "Term", and the definition of "Successive Periods of Disability."

You will no longer be qualified to receive this benefit upon the earlier of your: (1) being released by your Physician to perform the material and substantial duties of any job or (2) working at any job. **This benefit is limited to a lifetime maximum period of a total of three months, regardless of the number of Disabilities or the duration of any Disability.**

IF YOU HAVE ANY OTHER DISABILITY BENEFIT IN FORCE WITH US, ONLY ONE DISABILITY BENEFIT IS PAYABLE.

Additional Units of Disability Benefit Rider: (Series A57551) Applied For: Yes No

Aflac will pay the following benefits, as applicable, if your Disability is caused by a covered Sickness or covered Off-the-Job Injury and occurs while this coverage is in force. All benefits are subject to the Limitations and Exclusions, Pre-existing Condition Limitations, and other policy terms.

Disability due to pregnancy and childbirth is payable to the same extent as a covered Sickness. Disability benefits for childbirth will only be payable after this rider has been in force ten months. The maximum Benefit Period allowed for childbirth is six weeks for noncesarean delivery and eight weeks for cesarean delivery, less the Elimination Period, unless you furnish proof that your Disability continues beyond these time frames.

Benefits will be paid for only one Disability at a time even if the Disability is caused by more than one Sickness, more than one Injury, or a Sickness and an Injury. **We reserve the right to meet with you during the pendency of a claim or to use an independent consultant and Physician's statement to determine whether you are qualified to receive Disability benefits. You must be under the care and attendance of a Physician for these benefits to be payable. Benefits will cease on the date of your death.**

This benefit will be paid under the same terms as the applicable Total Disability Benefit, Partial Disability Benefit, or Transitional Disability Benefit as described in your policy. The additional units of coverage will only be payable for a Disability that begins after the Effective Date of this rider.

A. TOTAL DISABILITY BENEFIT: If you have a Full-Time Job at the time of your Sickness or Off-the-Job Injury, we will insure you as follows while coverage is in force:

If your covered Sickness or covered Off-the-Job Injury causes your Total Disability within 90 days of your last treatment for your covered Sickness or covered Off-the-Job Injury, we will pay you the Daily Disability Benefit for the Additional Units of Disability Benefit Rider for each day of your Disability or your Successive Periods of Disability. This benefit is payable up to the Benefit Period you selected and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled "Term", and the definitions of "Benefit Period" and "Successive Periods of Disability."

You will no longer be qualified to receive this benefit upon the earlier of your: (1) being released by your Physician to perform the material and substantial duties of your Full-Time Job or (2) working at any job.

B. PARTIAL DISABILITY BENEFIT: If you have a Full-Time Job at the time of your Sickness or Off-the-Job Injury, we will insure you as follows while coverage is in force:

If your covered Sickness or covered Off-the-Job Injury causes your Partial Disability within 90 days of your last treatment for your covered Sickness or covered Off-the-Job Injury, we will pay you the Daily Disability Benefit for the Additional Units of Disability Benefit Rider for each day of your Disability or your Successive Periods of Disability. This benefit is payable up to the Benefit Period you selected and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled "Term", and the definitions of "Benefit Period" and "Successive Periods of Disability."

You will no longer be qualified to receive this benefit upon the earlier of your: (1) being released by your Physician to perform the material and substantial duties of your Full-Time Job or (2) working at any job earning 80 percent or more of your pre-Disability Base Pay Earnings.

- C. TRANSITIONAL DISABILITY BENEFIT:** If you do not have a Full-Time Job at the time of your Sickness or Off-the-Job Injury, we will insure you as follows while coverage is in force:

If your covered Sickness or covered Off-the-Job Injury causes your Transitional Disability within 15 days of your last treatment for your covered Sickness or covered Off-the-Job Injury, we will pay you one-half of the Daily Disability Benefit for the Additional Units of Disability Benefit Rider for each day you remain unable to work at any job. This benefit is payable for a maximum period of three months of Disability or Successive Periods of Disability and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled "Term", and the definition of "Successive Periods of Disability."

You will no longer be qualified to receive this benefit upon the earlier of your: (1) being released by your Physician to perform the material and substantial duties of any job or (2) working at any job. **This benefit is limited to a lifetime maximum period of a total of three months, regardless of the number of Disabilities or the duration of any Disability.**

IMPORTANT PROVISIONS OF YOUR POLICY

LIMITATIONS AND EXCLUSIONS.

- A.** Disability caused by a Pre-existing Condition or reinjuries to a Pre-existing Condition will not be covered unless it begins more than 12 months after the Effective Date of coverage.
- B.** Aflac will not pay benefits for a Disability that is being treated outside the territorial limits of the United States.
- C.** Aflac will not pay benefits whenever coverage provided by this policy is in violation of any U.S. economic or trade sanctions. If the coverage violates U.S. economic or trade sanctions, such coverage shall be null and void.
- D.** Aflac will not pay benefits for a Disability that is caused by or occurs as a result of any bacterial, viral, or microorganism infection or infestation or any condition resulting from insect, arachnid, or other arthropod bites or stings as a Disability due to an Injury; such disability will be covered to the same extent as a Disability due to Sickness.
- E. Aflac will not pay benefits for a disability that is caused by or occurs as a result of your:**
1. Pregnancy or childbirth within the first ten months of the Effective Date of coverage. (Complications of Pregnancy will be covered to the same extent as a Sickness);
 2. Using any drug, narcotic, hallucinogen, or chemical substance (unless administered by a Physician and taken according to the Physician's instructions), or voluntarily taking any kind of poison or inhaling any kind of gas or fumes;
 3. Participating in any activity or event, including the operation of a vehicle, while under the influence of a controlled substance (unless administered by a Physician and taken according to the Physician's instructions) or while intoxicated ("intoxicated" means that condition as defined by the law of the jurisdiction in which the accident occurred);

4. Participating in, or attempting to participate in, an illegal activity that is defined as a felony, whether charged or not (“felony” is as defined by the law of the jurisdiction in which the activity takes place); or being incarcerated in any type penal institution;
5. Intentionally self-inflicting a bodily injury or committing or attempting suicide, while sane or insane;
6. Having cosmetic surgery or other elective procedures that are not Medically Necessary;
7. Having dental treatment except as a result of Injury;
8. Being exposed to war or any act of war, declared or undeclared;
9. Actively serving in any of the armed forces, or units auxiliary thereto, including the National Guard or Reserve;
10. Donating an organ within the first 12 months of the Effective Date of this policy; or
11. Mental or emotional disorders, including but not limited to the following: bipolar affective disorder (manic-depressive syndrome), delusional (paranoid) disorders, psychotic disorders, somatoform disorders (psychosomatic illness), eating disorders, schizophrenia, anxiety disorders, depression, stress or post-partum depression. This policy will pay, however, for covered disabilities resulting from Alzheimer’s disease, or similar forms of senility or senile dementia, first manifested while coverage is in force.

Benefits will be paid for only one Disability at a time even if the Disability is caused by more than one Sickness, more than one Injury, or a Sickness and an Injury.

Renewability. The Policy is guaranteed renewable to age 70 by payment of the premium in effect at the beginning of each renewal period. Premium rates may be changed only if changed on all policies of the same form number and class in force in your state.

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

American Family Life Assurance Company of Columbus (Aflac)
[Worldwide Headquarters, 1932 Wynnton Road
Columbus, Georgia 31999
TOLL-FREE 1-800-99-AFLAC (1-800-992-3522)]

LIMITED BENEFIT HEALTH COVERAGE

SHORT-TERM DISABILITY COVERAGE
Outline of Coverage for Policy Series A57500LB

THIS IS NOT A MEDICARE SUPPLEMENT POLICY.

If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from Aflac.

- 1. Read Your Policy Carefully.** This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and Aflac. It is, therefore, important that you **READ YOUR POLICY CAREFULLY!**
- 2. Limited Benefit Health Coverage.** Policies of this category are designed to provide, to persons insured, limited or supplemental insurance coverage, subject to any limitations, deductibles or copayment requirements set forth in the policy.
- 3. Short-Term Disability Coverage** is designed to provide, to persons insured, coverage for disabilities resulting from a covered accident or sickness, subject to any limitations set forth in the policy. Coverage is not provided for basic hospital, basic medical-surgical or major medical expenses.
- 4. Benefits.** The following benefits are a part of the policy.

Aflac will pay the following benefits, as applicable, if your Disability is caused by a covered Sickness or covered Off-the-Job Injury and occurs while this coverage is in force. All benefits are subject to the Limitations and Exclusions, Pre-existing Condition Limitations, and other policy terms.

Disability due to pregnancy and childbirth is payable to the same extent as a covered Sickness. Disability benefits for childbirth will only be payable after this policy has been in force ten months. The maximum Benefit Period allowed for childbirth is six weeks for noncesarean delivery and eight weeks for cesarean delivery, less the Elimination Period, unless you furnish proof that your Disability continues beyond these time frames.

Benefits will be paid for only one Disability at a time even if the Disability is caused by more than one Sickness, more than one Injury, or a Sickness and an Injury. **We reserve the right to meet with you during the pendency of a claim or to use an independent consultant and Physician's statement to determine whether you are qualified to receive Disability benefits. You must be under the care and attendance of a Physician for these benefits to be payable. Benefits will cease on the date of your death.**

A. TOTAL DISABILITY BENEFIT: If you have a Full-Time Job at the time of your Sickness or Off-the-Job Injury, we will insure you as follows while coverage is in force:

If your covered Sickness or covered Off-the-Job Injury causes your Total Disability within 90 days of your last treatment for your covered Sickness or covered Off-the-Job Injury, we will pay you the

Daily Disability Benefit for each day of your Disability or your Successive Periods of Disability. This benefit is payable up to the Benefit Period you selected and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled "Term", and the definitions of "Benefit Period" and "Successive Periods of Disability."

You will no longer be qualified to receive this benefit upon the earlier of your: (1) being released by your Physician to perform the material and substantial duties of your Full-Time Job or (2) working at any job.

- B. PARTIAL DISABILITY BENEFIT:** If you have a Full-Time Job at the time of your Sickness or Off-the-Job Injury, we will insure you as follows while coverage is in force:

If your covered Sickness or covered Off-the-Job Injury causes your Partial Disability within 90 days of your last treatment for your covered Sickness or covered Off-the-Job Injury, we will pay you the Daily Disability Benefit for each day of your Disability or your Successive Periods of Disability. This benefit is payable up to the Benefit Period you selected and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled "Term", and the definitions of "Benefit Period" and "Successive Periods of Disability."

You will no longer be qualified to receive this benefit upon the earlier of your: (1) being released by your Physician to perform the material and substantial duties of your Full-Time Job or (2) working at any job earning 80 percent or more of your pre-Disability Base Pay Earnings.

- C. TRANSITIONAL DISABILITY BENEFIT:** If you do not have a Full-Time Job at the time of your Sickness or Off-the-Job Injury, we will insure you as follows while coverage is in force:

If your covered Sickness or covered Off-the-Job Injury causes your Transitional Disability within 15 days of your last treatment for your covered Sickness or covered Off-the-Job Injury, we will pay you one-half of the Daily Disability Benefit for each day you remain unable to work at any job. This benefit is payable for a maximum period of three months of Disability or Successive Periods of Disability and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled "Term", and the definition of "Successive Periods of Disability."

You will no longer be qualified to receive this benefit upon the earlier of your: (1) being released by your Physician to perform the material and substantial duties of any job or (2) working at any job. **This benefit is limited to a lifetime maximum period of a total of three months, regardless of the number of Disabilities or the duration of any Disability.**

IF YOU HAVE ANY OTHER DISABILITY BENEFIT IN FORCE WITH US, ONLY ONE DISABILITY BENEFIT IS PAYABLE.

PRE-EXISTING CONDITION LIMITATIONS: A Pre-existing Condition is an illness, disease, infection, disorder, or injury for which, within the 12-month period before the Effective Date of coverage, medical advice, consultation, or treatment was recommended or received, or for which symptoms existed that would ordinarily cause a prudent person to seek diagnosis, care, or treatment. Disability caused by a Pre-existing Condition or reinjuries to a Pre-existing Condition will not be covered unless it begins more than 12 months after the Effective Date of coverage.

5. OPTIONAL BENEFITS:

Disability Benefit for On-the-Job Injury Rider: (Series A57550) Applied For: Yes No

Aflac will pay the following benefits, as applicable, if your Disability is caused by a covered On-the-Job Injury and occurs while this coverage is in force. All benefits are subject to the Limitations and Exclusions, Pre-existing Condition Limitations, and other policy terms.

Benefits will be paid for only one Disability at a time even if the Disability is caused by more than one Injury. **We reserve the right to meet with you during the pendency of a claim or to use an independent consultant and Physician's statement to determine whether you are qualified to receive Disability benefits. You must be under the care and attendance of a Physician for these benefits to be payable. Benefits will cease on the date of your death.**

A. TOTAL DISABILITY BENEFIT: If you have a Full-Time Job at the time of your On-the-Job Injury, we will insure you as follows while coverage is in force:

If your covered On-the-Job Injury causes your Total Disability within 90 days of your last treatment for your covered On-the-Job Injury, we will pay you the Daily Disability Benefit for the On-the-Job Injury Disability Rider for each day of your Disability or your Successive Periods of Disability. This benefit is payable up to the Benefit Period you selected and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled "Term", and the definitions of "Benefit Period" and "Successive Periods of Disability."

You will no longer be qualified to receive this benefit upon the earlier of your: (1) being released by your Physician to perform the material and substantial duties of your Full-Time Job or (2) working at any job.

B. PARTIAL DISABILITY BENEFIT: If you have a Full-Time Job at the time of your On-the-Job Injury, we will insure you as follows while coverage is in force:

If your covered On-the-Job Injury causes your Partial Disability within 90 days of your last treatment for your covered On-the-Job Injury, we will pay you the Daily Disability Benefit for the On-the-Job Injury Disability Rider for each day of your Disability or your Successive Periods of Disability. This benefit is payable up to the Benefit Period you selected and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled "Term", and the definitions of "Benefit Period" and "Successive Periods of Disability."

You will no longer be qualified to receive this benefit upon the earlier of your: (1) being released by your Physician to perform the material and substantial duties of your Full-Time Job or (2) working at any job earning 80 percent or more of your pre-Disability Base Pay Earnings.

C. TRANSITIONAL DISABILITY BENEFIT: If you do not have a Full-Time Job at the time of your On-the-Job Injury, we will insure you as follows while coverage is in force:

If your covered On-the-Job Injury causes your Transitional Disability within 15 days of your last treatment for your covered On-the-Job Injury, we will pay you one-half of the Daily Disability Benefit for the On-the-Job Injury Disability Rider for each day you remain unable to work at any job. This benefit is payable for a maximum period of three months of Disability or Successive Periods of Disability and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled "Term", and the definition of "Successive Periods of Disability."

You will no longer be qualified to receive this benefit upon the earlier of your: (1) being released by your Physician to perform the material and substantial duties of any job or (2) working at any job. **This benefit is limited to a lifetime maximum period of a total of three months, regardless of the number of Disabilities or the duration of any Disability.**

IF YOU HAVE ANY OTHER DISABILITY BENEFIT IN FORCE WITH US, ONLY ONE DISABILITY BENEFIT IS PAYABLE.

Additional Units of Disability Benefit Rider: (Series A57551) Applied For: Yes No

Aflac will pay the following benefits, as applicable, if your Disability is caused by a covered Sickness or covered Off-the-Job Injury and occurs while this coverage is in force. All benefits are subject to the Limitations and Exclusions, Pre-existing Condition Limitations, and other policy terms.

Disability due to pregnancy and childbirth is payable to the same extent as a covered Sickness. Disability benefits for childbirth will only be payable after this rider has been in force ten months. The maximum Benefit Period allowed for childbirth is six weeks for noncesarean delivery and eight weeks for cesarean delivery, less the Elimination Period, unless you furnish proof that your Disability continues beyond these time frames.

Benefits will be paid for only one Disability at a time even if the Disability is caused by more than one Sickness, more than one Injury, or a Sickness and an Injury. **We reserve the right to meet with you during the pendency of a claim or to use an independent consultant and Physician's statement to determine whether you are qualified to receive Disability benefits. You must be under the care and attendance of a Physician for these benefits to be payable. Benefits will cease on the date of your death.**

This benefit will be paid under the same terms as the applicable Total Disability Benefit, Partial Disability Benefit, or Transitional Disability Benefit as described in your policy. The additional units of coverage will only be payable for a Disability that begins after the Effective Date of this rider.

A. TOTAL DISABILITY BENEFIT: If you have a Full-Time Job at the time of your Sickness or Off-the-Job Injury, we will insure you as follows while coverage is in force:

If your covered Sickness or covered Off-the-Job Injury causes your Total Disability within 90 days of your last treatment for your covered Sickness or covered Off-the-Job Injury, we will pay you the Daily Disability Benefit for the Additional Units of Disability Benefit Rider for each day of your Disability or your Successive Periods of Disability. This benefit is payable up to the Benefit Period you selected and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled "Term", and the definitions of "Benefit Period" and "Successive Periods of Disability."

You will no longer be qualified to receive this benefit upon the earlier of your: (1) being released by your Physician to perform the material and substantial duties of your Full-Time Job or (2) working at any job.

B. PARTIAL DISABILITY BENEFIT: If you have a Full-Time Job at the time of your Sickness or Off-the-Job Injury, we will insure you as follows while coverage is in force:

If your covered Sickness or covered Off-the-Job Injury causes your Partial Disability within 90 days of your last treatment for your covered Sickness or covered Off-the-Job Injury, we will pay you the Daily Disability Benefit for the Additional Units of Disability Benefit Rider for each day of your Disability or your Successive Periods of Disability. This benefit is payable up to the Benefit Period

you selected and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled "Term", and the definitions of "Benefit Period" and "Successive Periods of Disability."

You will no longer be qualified to receive this benefit upon the earlier of your: (1) being released by your Physician to perform the material and substantial duties of your Full-Time Job or (2) working at any job earning 80 percent or more of your pre-Disability Base Pay Earnings.

- C. TRANSITIONAL DISABILITY BENEFIT:** If you do not have a Full-Time Job at the time of your Sickness or Off-the-Job Injury, we will insure you as follows while coverage is in force:

If your covered Sickness or covered Off-the-Job Injury causes your Transitional Disability within 15 days of your last treatment for your covered Sickness or covered Off-the-Job Injury, we will pay you one-half of the Daily Disability Benefit for the Additional Units of Disability Benefit Rider for each day you remain unable to work at any job. This benefit is payable for a maximum period of three months of Disability or Successive Periods of Disability and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled "Term", and the definition of "Successive Periods of Disability."

You will no longer be qualified to receive this benefit upon the earlier of your: (1) being released by your Physician to perform the material and substantial duties of any job or (2) working at any job. **This benefit is limited to a lifetime maximum period of a total of three months, regardless of the number of Disabilities or the duration of any Disability.**

IMPORTANT PROVISIONS OF YOUR POLICY

LIMITATIONS AND EXCLUSIONS.

- A. Disability caused by a Pre-existing Condition or reinjuries to a Pre-existing Condition will not be covered unless it begins more than 12 months after the Effective Date of coverage.
- B. Aflac will not pay benefits for a Disability that is being treated outside the territorial limits of the United States.
- C. Aflac will not pay benefits whenever coverage provided by this policy is in violation of any U.S. economic or trade sanctions. If the coverage violates U.S. economic or trade sanctions, such coverage shall be null and void.
- D. Aflac will not pay benefits for a Disability that is caused by or occurs as a result of any bacterial, viral, or microorganism infection or infestation or any condition resulting from insect, arachnid, or other arthropod bites or stings as a Disability due to an Injury; such disability will be covered to the same extent as a Disability due to Sickness.
- E. **Aflac will not pay benefits for a disability that is caused by or occurs as a result of your:**
 - 1. Pregnancy or childbirth within the first ten months of the Effective Date of coverage. (Complications of Pregnancy will be covered to the same extent as a Sickness);
 - 2. Using any drug, narcotic, hallucinogen, or chemical substance (unless administered by a Physician and taken according to the Physician's instructions), or voluntarily taking any kind of poison or inhaling any kind of gas or fumes;

3. Participating in any activity or event, including the operation of a vehicle, while under the influence of a controlled substance (unless administered by a Physician and taken according to the Physician's instructions) or while intoxicated ("intoxicated" means that condition as defined by the law of the jurisdiction in which the accident occurred);
4. Participating in, or attempting to participate in, an illegal activity that is defined as a felony, whether charged or not ("felony" is as defined by the law of the jurisdiction in which the activity takes place); or being incarcerated in any type penal institution;
5. Intentionally self-inflicting a bodily injury or committing or attempting suicide, while sane or insane;
6. Having cosmetic surgery or other elective procedures that are not Medically Necessary;
7. Having dental treatment except as a result of Injury;
8. Being exposed to war or any act of war, declared or undeclared;
9. Actively serving in any of the armed forces, or units auxiliary thereto, including the National Guard or Reserve;
10. Donating an organ within the first 12 months of the Effective Date of this policy; or
11. Mental or emotional disorders, including but not limited to the following: bipolar affective disorder (manic-depressive syndrome), delusional (paranoid) disorders, psychotic disorders, somatoform disorders (psychosomatic illness), eating disorders, schizophrenia, anxiety disorders, depression, stress or post-partum depression. This policy will pay, however, for covered disabilities resulting from Alzheimer's disease, or similar forms of senility or senile dementia, first manifested while coverage is in force.

Benefits will be paid for only one Disability at a time even if the Disability is caused by more than one Sickness, more than one Injury, or a Sickness and an Injury.

Renewability. The Policy is guaranteed renewable to age 70 by payment of the premium in effect at the beginning of each renewal period. Premium rates may be changed only if changed on all policies of the same form number and class in force in your state.

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