

SERFF Tracking Number: AFLA-126197800 State: Arkansas  
Filing Company: American Family Life Assurance Company of Columbus State Tracking Number: 42769  
Company Tracking Number:  
TOI: H071 Individual Health - Specified Disease - Limited Benefit Sub-TOI: H071.001 Critical Illness  
Product Name: Lump Sum Critical Illness  
Project Name/Number: /

## Filing at a Glance

Company: American Family Life Assurance Company of Columbus

Product Name: Lump Sum Critical Illness SERFF Tr Num: AFLA-126197800 State: ArkansasLH

TOI: H071 Individual Health - Specified Disease SERFF Status: Closed State Tr Num: 42769

- Limited Benefit

Sub-TOI: H071.001 Critical Illness

Co Tr Num:

State Status: Approved-Closed

Filing Type: Form

Co Status:

Reviewer(s): Rosalind Minor

Author: Connie Gates

Disposition Date: 06/30/2009

Date Submitted: 06/25/2009

Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

## General Information

Project Name:

Status of Filing in Domicile: Authorized

Project Number:

Date Approved in Domicile: 06/16/2009

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: 06/30/2009

Explanation for Other Group Market Type:

State Status Changed: 06/30/2009

Deemer Date:

Corresponding Filing Tracking Number:

Filing Description:

RE: Lump Sum Critical Illness Underwriting Application Forms LSCIR and LSCIGR and Request for

Additions/Application for Reinstatement Forms A72003RAR and A72003GRAR.

Referenced forms are submitted for your review and approval. Similar versions of these forms were approved by your

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department on February 2, 2009. Nebraska, our state of domicile, has approved similar versions of these forms on June 16, 2009.

The forms have been revised in order to improve and provide consistency in our underwriting by changing the following underwriting question as reflected below:

From:

During the last 6 months, have you received any medical treatment, including injections, or been prescribed or taken medications (other than prescription contraceptives)?  
If yes, please provide descriptive information below.

To:

During the last 6 months, has anyone to be covered received any medical treatment, including injections, or been prescribed or taken medications (other than prescription contraceptives)?  
If yes, please provide descriptive information below.

A column for the individual's Name has also been added to the descriptive information boxes below the question.

Underwriting Forms LSCIR and LSCIGR will be used in conjunction with Application Forms A72PAPPAR, A72GAPPAR and A72UAPPAR and Signature Forms AssigncARR and AssignARR, which were previously approved by your department on February 2, 2009. When the final application prints and is attached to the policy at the time of issue, the application form, the underwriting form, and a signature page will be combined to reflect a complete application.

Reinstatement Application Forms A72003RAR and A72003GRAR will be used to reinstate a lapsed policy. Form A72003RAR will be used for reinstatement of policies on a payroll or union basis and Form A72003GRAR will be used to reinstate a lapsed policy on a large account.

I certify that the forms submitted herewith meet the applicable provisions of Rule and Regulation 18 of the Arkansas

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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.

This is to certify that 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
Underwriting Application Form LSCIR 64.983	6
Underwriting Application Form LSCIGR 73.386	6
Reinstatement Application Form A72003RAR 75.695	4
Reinstatement Application Form A72003GRAR 71.189	5

The rates and actuarial memo remain the same. The appropriate filing fee is included as an EFT and fee certification form is attached under the supporting documentation tab.

Aflac reserves the right to alter the format of the forms without re-filing 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](mailto:cgates@aflac.com).

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## Company and Contact

### Filing Contact Information

Connie Gates, Policy Analyst cgates@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  
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## Filing Fees

Fee Required? Yes  
 Fee Amount: \$80.00  
 Retaliatory? No  
 Fee Explanation:  
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
American Family Life Assurance Company of Columbus	\$80.00	06/25/2009	28814882

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	06/30/2009	06/30/2009

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## Disposition

Disposition Date: 06/30/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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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	Yes
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	Fee Certification	Approved-Closed	Yes
Form	Payroll Underwriting Application	Approved-Closed	Yes
Form	Large Account Underwriting Application	Approved-Closed	Yes
Form	REQUEST FOR ADDITIONS/APPLICATION FOR REINSTATEMENT	Approved-Closed	Yes
Form	REQUEST FOR ADDITIONS/APPLICATION FOR REINSTATEMENT - LARGE ACCOUNTS	Approved-Closed	Yes

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## Form Schedule

### Lead Form Number:

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	LSCIR	Application/ Enrollment Form	Payroll Underwriting Application	Revised	Replaced Form #: LSCI Previous Filing #: AFLA-125856287 State Tr# 40777	65	LSCIR.pdf
Approved-Closed	LSCIGR	Application/ Enrollment Form	Large Account Underwriting Application	Revised	Replaced Form #: LSCIG Previous Filing #: AFLA-125856287 State Tr# 40777	73	LSCIGR.pdf
Approved-Closed	A72003RA R	Application/ Enrollment Form	REQUEST FOR ADDITIONS/APPLICATION FOR REINSTATEMENT	Revised	Replaced Form #: A72003AR Previous Filing #: AFLA-125856287 State Tr# 40777	76	A72003RAR.pdf
Approved-Closed	A72003GR AR	Application/ Enrollment Form	REQUEST FOR ADDITIONS/APPLICATION FOR REINSTATEMENT - LARGE ACCOUNTS	Revised	Replaced Form #: A72003GAR Previous Filing #: AFLA-125856287 State Tr# 40777	71	A72003GRAR.pdf

**PAYROLL –  LUMP SUM CRITICAL ILLNESS**

**PLEASE COMPLETE THE FOLLOWING QUESTIONS  
IF YOU ARE APPLYING FOR THE LUMP SUM CRITICAL ILLNESS POLICY**

1. Has anyone to be covered used tobacco products or products containing nicotine of any type in the last 12 months?  Yes  No  
If yes, you are eligible to apply for a maximum of \$20,000 (4 units) of coverage. This information will be verified at the time of claim.
2. 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  
If yes, you are eligible to apply for a maximum of \$20,000 (4 units) of coverage.

**If Question 1 or 2 is answered Yes, was it the:**

- Proposed Insured/Employee                       Spouse                       Child

\_\_\_\_\_  
Name of person(s)

**You are eligible to apply for a maximum of \$20,000 (4 units) of coverage.**

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. 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
- |   |   |
|---|---|
| Systemic lupus                                | irregular heart beat                          |
| pulmonary hypertension                        | chest pains                                   |
| cystic fibrosis                               | vascular insufficiency (circulatory problems) |
| uncontrolled hypertension/high blood pressure | renal hypertension                            |
| tachycardia                                   | diabetes (Type II) diagnosed prior to age 30  |
5. 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  | pulmonary fibrosis                                  |
| cardiomyopathy  | diabetes and used tobacco after diagnosis           |
| bypass/stents/angioplasty                                 | diabetes treated with insulin                       |
| atrial fibrillation                                       | diabetes with complications to include nephropathy; |
| implant of pacemaker/defibrillator                        | neuropathy; or retinopathy                          |
| heart surgery (including valve replacement or correction) | kidney disease or disorder (not including stones)   |
| congestive heart failure                                  | liver disease or disorder (excluding Hepatitis A)   |
| stroke/TIA  | the administration of chemotherapy                  |
| chronic obstructive pulmonary disease (COPD)              | sarcoidosis   |
| emphysema   | alcohol or drug abuse                               |

**If any one of Questions 3 – 5 is answered Yes, was it the:**

- Proposed Insured/Employee                       Spouse                       Child

\_\_\_\_\_  
Name of person(s)

**Any person(s) indicated above will not be covered under this policy. If the Proposed Insured/Employee, a policy will not be issued; therefore, do not submit this application.  
If a Child, are there other children to be covered?                       Yes  No**

**PLEASE COMPLETE THE FOLLOWING QUESTION  
 IF YOU ARE APPLYING FOR MORE THAN \$20,000 (4 UNITS) OF COVERAGE.  
 Additional underwriting may be required.**

6. During the last 6 months, has anyone to be covered 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.

Name	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	

Name	Medication Name	Dosage	Date First Prescribed	Medical Condition

**PLEASE COMPLETE THE FOLLOWING QUESTIONS  
 IF YOU ARE APPLYING FOR THE LUMP SUM CANCER BENEFIT RIDER**

7. 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
8. 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  
 Internal cancer (including myelodysplastic blood disorder and myeloproliferative blood disorder)  
 Melanoma (Clark's Level III or higher or a Breslow Level greater than 1.5 mm.)  
 Carcinoma In Situ

**If Question 7 or 8 is answered Yes, was it the:**

- Proposed Insured/Employee  Spouse  Child

\_\_\_\_\_ Name of person(s)

**Any person(s) indicated above will not be covered under this rider.  
If the Proposed Insured/Employee, this rider will not be issued.  
If a Child, are there other children to be covered?    Yes No**

9. Has anyone to be covered had Internal Cancer that was diagnosed or last treated over five years ago?     Yes  No  
If yes, you are eligible to apply for a maximum of \$20,000 (4 units) of coverage. This information will be verified at the time of claim.

**If Question 9 is answered Yes, was it the:**

Proposed Insured/Employee

Spouse

Child

\_\_\_\_\_  
Name of person(s)

**You are eligible to apply for a maximum of \$20,000 (4 units) of coverage.**

**PAYROLL – FOR LARGE ACCOUNT ONLY**

**LUMP SUM CRITICAL ILLNESS**

**PLEASE COMPLETE THE FOLLOWING QUESTION  
IF YOU ARE APPLYING FOR THE LUMP SUM CRITICAL ILLNESS POLICY**

1. Within the last 24 months, (excluding routine childbirth), has anyone to be covered been (a) out of work due to sickness or injury more than 5 consecutive days; (b) in a hospital or emergency room (ER) for more than 24 hours for sickness; (c) diagnosed or treated for hypertension or diabetes; or is anyone to be covered currently disabled due to sickness or injury?  Yes  No

**PLEASE COMPLETE THE FOLLOWING QUESTIONS  
IF QUESTION 1 IS ANSWERED YES OR YOU ARE APPLYING FOR  
MORE THAN \$20,000 (4 UNITS) OF COVERAGE.**

2. 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

3. 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

Systemic lupus	irregular heart beat
pulmonary hypertension	chest pains
cystic fibrosis	vascular insufficiency (circulatory problems)
uncontrolled hypertension/high blood pressure	renal hypertension
tachycardia	diabetes (Type II) diagnosed prior to age 30

4. 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)	the administration of chemotherapy
congestive heart failure	sarcoidosis
stroke/TIA	alcohol or drug abuse
chronic obstructive pulmonary disease (COPD)	
emphysema	
pulmonary fibrosis	
diabetes and used tobacco after diagnosis	

**If any one of Questions 2 – 4 is answered Yes, was it the:**

Proposed Insured/Employee  Spouse  Child

\_\_\_\_\_  
Name of person(s)

**If spouse or child is indicated above, he/she will not be covered under the policy. If the Proposed Insured/Employee, a policy will not be issued; therefore, do not submit this application.**

**If a Child, are there other children to be covered?  Yes  No**

**PLEASE COMPLETE THE FOLLOWING QUESTION  
 IF YOU ARE APPLYING FOR MORE THAN \$20,000 (4 UNITS) OF COVERAGE.  
 Additional underwriting may be required.**

5. During the last 6 months, has anyone to be covered 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.

Name	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	

Name	Medication Name	Dosage	Date First Prescribed	Medical Condition

**PLEASE COMPLETE THE FOLLOWING QUESTIONS  
 IF YOU ARE APPLYING FOR THE LUMP SUM CANCER BENEFIT RIDER**

6. 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
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

Internal cancer (including myelodysplastic blood disorder and myeloproliferative blood disorder)  
 Melanoma (Clark's Level III or higher or a Breslow Level greater than 1.5 mm.)  
 Carcinoma In Situ

**If Question 6 or 7 is answered Yes, was it the:**

Proposed Insured/Employee

Spouse

Child

\_\_\_\_\_  
Name of person(s)

**Any person(s) indicated above will not be covered under this rider.  
If the Proposed Insured/Employee, this rider will not be issued.**

**If a Child, are there other children to be covered?    Yes  No**

8. Has anyone to be covered had Internal Cancer that was diagnosed or last treated over five years ago?  Yes  No  
If yes, you are eligible to apply for a maximum of \$20,000 (4 units) of coverage. This information will be verified at the time of claim.

**If Question 8 is answered Yes, was it the:**

Proposed Insured/Employee

Spouse

Child

\_\_\_\_\_  
Name of person(s)

**You are eligible to apply for a maximum of \$20,000 (4 units) of coverage.**

**REQUEST FOR ADDITIONS/APPLICATION FOR REINSTATEMENT  
LUMP SUM CRITICAL ILLNESS INSURANCE FOR A72100 SERIES  
LUMP SUM CANCER INSURANCE FOR A72200 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 \_\_\_\_\_ (Optional)

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/Agent Signature and Writing Number \_\_\_\_\_  
Licensed Associate/Agent

**PLEASE MAKE THE FOLLOWING CHANGES TO MY POLICY:**

**ADDITIONS ONLY – Complete applicable questions listed below. Dependent Children must be under age 25 at the time of application.**

Does anyone to be added currently have a Specified Health Event policy with Aflac?  Yes  No

If Yes, please complete the Supplemental Notification section at the end of this application and be aware that anyone to be added cannot have this policy without canceling their Specified Health Event policy with Aflac.

Does anyone to be added under the Lump Sum Cancer Benefit Rider or Lump Sum Cancer Policy have any other Cancer coverage with Aflac?  Yes  No  N/A

If Yes, please complete the Supplemental Notification section at the end of this application and be aware that anyone to be added cannot have this policy without canceling their Cancer policy with Aflac.

Person(s) to be Added \_\_\_\_\_

	Last Name	First Name	MI	Title
--	-----------	------------	----	-------

Sex  Male  Female

Relationship  Spouse  Child

DOB of spouse or Dependent Child (other than a newborn) \_\_\_\_\_

Reason for Addition  Marriage  Birth  Request

Date of Marriage/Birth/Request \_\_\_\_\_

New Coverage Desired  One-Parent Family  Two-Parent Family  Named Insured/Spouse Only

**PLEASE COMPLETE THE FOLLOWING QUESTIONS  
FOR REINSTATEMENT OF OR ADDITIONS TO THE LUMP SUM CRITICAL ILLNESS POLICY**

1. Has anyone to be covered used tobacco products or products containing nicotine of any type in the last 12 months?  Yes  No  
If yes, you are eligible to reinstate/apply for a maximum of \$20,000 (4 units) of coverage. This information will be verified at the time of claim.
2. 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  
If yes, you are eligible to reinstate/apply for a maximum of \$20,000 (4 units) of coverage.

**If Question 1 or 2 is answered Yes, was it the:**

- Policyholder                       Spouse                       Child

\_\_\_\_\_  
Name of person(s)

**You are eligible to reinstate/apply for a maximum of \$20,000 (4 units) of coverage.**

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. 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
- |   |   |
|---|---|
| Systemic lupus                                | irregular heart beat                          |
| pulmonary hypertension                        | chest pains                                   |
| cystic fibrosis                               | vascular insufficiency (circulatory problems) |
| uncontrolled hypertension/high blood pressure | renal hypertension                            |
| tachycardia                                   | diabetes (Type II) diagnosed prior to age 30  |
5. 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  | pulmonary fibrosis                                 |
| cardiomyopathy  | diabetes and used tobacco after diagnosis          |
| bypass/stents/angioplasty                                 | diabetes treated with insulin                      |
| atrial fibrillation                                       | diabetes with complications to include nephropathy |
| implant of pacemaker/defibrillator                        | neuropathy; or retinopathy                         |
| heart surgery (including valve replacement or correction) | kidney disease or disorder (not including stones)  |
| congestive heart failure                                  | liver disease or disorder (excluding Hepatitis A)  |
| stroke/TIA  | the administration of chemotherapy                 |
| chronic obstructive pulmonary disease (COPD)              | sarcoidosis  |
| emphysema   | alcohol or drug abuse                              |

**If any one of Questions 3 – 5 is answered Yes, was it the:**

- Policyholder                       Spouse                       Child

\_\_\_\_\_  
Name of person(s)

**Any person(s) indicated above will not be covered under this policy. If the Policyholder, the policy will not be reinstated; therefore, do not submit this application.**

**If a Child, are there other children to be covered? Yes  No**

**PLEASE COMPLETE THE FOLLOWING QUESTION  
FOR REINSTATEMENT OF OR ADDITIONS FOR MORE THAN \$20,000 (4 UNITS) OF COVERAGE.  
Additional underwriting may be required.**

6. During the last 6 months, has anyone to be covered 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.

Name	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	

Name	Medication Name	Dosage	Date First Prescribed	Medical Condition

**PLEASE COMPLETE THE FOLLOWING QUESTIONS  
FOR REINSTATEMENT OF OR ADDITIONS TO THE LUMP SUM CANCER BENEFIT RIDER**

7. 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
8. 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
- Internal cancer (including myelodysplastic blood disorder and myeloproliferative blood disorder)  
Melanoma (Clark's Level III or higher or a Breslow Level greater than 1.5 mm.)  
Carcinoma In Situ

**If Question 7 or 8 is answered Yes, was it the:**

- Policyholder                       Spouse                       Child

\_\_\_\_\_  
Name of person(s)

**Any person(s) indicated above will not be covered under this rider.  
If the Policyholder, this rider will not be reinstated.**

**If a Child, are there other children to be covered?    Yes  No**

9. Has anyone to be covered had Internal Cancer that was diagnosed or last treated over five years ago?     Yes  No  
If yes, you are eligible to reinstate/apply for a maximum of \$20,000 (4 units) of coverage. This information will be verified at the time of claim.

**If Question 9 is answered Yes, was it the:**

- Policyholder                       Spouse                       Child

\_\_\_\_\_  
Name of person(s)

**You are eligible to reinstate/apply for a maximum of \$20,000 (4 units) of coverage.**

**PLEASE COMPLETE THE FOLLOWING QUESTIONS  
FOR REINSTATEMENT OF OR ADDITIONS TO THE LUMP SUM CANCER POLICY**

1. 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
2. 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

Internal cancer (including myelodysplastic blood disorder and myeloproliferative blood disorder)  
Melanoma (Clark's Level III or higher or a Breslow Level greater than 1.5 mm.)  
Carcinoma In Situ

**If Question 1 or 2 is answered Yes, was it the:**

- Policyholder                       Spouse                       Child

\_\_\_\_\_  
Name of person(s)

**Any person(s) indicated above will not be covered under this policy. If the Policyholder,  
the policy will not be reinstated; therefore, do not submit this application.**

**If a Child, are there other children to be covered?    Yes  No**

3. Has anyone to be covered used tobacco products or products containing nicotine of any type in the last 12 months?     Yes  No  
If yes, you are eligible to reinstate/apply for a maximum of \$20,000 (4 units) of the Internal Cancer Benefit. This information will be verified at the time of claim.
4. Has anyone to be covered had Internal Cancer that was diagnosed or last treated over five years ago?     Yes  No  
If yes, you are eligible to reinstate/apply for a maximum of \$20,000 (4 units) of the Internal Cancer Benefit. This information will be verified at the time of claim.

If Question 3 or 4 is answered Yes, was it the:

Policyholder

Spouse

Child

\_\_\_\_\_  
Name of person(s)

**You are eligible to reinstate/apply for a maximum of \$20,000 (4 units) of the Internal Cancer Benefit.**

**SUPPLEMENTAL NOTIFICATION**

**COMPLETE IF YOU ARE REPLACING/TERMINATING EXISTING AFLAC SPECIFIED HEALTH EVENT COVERAGE.**

I, \_\_\_\_\_, am applying for Aflac's Lump Sum Critical Illness policy which contains Specified Health Event benefits. I currently have benefits under Aflac's Specified Health Event policy number \_\_\_\_\_. I understand that I must cancel my existing Aflac Specified Health Event policy to purchase this policy.

Please cancel my Aflac Specified Health Event policy number \_\_\_\_\_ so that this Lump Sum Critical Illness policy can be issued. **I understand that I will be terminating benefits provided for in my Specified Health Event policy that may not be provided for in the new Lump Sum Critical Illness policy.**

**SUPPLEMENTAL NOTIFICATION**

**COMPLETE IF YOU ARE REPLACING/TERMINATING EXISTING AFLAC CANCER COVERAGE.**

I, \_\_\_\_\_, am applying for Aflac's Lump Sum Critical Illness Policy with a Lump Sum Cancer Benefit Rider or Aflac's Lump Sum Cancer Policy which contains cancer benefits. I currently have cancer benefits under Aflac's Cancer Policy Number \_\_\_\_\_. I understand that I must cancel my existing Aflac Cancer policy to purchase this policy.

Please cancel my Aflac Cancer policy number \_\_\_\_\_ so that this Lump Sum Critical Illness policy with a Lump Sum Cancer Benefit Rider or Lump Sum Cancer Policy can be issued. **I understand that I will be terminating benefits provided for in my Cancer policy that may not be provided for in the new Lump Sum Critical Illness policy with a Lump Sum Cancer Benefit Rider or Lump Sum Cancer 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 decline 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 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. No person to be insured is covered by any Title XIX programs such as Medicaid.

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.]**

**REQUEST FOR ADDITIONS/APPLICATION FOR REINSTATEMENT  
LUMP SUM CRITICAL ILLNESS INSURANCE FOR A72100 SERIES  
LUMP SUM CANCER INSURANCE FOR A72200 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 \_\_\_\_\_  
(Optional)

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/Agent Signature and Writing Number \_\_\_\_\_  
Licensed Associate/Agent

**PLEASE MAKE THE FOLLOWING CHANGES TO MY POLICY:**

**ADDITIONS ONLY – Complete applicable questions listed below. Dependent Children must be under age 25 at the time of application.**

Does anyone to be added currently have a Specified Health Event policy with Aflac?  Yes  No

If Yes, please complete the Supplemental Notification section at the end of this application and be aware that anyone to be added cannot have this policy without canceling their Specified Health Event policy with Aflac.

Does anyone to be added under the Lump Sum Cancer Benefit Rider or Lump Sum Cancer Policy have any other Cancer coverage with Aflac?  Yes  No  N/A

If Yes, please complete the Supplemental Notification section at the end of this application and be aware that anyone to be added cannot have this policy without canceling their Cancer policy with Aflac.

Person(s) to be Added \_\_\_\_\_

	Last Name	First Name	MI	Title
--	-----------	------------	----	-------

Sex  Male  Female

Relationship  Spouse  Child

DOB of spouse or Dependent Child (other than a newborn) \_\_\_\_\_

Reason for Addition  Marriage  Birth  Request

Date of Marriage/Birth/Request \_\_\_\_\_

New Coverage Desired  One-Parent Family  Two-Parent Family  Named Insured/Spouse Only

**PLEASE COMPLETE THE FOLLOWING QUESTION  
FOR REINSTATEMENT OF OR ADDITIONS TO THE LUMP SUM CRITICAL ILLNESS POLICY**

1. Within the last 24 months, (excluding routine childbirth), has anyone to be covered been (a) out of work due to sickness or injury more than 5 consecutive days; (b) in a hospital or emergency room (ER) for more than 24 hours for sickness; (c) diagnosed or treated for hypertension or diabetes; or is anyone to be covered currently disabled due to sickness or injury?  Yes  No

**PLEASE COMPLETE THE FOLLOWING QUESTIONS IF QUESTION 1 IS ANSWERED YES OR YOU ARE REINSTATING OR APPLYING FOR MORE THAN \$20,000 (4 UNITS) OF COVERAGE.**

2. 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

3. 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

Systemic lupus	irregular heart beat
pulmonary hypertension	chest pains
cystic fibrosis	vascular insufficiency (circulatory problems)
uncontrolled hypertension/high blood pressure	renal hypertension
tachycardia	diabetes (Type II) diagnosed prior to age 30

4. 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)	the administration of chemotherapy
congestive heart failure	sarcoidosis
stroke/TIA	alcohol or drug abuse
chronic obstructive pulmonary disease (COPD)	
emphysema	
pulmonary fibrosis	
diabetes and used tobacco after diagnosis	

**If any one of Questions 2 – 4 is answered Yes, was it the:**

- Policyholder                       Spouse                       Child

\_\_\_\_\_

Name of person(s)

**If spouse or child is indicated above, he/she will not be covered under the policy. If the Policyholder, the policy will not be reinstated; therefore, do not submit this application.**

**If a Child, are there other children to be covered? Yes  No**

**PLEASE COMPLETE THE FOLLOWING QUESTION  
FOR REINSTATEMENT OF OR ADDITIONS FOR MORE THAN \$20,000 (4 UNITS) OF COVERAGE.  
Additional underwriting may be required.**

5. During the last 6 months, has anyone to be covered 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.

Name	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	

Name	Medication Name	Dosage	Date First Prescribed	Medical Condition

**PLEASE COMPLETE THE FOLLOWING QUESTIONS  
FOR REINSTATEMENT OF OR ADDITIONS TO THE LUMP SUM CANCER BENEFIT RIDER**

6. 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
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

Internal cancer (including myelodysplastic blood disorder and myeloproliferative blood disorder)  
Melanoma (Clark's Level III or higher or a Breslow Level greater than 1.5 mm.)  
Carcinoma In Situ

**If Question 6 or 7 is answered Yes, was it the:**

- Policyholder                       Spouse                       Child

\_\_\_\_\_ Name of person(s)

**Any person(s) indicated above will not be covered under this rider.  
If the Policyholder, this rider will not be reinstated.**

**If a Child, are there other children to be covered?    Yes  No**

8. Has anyone to be covered had Internal Cancer that was diagnosed or last treated over five years ago?  Yes  No  
 If yes, you are eligible to reinstate/apply for a maximum of \$20,000 (4 units) of coverage. This information will be verified at the time of claim.

**If Question 8 is answered Yes, was it the:**

- Policyholder  Spouse  Child

\_\_\_\_\_  
 Name of person(s)

**You are eligible to reinstate/apply for a maximum of \$20,000 (4 units) of coverage.**

**PLEASE COMPLETE THE FOLLOWING QUESTIONS  
 FOR REINSTATEMENT OF OR ADDITIONS TO THE LUMP SUM CANCER POLICY**

1. 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
2. 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

Internal cancer (including myelodysplastic blood disorder and myeloproliferative blood disorder)  
 Melanoma (Clark's Level III or higher or a Breslow Level greater than 1.5 mm.)  
 Carcinoma In Situ

**If Question 1 or 2 is answered Yes, was it the:**

- Policyholder  Spouse  Child

\_\_\_\_\_  
 Name of person(s)

**Any person(s) indicated above will not be covered under this policy. If the Policyholder, the policy will not be reinstated; therefore, do not submit this application.**

**If a Child, are there other children to be covered?  Yes  No**

3. Has anyone to be covered had Internal Cancer that was diagnosed or last treated over five years ago?  Yes  No  
 If yes, you are eligible to reinstate/apply for a maximum of \$20,000 (4 units) of the Internal Cancer Benefit. This information will be verified at time of claim.

**If Question 3 is answered Yes, was it the:**

- Policyholder  Spouse  Child

\_\_\_\_\_  
 Name of person(s)

**You are eligible to reinstate/apply for a maximum of \$20,000 (4 units) of the Internal Cancer Benefit.**

**SUPPLEMENTAL NOTIFICATION**

**COMPLETE IF YOU ARE REPLACING/TERMINATING EXISTING AFLAC SPECIFIED HEALTH EVENT COVERAGE.**

I, \_\_\_\_\_, am applying for Aflac's Lump Sum Critical Illness policy which contains Specified Health Event benefits. I currently have benefits under Aflac's Specified Health Event policy number \_\_\_\_\_. I understand that I must cancel my existing Aflac Specified Health Event policy to purchase this policy.

- Please cancel my Aflac Specified Health Event policy number \_\_\_\_\_ so that this Lump Sum Critical Illness policy can be issued. **I understand that I will be terminating benefits provided for in my Specified Health Event policy that may not be provided for in the new Lump Sum Critical Illness policy.**

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

I, \_\_\_\_\_, am applying for Aflac's Lump Sum Critical Illness Policy with a Lump Sum Cancer Benefit Rider or Aflac's Lump Sum Cancer Policy which contains cancer benefits. I currently have cancer benefits under Aflac's Cancer Policy Number \_\_\_\_\_. I understand that I must cancel my existing Aflac Cancer policy to purchase this policy.

Please cancel my Aflac Cancer policy number \_\_\_\_\_ so that this Lump Sum Critical Illness policy with a Lump Sum Cancer Benefit Rider or Lump Sum Cancer Policy can be issued. **I understand that I will be terminating benefits provided for in my Cancer policy that may not be provided for in the new Lump Sum Critical Illness policy with a Lump Sum Cancer Benefit Rider or Lump Sum Cancer 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 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. No person to be insured is covered by any Title XIX programs such as Medicaid.

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.]**

SERFF Tracking Number: AFLA-126197800 State: Arkansas  
Filing Company: American Family Life Assurance Company of Columbus State Tracking Number: 42769  
Company Tracking Number:  
TOI: H071 Individual Health - Specified Disease - Limited Benefit Sub-TOI: H071.001 Critical Illness  
Product Name: Lump Sum Critical Illness  
Project Name/Number: /

## Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number: AFLA-126197800 State: Arkansas  
Filing Company: American Family Life Assurance Company of Columbus State Tracking Number: 42769  
Company Tracking Number:  
TOI: H071 Individual Health - Specified Disease - Limited Benefit Sub-TOI: H071.001 Critical Illness  
Product Name: Lump Sum Critical Illness  
Project Name/Number: /

## Supporting Document Schedules

**Satisfied -Name:** Flesch Certification **Review Status:** Approved-Closed 06/30/2009  
**Comments:**  
The filing letter is attached. The flesch certification and regulation requirements are included in the filing letter.  
**Attachment:**  
AR a72lsi03 rev DTGltr.pdf

**Bypassed -Name:** Application **Review Status:** Approved-Closed 06/30/2009  
**Bypass Reason:** The following is included in the filing letter.

Underwriting Forms LSCIR and LSCIGR will be used in conjunction with Application Forms A72PAPPAR, A72GAPPAR and A72UAPPAR and Signature Forms AsigncARR and AsignARR, which were previously approved by your department on February 2, 2009. When the final application prints and is attached to the policy at the time of issue, the application form, the underwriting form, and a signature page will be combined to reflect a complete application.

Reinstatement Application Forms A72003RAR and A72003GRAR will be used to reinstate a lapsed policy. Form A72003RAR will be used for reinstatement of policies on a payroll or union basis and Form A72003GRAR will be used to reinstate a lapsed policy on a large account.

**Comments:**

**Bypassed -Name:** Health - Actuarial Justification **Review Status:** Approved-Closed 06/30/2009  
**Bypass Reason:** The rates and actuarial memo remain the same.  
**Comments:**

**Bypassed -Name:** Outline of Coverage **Review Status:** Approved-Closed 06/30/2009  
**Bypass Reason:** Not applicable there are not any revisions to the Outline of Coverage forms.  
**Comments:**

SERFF Tracking Number: AFLA-126197800 State: Arkansas  
Filing Company: American Family Life Assurance Company of Columbus State Tracking Number: 42769  
Company Tracking Number:  
TOI: H071 Individual Health - Specified Disease - Limited Benefit Sub-TOI: H071.001 Critical Illness  
Product Name: Lump Sum Critical Illness  
Project Name/Number: /

**Satisfied -Name:** Fee Certification **Review Status:** Approved-Closed 06/30/2009  
**Comments:**  
The fee certification is attached.  
**Attachment:**  
AR a72lsi03 rev FEECERT.pdf



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

June 25, 2009

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

NAIC# 60380

**RE: Lump Sum Critical Illness Underwriting Application Forms LSCIR and LSCIGR and Request for Additions/Application for Reinstatement Forms A72003RAR and A72003GRAR.**

Dear Mr. Musgrove:

Referenced forms are submitted for your review and approval. Similar versions of these forms were approved by your department on February 2, 2009. Nebraska, our state of domicile, has approved similar versions of these forms on June 16, 2009.

The forms have been revised in order to improve and provide consistency in our underwriting by changing the following underwriting question as reflected below:

From:

During the last 6 months, have you received any medical treatment, including injections, or been prescribed or taken medications (other than prescription contraceptives)?  
If yes, please provide descriptive information below.

To:

During the last 6 months, has anyone to be covered received any medical treatment, including injections, or been prescribed or taken medications (other than prescription contraceptives)?  
If yes, please provide descriptive information below.

A column for the individual's Name has also been added to the descriptive information boxes below the question.

Underwriting Forms LSCIR and LSCIGR will be used in conjunction with Application Forms A72PAPPAR, A72GAPPAR and A72UAPPAR and Signature Forms AsigncARR and AsignARR, which were previously approved by your department on February 2, 2009. When the final application prints and is attached to the policy at the time of issue, the application form, the underwriting form, and a signature page will be combined to reflect a complete application.

Reinstatement Application Forms A72003RAR and A72003GRAR will be used to reinstate a lapsed policy. Form A72003RAR will be used for reinstatement of policies on a payroll or union basis and Form A72003GRAR will be used to reinstate a lapsed policy on a large account.

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.

This is to certify that 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:

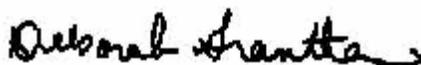
	<u>FLESCH Score</u>	<u>Grade Level</u>
Underwriting Application Form LSCIR	64.983	6
Underwriting Application Form LSCIGR	73.386	6
Reinstatement Application Form A72003RAR	75.695	4
Reinstatement Application Form A72003GRAR	71.189	5

The rates and actuarial memo remain the same. The appropriate filing fee is included as an EFT and fee certification form is attached under the supporting documentation tab.

Aflac reserves the right to alter the format of the forms without re-filing 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](mailto:cgates@aflac.com).

Sincerely,



Deborah T. Grantham  
DTG/CG/cg  
Enclosures

**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. \* \_\_\_\_ x \$50 = \_\_\_\_  
\*\* 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. \* 4 x \$20 = \$80  
\*\* 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.