

SERFF Tracking Number: AFLA-126031425 State: Arkansas
Filing Company: American Family Life Assurance Company of Columbus State Tracking Number: 41497
Company Tracking Number: ASIGNARR
TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other
Product Name: Signature form
Project Name/Number: Signature Forms/AssignARR

Filing at a Glance

Company: American Family Life Assurance Company of Columbus

Product Name: Signature form	SERFF Tr Num: AFLA-126031425	State: ArkansasLH
TOI: H21 Health - Other	SERFF Status: Closed	State Tr Num: 41497
Sub-TOI: H21.000 Health - Other	Co Tr Num: ASIGNARR	State Status: Approved-Closed
Filing Type: Form	Co Status:	Reviewer(s): Rosalind Minor
	Author: Connie Gates	Disposition Date: 02/12/2009
	Date Submitted: 02/11/2009	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name: Signature Forms	Status of Filing in Domicile: Authorized
Project Number: AssignARR	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: 02/12/2009	Explanation for Other Group Market Type:
	State Status Changed: 02/12/2009
Deemer Date:	Corresponding Filing Tracking Number:
Filing Description:	

Please note Signature Forms AssignAR and AssigncAR forms are being replaced. It is necessary to arrange the consumer information at the bottom of the form to be consistent with the layout previously agreed upon by your department and ours. This clarifies to the applicant who to make checks payable to and where to mail checks.

AssignARR replaces AssignAR

AssigncARR replaces AssigncAR

SERFF Tracking Number: AFLA-126031425 State: Arkansas
Filing Company: American Family Life Assurance Company of Columbus State Tracking Number: 41497
Company Tracking Number: ASIGNARR
TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other
Product Name: Signature form
Project Name/Number: Signature Forms/AssignARR

The Signature Forms were previously approved with:

SERFF Filing AFLA-125900873 (A57500 series) on 02/02/2009
SERFF Filing AFLA-125856287 (A72000 series) on 02/02/2009
SERFF Filing AFLA-125970924 (A35000 series) on 01/30/2009

Per Rosalind Minor, on February 11, 2009, there is no fee with this filing.

Form AssigncARR or AssignARR will be used to collect the applicant's and agent's signature. These forms differ in that Form AssigncARR contains an agent's certification statement. Form AssignARR 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.

Company and Contact

Filing Contact Information

Connie Gates, Policy Analyst c gates@aflac.com
1932 Wynnton Road (706) 596-5048 [Phone]
Columbus, GA 31999 (706) 660-7080[FAX]

Filing Company Information

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

Filing Fees

Fee Required? No
Retaliatory? No
Fee Explanation:

SERFF Tracking Number: AFLA-126031425 State: Arkansas
Filing Company: American Family Life Assurance Company of Columbus State Tracking Number: 41497
Company Tracking Number: ASIGNARR
TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other
Product Name: Signature form
Project Name/Number: Signature Forms/AsignARR

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
American Family Life Assurance Company of Columbus	\$0.00	02/11/2009	

SERFF Tracking Number: AFLA-126031425 State: Arkansas
Filing Company: American Family Life Assurance Company of Columbus State Tracking Number: 41497
Company Tracking Number: ASIGNARR
TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other
Product Name: Signature form
Project Name/Number: Signature Forms/AsignARR

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	02/12/2009	02/12/2009

SERFF Tracking Number: AFLA-126031425 State: Arkansas
Filing Company: American Family Life Assurance Company of Columbus State Tracking Number: 41497
Company Tracking Number: ASIGNARR
TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other
Product Name: Signature form
Project Name/Number: Signature Forms/AsignARR

Disposition

Disposition Date: 02/12/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: AFLA-126031425 State: Arkansas
 Filing Company: American Family Life Assurance Company of Columbus State Tracking Number: 41497
 Company Tracking Number: ASIGNARR
 TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other
 Product Name: Signature form
 Project Name/Number: Signature Forms/AsignARR

Item Type	Item Name	Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	No
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Form	Signature Form	Approved-Closed	Yes
Form	Signature Form	Approved-Closed	Yes

SERFF Tracking Number: AFLA-126031425 State: Arkansas
 Filing Company: American Family Life Assurance Company of Columbus State Tracking Number: 41497
 Company Tracking Number: ASIGNARR
 TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other
 Product Name: Signature form
 Project Name/Number: Signature Forms/AsignARR

Form Schedule

Lead Form Number: AsignARR

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	AsignARR	Application/Signature Form Enrollment Form		Initial		67	AsignARR.pdf
Approved-Closed	AsigncARR	Application/Signature Form Enrollment Form		Initial		74	AsigncARR.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 _____

**MAKE CHECK OR MONEY ORDER PAYABLE TO AFLAC.
AMERICAN FAMILY LIFE ASSURANCE COMPANY OF COLUMBUS (AFLAC),
CLIENT SERVICES AND ADMINISTRATION,
[WORLDWIDE HEADQUARTERS • 1932 WYNNTON ROAD • COLUMBUS, GEORGIA 31999.]
[FOR INFORMATION, CALL TOLL-FREE 1-800-99-AFLAC (1-800-992-3522).
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.**

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

**MAKE CHECK OR MONEY ORDER PAYABLE TO AFLAC.
AMERICAN FAMILY LIFE ASSURANCE COMPANY OF COLUMBUS (AFLAC),
CLIENT SERVICES AND ADMINISTRATION,
[WORLDWIDE HEADQUARTERS • 1932 WYNNTON ROAD • COLUMBUS, GEORGIA 31999.]
[FOR INFORMATION, CALL TOLL-FREE 1-800-99-AFLAC (1-800-992-3522).
VISIT OUR WEB SITE AT AFLAC.COM.]**

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

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.**

SERFF Tracking Number: AFLA-126031425 State: Arkansas
Filing Company: American Family Life Assurance Company of Columbus State Tracking Number: 41497
Company Tracking Number: ASIGNARR
TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other
Product Name: Signature form
Project Name/Number: Signature Forms/AssignARR

Supporting Document Schedules

Review Status:
Bypassed -Name: Flesch Certification Approved-Closed 02/12/2009
Bypass Reason: 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.

Comments:

Review Status:
Satisfied -Name: Application Approved-Closed 02/12/2009
Comments:
AssignARR replaces AssignAR
AssigncARR replaces AssigncAR

The Signature Forms were previously approved with:

SERFF Filing AFLA-125900873 (A57500 series) on 02/02/2009
SERFF Filing AFLA-125856287 (A72000 series) on 02/02/2009
SERFF Filing AFLA-125970924 (A35000 series) on 01/30/2009

The previously approved forms and the redlined compares are attached.

Attachments:

AssignAR.pdf
AssignARR CMP 02 11 2009.pdf
AssigncAR.pdf
AssigncARR CMP 02 11 2009.pdf

SERFF Tracking Number: AFLA-126031425 State: Arkansas
Filing Company: American Family Life Assurance Company of Columbus State Tracking Number: 41497
Company Tracking Number: ASIGNARR
TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other
Product Name: Signature form
Project Name/Number: Signature Forms/AssignARR

Bypassed -Name: Health - Actuarial Justification **Review Status:** Approved-Closed 02/12/2009
Bypass Reason: Actuarial Memorandum and Rates remain the same.
Comments:

Bypassed -Name: Outline of Coverage **Review Status:** Approved-Closed 02/12/2009
Bypass Reason: The previously approved Outline of Coverage forms remain the same.
Comments:

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 | | |

- 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 _____

MAKE CHECK OR MONEY ORDER PAYABLE TO AFLAC.

~~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.]
[FOR INFORMATION, CALL TOLL-FREE 1-800-99-AFLAC (1-800-992-3522).
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.**

~~**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.]**~~

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.]**

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

MAKE CHECK OR MONEY ORDER PAYABLE TO AFLAC.

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.]
[FOR INFORMATION, CALL TOLL-FREE 1-800-99-AFLAC (1-800-992-3522).
VISIT OUR WEB SITE AT AFLAC.COM.]**

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

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.]