

SERFF Tracking Number: AFLA-126480197 State: Arkansas
Filing Company: American Family Life Assurance Company of Columbus State Tracking Number: 44731
Company Tracking Number:
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: Juvenile Term Life
Project Name/Number: /

Filing at a Glance

Company: American Family Life Assurance Company of Columbus

Product Name: Juvenile Term Life

TOI: L08 Life - Other

Sub-TOI: L08.000 Life - Other

Filing Type: Form

SERFF Tr Num: AFLA-126480197 State: Arkansas

SERFF Status: Closed-Approved-
Closed State Tr Num: 44731

Co Tr Num:

Author: Leslie Steele

Date Submitted: 01/29/2010

State Status: Approved-Closed

Reviewer(s): Linda Bird

Disposition Date: 02/03/2010

Disposition Status: Approved-
Closed

Implementation Date:

Implementation Date Requested: On Approval

State Filing Description:

General Information

Project Name:

Project Number:

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 02/03/2010

Status of Filing in Domicile: Authorized

Date Approved in Domicile: 01/26/2010

Domicile Status Comments:

Market Type: Individual

Group Market Size:

Group Market Type:

Explanation for Other Group Market Type:

State Status Changed: 02/03/2010

Created By: Leslie Steele

Corresponding Filing Tracking Number:

Deemer Date:

Submitted By: Leslie Steele

Filing Description:

RE: Juvenile Term to Age 25 Life Policy Form A65JTORAR

Referenced form is submitted for your review and approval.

Policy Form A65JTORAR is a Juvenile Term to 25 Policy. Proceeds are payable at death. No dividends are payable. The policy will be marketed through our field force on a payroll or nonpayroll basis to applicants, age 14 days to 17 years.

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Payroll or Direct Application Form A65J01AR, previously approved December 3, 2009 under SERFF Tracking # AFLA-126403526, will be used to make application for the policy and is self-explanatory.

Application for Reinstatement/Change Form A65J03AR, also previously approved December 3, 2009 under SERFF Tracking # AFLA-126403526, will be used to reinstate the policies and is self-explanatory.

Temporary Life Insurance Agreement for Life Insurance Form A64016 was approved October 28, 2009 with our A64000 Series, SERFF Tracking # AFLA-126318884, and will be used on a direct basis only when premium has been collected at the time of application.

An actuarial memorandum with rate structure, a statement of policy costs and benefit information, a worksheet for calculating cost indexes and a cost comparison disclosure are enclosed for your review.

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This filing has been prepared by Leslie Steele. Should you have any questions or comments concerning this submission, please do not hesitate to call her collect at (706) 596-2971, by fax at (706) 660-7080 or email at lmsteele@aflac.com.

Company and Contact

Filing Contact Information

Leslie Steele, Policy Analyst
1932 Wynnton Road
Columbus, GA 31999
lmsteele@aflac.com
706-596-2971 [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:

SERFF Tracking Number: AFLA-126480197 State: Arkansas
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Filing Fees

Fee Required? Yes
Fee Amount: \$50.00
Retaliatory? No
Fee Explanation: 1 policy X \$50.00
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
American Family Life Assurance Company of Columbus	\$50.00	01/29/2010	33890052

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	02/03/2010	02/03/2010

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Disposition

Disposition Date: 02/03/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		Yes
Supporting Document	Actuarial Information		No
Form	JUVENILE TERM TO 25, WHOLE LIFE POLICY THEREAFTER		Yes

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Form Schedule

Lead Form Number: A65JTORAR

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	A65JTORA R	Policy/Cont ract/Fratern al	JUVENILE TERM 25, WHOLE LIFE POLICY Certificate	Initial THEREAFTER		62.130	A65JTORAR. pdf

JUVENILE TERM TO 25

The Owner of the policy 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 the application and the first payment of the premium shown in the Policy Schedule. A copy of the 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.

When we receive proof satisfactory to us of the Named Insured’s death while this policy is In Force, we will pay the Proceeds then In Force to the Beneficiary, subject to the provisions of this policy.

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 Policy Effective Date. If you return this policy, please note in writing: “This policy is returned for cancellation and refund of premium.”

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.



Paul S. Amos II, President



Joey M. Loudermilk, Secretary

THIS IS A JUVENILE TERM TO 25 INSURANCE POLICY.

PROCEEDS ARE PAYABLE AT DEATH.

THIS IS A NONPARTICIPATING POLICY; NO DIVIDENDS ARE PAYABLE.

AMERICAN FAMILY LIFE ASSURANCE COMPANY OF COLUMBUS (AFLAC)

[CLIENT SERVICES AND ADMINISTRATION

1932 WYNNTON ROAD, COLUMBUS, GEORGIA 31999

For assistance or information about this policy, call 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]

POLICY SCHEDULE

JUVENILE TERM TO 25

Named Insured:	John Doe	Policy Number:	A1223450
Age at Issue:	10	Reinstatement Interest Rate:	6%
Policy Effective Date:	January 1, 2010	Maturity Date:	January 1, 2095
Face Amount:	\$10,000	Term Expiration Date:	January 1, 2025

Benefits as Specified in the Policy	<u>Annual</u>	<u>Premium</u>	<u>Period</u>
Juvenile Term To 25 Insurance Policy	48.36	To Attained	Age 25
Total Annual Premium:	\$48.36		
Modal Premium:	Quarterly	\$12.09	

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This policy is a legal contract between the Owner and Aflac.

READ YOUR POLICY CAREFULLY!

Part 1
DEFINITIONS

AGE AT ISSUE: the Named Insured's age on his or her last birthday prior to the Policy Effective Date.

ATTAINED AGE: the Named Insured's Age at Issue plus the number of completed policy years since the Policy Effective Date.

BENEFICIARY: the person or persons to receive the Proceeds upon the Named Insured's death.

INDEBTEDNESS: all existing due and unpaid premiums or Liens secured by this policy plus unpaid interest.

IN FORCE: the active status of the policy while the Named Insured remains insured under the terms of the policy.

LAPSE: termination of the policy if any premium remains unpaid after the grace period.

LIEN: our right to or interest in the policy benefits and death benefits.

NAMED INSURED: the person whose life is insured under the policy and is named as such on the Policy Schedule. The "Named Insured" means your or your spouse's natural child, stepchild, legally adopted child, or grandchild. The Named Insured must be the later of: (1) 14 days old, or (2) released from the hospital after birth.

OWNER: the Owner of this policy is shown in the application, unless a change of ownership has been made.

POLICY EFFECTIVE DATE: the date(s) coverage begins as shown in the Policy Schedule. The Policy Effective Date **is not** the date you signed the application for coverage. Policy years and policy anniversaries are measured in 12-month increments from the Policy Effective Date.

PROCEEDS: the amount we are obligated to pay under the terms of this policy when the Named Insured dies.

REINSTATE: to restore coverage after this policy has Lapsed.

TERMINATE: to end this policy.

TERM EXPIRATION DATE: the date shown in the Policy Schedule.

WRITTEN REQUEST: a request delivered to us and signed by you.

Part 2
PAYMENT OF PROCEEDS

WHAT ARE THE PROCEEDS UPON THE DEATH OF THE NAMED INSURED? All amounts payable under this policy will be paid in a lump sum. The amount payable will be:

- The amount of insurance then In Force,
- Plus a refund of any portion of a premium paid for a period beyond the date of death,
- Less any premium due, and
- Less the amount of any Indebtedness.

WHEN WILL DEATH PROCEEDS BE PAID? We will pay the benefits when we receive proof satisfactory to us that the Named Insured's death occurred while this policy was In Force. If the proceeds or refunds of premiums are not paid within 30 days after proof of death of the Named Insured has been furnished to us, we will pay interest upon the proceeds or refunds of premiums at the rate of eight percent per year.

IS THERE A BENEFIT LIMITATION IF THE NAMED INSURED COMMITS SUICIDE? If the Named Insured commits suicide, while sane or insane, within two years from the Policy Effective Date, benefits will be limited to a refund of all premiums paid.

Part 3
GENERAL INFORMATION

WHAT IS THE CONTRACT WITH US? This policy is issued in consideration of the application and the first premium payment. This policy, the application, and any attached amendments constitute the entire contract.

In the absence of fraud, we consider statements made in the application to be representations and not warranties. This policy may be contested if we rely on material misrepresentation in the application. However, except for nonpayment of premiums, we may not contest this policy after it has been In Force during the Named Insured's lifetime for two years from the Policy Effective Date. If the law of the state where the policy is delivered provides for a shorter contestable period, that law will govern.

No change or waiver of any of the provisions of the policy will be valid unless made in writing and signed by Aflac's president and secretary. This policy does not participate in our profits or surplus.

WHAT IF THE NAMED INSURED'S AGE HAS BEEN MISSTATED? If the Named Insured's age has been misstated on the application, the benefits provided will be those that the premiums paid would have bought for the correct age.

CAN YOU ASSIGN THIS POLICY? You may assign this policy. The assignment will not be binding on us unless it is submitted in writing and filed with us at Aflac Worldwide Headquarters. Assignments, unless otherwise specified by the Owner, shall take effect on the date the notice of assignment is signed by the Owner, subject to any payments made or actions taken by Aflac prior to receipt of the assignment notice. We will not be responsible for determining the validity or effect of any assignment.

Any claim made by an assignee will be subject to proof of the assignment. The interest of any Beneficiary is subject to the interest of the assignee.

IS THERE A BENEFIT LIMITATION IF THE NAMED INSURED COMMITS SUICIDE? If the Named Insured commits suicide, while sane or insane, within two years from the Policy Effective Date, benefits will be limited to a refund of all premiums paid.

CAN CREDITORS GET THE PROCEEDS? Unless assigned, Proceeds payable to a Beneficiary will be free from the claims of creditors to the extent allowable by law.

Part 4 **OWNERSHIP OF THE POLICY**

WHO IS THE OWNER OF THIS POLICY? You are the Owner of the policy unless a change of ownership has been made. All rights and benefits available under this policy while the Named Insured is alive belong to you, the Owner. If you die before the Named Insured, all ownership rights then belong to your estate. Your rights are subject to the rights of any assignee or living Beneficiary when the designation is irrevocable.

HOW DO YOU EXERCISE YOUR RIGHTS OR TRANSFER OWNERSHIP? During your lifetime, you may exercise all of the rights under this policy by making a Written Request. This includes the right to change the ownership. If you transfer ownership of this policy, your ownership rights Terminate and the new Owner will be entitled to all rights available under this policy. To transfer ownership, we must receive a Written Request from you on a form satisfactory to us during the lifetime of the Named Insured. The written consent of any irrevocable Beneficiary on a form satisfactory to us is also required. Your Written Request, once recorded in our worldwide headquarters, will be effective as of the date you signed the request. A transfer of ownership will not apply to any actions, including payments received by us before transfer has been recorded by us.

Part 5 **PREMIUMS**

WHEN AND WHERE DO YOU PAY YOUR PREMIUMS? Your first premium, shown in the Policy Schedule, is due as of the Policy Effective Date and must be paid before coverage begins. Subsequent premiums are due in advance of the period they are to cover.

All premiums may be paid to us at Aflac Worldwide Headquarters. You may change the frequency of the premium payments, subject to our approval.

CAN YOU PAY A PREMIUM AFTER THE DATE IT IS DUE? We allow each premium, after the first one, to be paid within the 31 day period immediately following the date it is due. These 31 days are called the "grace period". If you have a claim during the grace period, we will deduct any unpaid premium from the amount we would otherwise pay.

WHAT HAPPENS IF YOUR PREMIUM IS NOT PAID BY THE END OF THE GRACE PERIOD? If any premium remains unpaid at the end of the grace period, your policy will Lapse and no further premium payment may be made except as provided by the Reinstatement provision.

Part 6 **CONVERSION**

CAN THIS POLICY BE CONVERTED? When the original term of insurance on the Named Insured ends for any reason other than nonpayment of premium, this policy may be converted. The policy can only convert on the policy anniversary date following the Named Insured's 25th birthday. The new policy must be an individual permanent life policy that we currently issue. The face amount of insurance will be no more than twice the face amount of this policy. No evidence of insurability will be needed. To exercise the right of conversion, an application signed by the Named Insured must be sent to us within 31 days after the date the insurance is no longer In Force.

WHAT WILL BE THE DATE OF CONVERSION? The conversion will be processed when the following conditions are satisfied:

- We receive Written Request for conversion, and
- We receive the premium due on the new policy.

Premiums for the new policy will be those in effect when the new policy is issued. We will base the premium on the Named Insured's attained age.

The new policy will become effective only if the Named Insured is living on the conversion date. If, however, the Named Insured is entitled to a new policy but dies during the 31-day period within which we allow application for the new policy, we will pay the amount of insurance that was In Force under this policy for the Named Insured.

Part 7 **REINSTATEMENT**

CAN THE POLICY BE RESTORED TO A PREMIUM-PAYING BASIS AFTER IT LAPSES? You may request to have this policy Reinstated at any time within five years after it Lapses. To Reinstatement, we will require from you:

- An Aflac reinstatement application,
- Evidence of the Named Insured's insurability (at your expense), and
- Payment of all past-due premiums with annual interest at the interest rate shown in the Policy Schedule.

The policy will be Reinstated if we approve the Reinstatement.

Part 8 **BENEFICIARY**

TO WHOM WILL WE PAY THE PROCEEDS? Unless assigned, we will pay the Proceeds to the Beneficiary named in the application for this policy, unless you have subsequently changed the Named Insured's Beneficiary. In that event, we will pay the Proceeds to the Beneficiary named in your last change of Beneficiary request of record. If you name a minor child as the Beneficiary, any benefits due to the Beneficiary will not be payable until a guardian for the financial estate of the minor is appointed by the court or until such Beneficiary reaches the age of majority as defined by your state. If any Beneficiary is disqualified from receiving the Proceeds by operation of law, then the Proceeds will be paid as though that Beneficiary died before the Named

Insured, unless we have paid the Proceeds before receiving notice of the Beneficiary's disqualification.

WHAT HAPPENS IF A BENEFICIARY DIES? When a Beneficiary dies before the Named Insured, the interest of the Beneficiary Terminates. Only those Beneficiaries surviving the Named Insured will be eligible to share in the Proceeds. If a Beneficiary does not survive the Named Insured by 15 days, the Proceeds will be paid as though the Beneficiary died before the Named Insured, unless we have paid the Proceeds before receiving notice of the Beneficiary's death. If no Beneficiary survives the Named Insured, we will pay the Proceeds to the Named Insured's estate.

CAN THE BENEFICIARY BE CHANGED? You may change the Named Insured's Beneficiary at any time during the Named Insured's lifetime by making a Written Request. The Written Request will not be effective until we have recorded it at Aflac Worldwide Headquarters. After it has been recorded, the request will be effective as of the date it is signed. However, the Named Insured's dying before the request is recorded will not affect those Proceeds we have already paid.

CAN BENEFITS BE PAID OTHER THAN IN A LUMP SUM? Benefits may be paid in any manner agreeable to the Beneficiary and us.

**THIS IS A JUVENILE TERM TO 25 INSURANCE POLICY.
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Supporting Document Schedules

Item Status: **Status**
Date:

Satisfied - Item: Flesch Certification

Comments:

All requested certifications are included in the attached cover letter.

Attachment:

ARA65JTORFiling Ltr1 (2).pdf

Item Status: **Status**
Date:

Satisfied - Item: Application

Comments:

The attached applications were previously approved December 3, 2009 under SERFF filing # AFLA-126403526.

Attachments:

A65J01AR.pdf

A65J03AR.pdf



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

January 29, 2010

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

NAIC #60380

RE: Juvenile Term to Age 25 Life Policy Form A65JTORAR

Dear Mr. Musgrove:

Referenced form is submitted for your review and approval.

Policy Form A65JTORAR is a Juvenile Term to 25 Policy. Proceeds are payable at death. No dividends are payable. The policy will be marketed through our field force on a payroll or nonpayroll basis to applicants, age 14 days to 17 years.

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Temporary Life Insurance Agreement for Life Insurance Form A64016 was approved October 28, 2009 with our A64000 Series, SERFF Tracking # AFLA-126318884, and will be used on a direct basis only when premium has been collected at the time of application.

I certify that the form submitted herewith meets the requirements of Arkansas Rule and Regulation 17, 19, and 49 as well as meeting the requirements of the Arkansas Insurance Department.

I further certify that this submission meets the minimum reading ease score for the FLESCH test and that the scores are as follows:

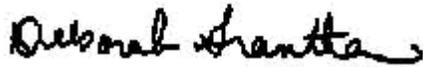
	FLESCH Score	Grade Level
Policy Form A65JTORAR	62.130	8

An actuarial memorandum with rate structure, a statement of policy costs and benefit information, a worksheet for calculating cost indexes and a cost comparison disclosure are enclosed for your review.

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This filing has been prepared by Leslie Steele. Should you have any questions or comments concerning this submission, please do not hesitate to call her collect at (706) 596-2971, by fax at (706) 660-7080 or email at lmsteele@aflac.com.

Sincerely,

A handwritten signature in black ink that reads "Deborah T. Grantham". The signature is written in a cursive style with a prominent flourish at the end.

Deborah T. Grantham
DTG/lis
Enclosures

TO BE COMPLETED BY AFLAC ASSOCIATE/AGENT

Billing Method

- Payroll Deduction
- List Bill
- Direct Billing
- Bank Draft (B/D, ACH)**
- Credit Card (C/C)**

Mode

- 01 Weekly*(not available for List Bill, Direct Billing, BD, or CC)
- 01 Semimonthly*
- 01 14-Day Biweekly*
- 01 28-Day Biweekly*
- 01 Monthly (not available on Direct Billing)
- 03 Quarterly
- 06 Semiannual
- 12 Annual

*Weekly, Semimonthly, 14-day and 28-day Biweekly modes are not available for Bank Draft and Credit Card Billing Methods. **For Bank Draft / ACH or Credit Card billing method, an Authorization Form must accompany this application.]

Billable Premium \$ _____ Premium Collected \$ _____

Associate/Agent's No. _____ Sit. Code _____

If a check or money order is collected, please leave a temporary life insurance agreement form with the applicant and submit a copy to worldwide headquarters.

BENEFICIARY INFORMATION

PLEASE NOTE: We do not recommend that you name a minor child as your Beneficiary. If you name a minor child as your Beneficiary, any benefits due your minor Beneficiary will not be payable until a guardian for the financial estate of the minor is appointed by the court or such Beneficiary reaches the age of majority as defined by your state. If there is no Beneficiary, Aflac will pay any applicable benefit to your estate.

PRIMARY BENEFICIARY

FULL NAME (Last, First, MI)	RELATIONSHIP	CITY/STATE	DATE OF BIRTH	% OF PROCEEDS

CONTINGENT BENEFICIARY

FULL NAME (Last, First, MI)	RELATIONSHIP	CITY/STATE	DATE OF BIRTH	% OF PROCEEDS

Proposed Insured's Physician's Name _____ Phone Number _____
(if no regular Physician, Physician last seen)

Address _____

Date Last Seen by Physician _____ Reason for Last Visit _____

1. I certify that the Proposed Insured and Owner are citizens or permanent legal residents of the United States. Yes No

If you answered no to Question 1, a policy will not be issued; therefore, do not submit this application.

2. Has the Proposed Insured ever been diagnosed by a member of the medical profession or tested positive for the human immunodeficiency virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS)? Yes No

If you answered yes to Question 2, a policy will not be issued; therefore, do not submit this application.

3. In the last year, has the Proposed Insured been declined or postponed for medical reasons on any life insurance application? Yes No
4. Has the Proposed Insured been diagnosed or treated by a member of the medical profession for any disorder of the heart, lungs, liver, intestines, kidney, blood or nervous/mental system, convulsive disorder, tumor or cancer, diabetes, hypertension, or any congenital abnormality? Yes No
5. In the past five years, has the Proposed Insured been unable to attend school or perform normal activities of like age, or been confined at home for more than five days, not including minor illnesses or injuries? Yes No

If you answered yes to any of Questions 3–5, please provide details in Item 7.

PLEASE COMPLETE THE FOLLOWING QUESTION IF THE PROPOSED INSURED IS AGE 15 OR OLDER.

6. Has the Proposed Insured been charged two or more times with a moving violation or within the past 12 months had a suspended or revoked driver's license? Yes No

If you answered yes to Question 6, a policy will not be issued; therefore, do not submit this application.

7. Details to Questions 3–5

Question	Medical Condition(s)	Onset (mo/yr)	Does the Condition Still Exist? <input type="checkbox"/> Yes <input type="checkbox"/> No
3.			<input type="checkbox"/> Yes <input type="checkbox"/> No
4.			<input type="checkbox"/> Yes <input type="checkbox"/> No
5.			<input type="checkbox"/> Yes <input type="checkbox"/> No

PROPOSED INSURED'S STATEMENTS AND AGREEMENTS

I understand that the Policy Effective Date will be the date recorded in the Policy Schedule by Aflac Worldwide Headquarters. It is not the date this application was signed.

I acknowledge receipt of, if applicable: Replacement Notice Life Buyer's Guide

I understand that: (1) the policy of insurance I am now applying for will be issued based upon the written answers to the questions, information asked for in this application, and any other pertinent information Aflac may require for proper underwriting; (2) Aflac is not bound by any statement made by me or any associate/agent of Aflac, unless written herein; (3) the associate/agent cannot change the provisions of the policy or waive any of its provisions either orally or in writing; (4) the policy, together with this application, endorsements, benefit agreements, and attached papers, if any, constitutes the entire contract of insurance; and (5) no change to the policy will be valid until approved by Aflac's president and secretary, and noted in or attached to the 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.

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 have read, or had read to me, the completed application. I realize that policy issuance is based upon statements and answers provided herein, and they are complete and true. All statements made in this application are deemed representations and not warranties. I realize that any material misrepresentation therein may result in loss of coverage under the policy.

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.

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

Signed and Dated at _____ on _____
City and State Date

Owner's Signature (X) _____

I certify that I personally saw the Owner when the application was completed, and each question was asked of the Owner and answered as recorded. All answers are correct to the best of my knowledge. To the best of my knowledge, this policy **will** **will not** replace or change any existing life insurance or annuity policy(ies).

Associate/Agent Signature_____

Date_____ Associate/Agent Writing Number_____ Sit. Code_____

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

**AMERICAN FAMILY LIFE ASSURANCE COMPANY OF COLUMBUS (AFLAC),
[CLIENT SERVICES AND ADMINISTRATION, 1932 WYNNTON ROAD, COLUMBUS, GEORGIA 31999,
TOLL-FREE 1-800-99-AFLAC (1-800-992-3522)]**

Associate's/Agent's Name_____

Associate's/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.]**

APPLICATION FOR REINSTATEMENT/CHANGE FORM
Aflac's Juvenile Whole Life and Juvenile Term Life Insurance (A65JWO and A65JTO Series)
ATTENTION: POLICYHOLDER SERVICES
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).
 Fax number – 1-800-448-8922]

Named Insured _____ SSN _____

Height _____ Current Weight _____
 ft. in. lbs.

Policy Number _____ Date of Birth _____

Current Address of Named Insured _____

City _____ State _____ ZIP _____ Primary Telephone No. _____

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

PLEASE MAKE THE FOLLOWING CHANGES TO THE POLICY:

ADDRESS CHANGE FOR NAMED INSURED ONLY

Former Address of Named Insured _____
 Street Apt.No.

City _____ State _____ ZIP _____

New Address of Named Insured _____
 Street Apt.No.

City _____ State _____ ZIP _____ Telephone No. _____

ADDRESS CHANGE FOR OWNER ONLY

Former Address of Owner _____
 Street Apt.No.

City _____ State _____ ZIP _____

New Address of Owner _____
 Street Apt.No.

City _____ State _____ ZIP _____ Telephone No. _____

CONTINGENT BENEFICIARY

FULL NAME (Last, First, MI)	RELATIONSHIP	CITY/STATE	DATE OF BIRTH	% OF PROCEEDS

1. I certify that the Proposed Insured and Owner are citizens or permanent legal residents of the United States. Yes No

If you answered no to Question 1, a policy will not be issued; therefore, do not submit this application.

2. Has the Proposed Insured ever been diagnosed by a member of the medical profession or tested positive for the human immunodeficiency virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS)? Yes No

If you answered yes to Question 2, a policy will not be issued; therefore, do not submit this application.

3. In the last year, has the Proposed Insured been declined or postponed for medical reasons on any life insurance application? Yes No
4. Has the Proposed Insured been diagnosed or treated by a member of the medical profession for any disorder of the heart, lungs, liver, intestines, kidney, blood or nervous/mental system, convulsive disorder, tumor or cancer, diabetes, hypertension, or any congenital abnormality? Yes No
5. In the past five years, has the Proposed Insured been unable to attend school or perform normal activities of like age, or been confined at home for more than five days, not including minor illnesses or injuries? Yes No

If you answered yes to any of Questions 3–5, please provide details in Item 7.

PLEASE COMPLETE THE FOLLOWING QUESTION IF THE NAMED INSURED IS AGE 15 OR OLDER.

6. Has the Proposed Insured been charged two or more times with a moving violation or within the past 12 months had a suspended or revoked driver's license? Yes No

If you answered yes to Question 6, a policy will not be issued; therefore, do not submit this application.

7. Details to Questions 3–5

Question	Medical Condition(s)	Onset (mo/yr)	Does the Condition Still Exist?
3.			<input type="checkbox"/> Yes <input type="checkbox"/> No
4.			<input type="checkbox"/> Yes <input type="checkbox"/> No
5.			<input type="checkbox"/> Yes <input type="checkbox"/> No

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.

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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

Owner's Signature _____ on _____

Named Insured's signature if age 18 or older _____

I certify that I personally saw the applicant when the application was completed, and each question was asked of the applicant and answered as recorded. All answers are correct to the best of my knowledge.

Associate's/Agent's Signature _____

Date _____ Associate's/Agent's Writing Number _____ Sit. Code _____

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