Filing at a Glance

Company: American Family Life Assurance Company of Columbus

Product Name: Short Term Disability
SERFF Tr Num: AFLA-127072212
State: Arkansas

TOI: H21 Health - Other
SERFF Status: Closed-Approved-Closed
State Tr Num: 48226

Sub-TOI: H21.000 Health - Other
Co Tr Num: A57600
State Status: Approved-Closed

Filing Type: Form
Reviewer(s): Rosalind Minor

Author: Connie Gates
Disposition Date: 05/12/2011

Date Submitted: 03/11/2011
Disposition Status: Approved-Closed

Implementation Date Requested: On Approval
Implementation Date:

State Filing Description:

General Information

Project Name: STD
Status of Filing in Domicile: Pending

Project Number: A57600
Date Approved in Domicile:

Requested Filing Mode: Review & Approval
Domicile Status Comments: Similar versions of these forms are being filed concurrently in Nebraska, our state of domicile.

Explanation for Combination/Other:
Market Type: Individual

Submission Type: New Submission
Individual Market Type: Individual

Overall Rate Impact:
Filing Status Changed: 05/12/2011

State Status Changed: 05/12/2011

Deemer Date:
Created By: Connie Gates

Submitted By: Connie Gates
Corresponding Filing Tracking Number:

PPACA: Not PPACA-Related

PPACA Notes: null

Filing Description:

See attached filing letter under Supporting Documentation tab.

Company and Contact

Filing Contact Information

Connie Gates, Policy Analyst
1932 Wynnton Road
Columbus, GA 31999

cgates@aflac.com
706-596-5048 [Phone]
706-660-7080 [FAX]

Filing Company Information

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

Filing Fees

Fee Required?	Yes
Fee Amount:	$650.00
Retaliatory?	No
Fee Explanation:	13 forms x $50
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
American Family Life Assurance Company of Columbus	$650.00	03/11/2011	45493782

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	05/12/2011	05/12/2011
Approved-Closed	Rosalind Minor	03/14/2011	03/14/2011

Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Supporting Document	Health - Actuarial Justification	Connie Gates	05/12/2011	05/12/2011

Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
RE: Rates for On-the-Job Injury Rider Form A57650LB	Note To Reviewer	Connie Gates	05/12/2011	05/12/2011
re-opened	Reviewer Note	Rosalind Minor	05/12/2011	

SERFF Tracking Number:	*AFLA-127072212*	*State:*	*Arkansas*
Filing Company:	*American Family Life Assurance Company of Columbus*	*State Tracking Number:*	*48226*
Company Tracking Number:	*A57600*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*Short Term Disability*		
Project Name/Number:	*STD/A57600*		

Disposition

Disposition Date: 05/12/2011
Implementation Date:
Status: Approved-Closed
HHS Status: HHS Approved
State Review: Reviewed by Actuary
Comment:

This submission was re-opened in order to include the "P" rate for the O EB/3 mo BP Option. The additional rate sheet is being approved effective on this date.

The remainder of the filing will maintain the original approval date of 3/14/11.

Rate data does NOT apply to filing.

SERFF Tracking Number:	*AFLA-127072212*	*State:*	*Arkansas*
Filing Company:	*American Family Life Assurance Company of Columbus*	*State Tracking Number:*	*48226*
Company Tracking Number:	*A57600*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*Short Term Disability*		
Project Name/Number:	*STD/A57600*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document *(revised)*	Health - Actuarial Justification	Approved-Closed	No
Supporting Document	Health - Actuarial Justification	Replaced	No
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	PPACA Uniform Compliance Summary	Approved-Closed	Yes
Form	Short-Term Disability Policy Form	Approved-Closed	Yes
Form	Disability Benefit for On-the-Job Injury Rider Form	Approved-Closed	Yes
Form	Additional Units of Disability Rider Form	Approved-Closed	Yes
Form	Payroll Application Form	Approved-Closed	Yes
Form	Payroll Application Form	Approved-Closed	Yes
Form	Payroll Application Form	Approved-Closed	Yes
Form	Payroll Application Form	Approved-Closed	Yes
Form	Associate Only Application Form	Approved-Closed	Yes
Form	Application for Reinstatement Form	Approved-Closed	Yes
Form	Outline of Coverage Form	Approved-Closed	Yes
Form	Short-Term Disability Policy Form	Approved-Closed	Yes
Form	Disability Benefit for On-the-Job Injury Rider Form	Approved-Closed	Yes
Form	Outline of Coverage Form	Approved-Closed	Yes

SERFF Tracking Number:	*AFLA-127072212*	*State:*	*Arkansas*
Filing Company:	*American Family Life Assurance Company of Columbus*	*State Tracking Number:*	*48226*
Company Tracking Number:	*A57600*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*Short Term Disability*		
Project Name/Number:	*STD/A57600*		

Disposition

Disposition Date: 03/14/2011
Implementation Date:
Status: Approved-Closed
HHS Status: Not Reported
State Review: Reviewed by Actuary
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*AFLA-127072212*	*State:*	*Arkansas*
Filing Company:	*American Family Life Assurance Company of Columbus*	*State Tracking Number:*	*48226*
Company Tracking Number:	*A57600*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*Short Term Disability*		
Project Name/Number:	*STD/A57600*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document *(revised)*	Health - Actuarial Justification	Approved-Closed	No
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Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	PPACA Uniform Compliance Summary	Approved-Closed	Yes
Form	Short-Term Disability Policy Form	Approved-Closed	Yes
Form	Disability Benefit for On-the-Job Injury Rider Form	Approved-Closed	Yes
Form	Additional Units of Disability Rider Form	Approved-Closed	Yes
Form	Payroll Application Form	Approved-Closed	Yes
Form	Payroll Application Form	Approved-Closed	Yes
Form	Payroll Application Form	Approved-Closed	Yes
Form	Payroll Application Form	Approved-Closed	Yes
Form	Associate Only Application Form	Approved-Closed	Yes
Form	Application for Reinstatement Form	Approved-Closed	Yes
Form	Outline of Coverage Form	Approved-Closed	Yes
Form	Short-Term Disability Policy Form	Approved-Closed	Yes
Form	Disability Benefit for On-the-Job Injury Rider Form	Approved-Closed	Yes
Form	Outline of Coverage Form	Approved-Closed	Yes

Amendment Letter

Submitted Date: 05/12/2011

Comments:

This filing is made in reference to recently approved Short Term Disability Policy Form Series A57600LBAR.

The rates that were previously filed for the On-the-Job Rider A57650LB failed to include a P rate for the 0 EP/3 mo BP option.

The additional rate sheet titled "Annual Rate OTJ Rider 0EP PClass LB AR" is attached below for your review and approval.

Changed Items:

Supporting Document Schedule Item Changes:

Satisfied -Name: Health - Actuarial Justification

Comment: This filing is made in reference to recently approved Short Term Disability Policy Form Series A57600LBAR.

The rates that were previously filed for the On-the-Job Rider A57650LB failed to include a P rate for the 0 EP/3 mo BP option.

The additional rate sheet is attached below for your review and approval.

57600 no 3 month Memo AR.pdf

Annual Rates LB AR no 3 mth.pdf

57600LB 3 month Memo AR.pdf

Annual Rates LB AR.pdf

Annual Rate OTJ Rider 0EP PClass LB AR.pdf

Note To Reviewer

Created By:
Connie Gates on 05/12/2011 11:43 AM
Last Edited By:
Connie Gates
Submitted On:
05/12/2011 11:43 AM
Subject:
RE: Rates for On-the-Job Injury Rider Form A57650LB
Comments:

This request is made in reference to recently approved Short Term Disability Policy Form Series A57600LBAR.

The rates that were previously filed for the On-the-Job Rider A57650LB failed to include a P rate for the 0 EP/3 mo BP option.

We would like to amend this filing so it will include the additional rate sheet.

Reviewer Note

Created By:

Rosalind Minor on 05/12/2011 11:56 AM

Subject:

re-opened

Comments:

The file is being re-opened as requested in a telephone converation on this date with Connie Gates.

Form Schedule

Lead Form Number: A57600AR

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 03/14/2011	A57600AR	Policy/Contract/Fraternal Certificate	Short-Term Disability Policy Form	Initial		56.365	A57600AR.pdf
Approved-Closed 03/14/2011	A57650AR	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Disability Benefit for On-the-Job Injury Rider Form	Initial		58.231	A57650AR.pdf
Approved-Closed 03/14/2011	A57651	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Additional Units of Disability Rider Form	Initial		55.372	A57651.pdf
Approved-Closed 03/14/2011	A57601AR	Application/Enrollment Form	Payroll Application Form	Initial		49.853	A57601AR.pdf
Approved-Closed 03/14/2011	A57601cAR	Application/Enrollment Form	Payroll Application Form	Initial		50.363	A57601cAR.pdf
Approved-Closed	A57601GAR	Application/Enrollment	Payroll Application Form	Initial		64.799	A57601GAR.pdf

03/14/2011 Approved-Closed	A57601GcAR	Form Application/Enrollment Form	Payroll Application Form	Initial		60.966	A57601GcAR.pdf
03/14/2011 Approved-Closed	A57601AAR	Application/Enrollment Form	Associate Only Application Form	Initial		49.366	A57601AAR.pdf
03/14/2011 Approved-Closed	A57603AR	Application/Enrollment Form	Application for Reinstatement Form	Initial		59.422	A57603AR.pdf
03/14/2011 Approved-Closed	A57625AR	Outline of Coverage	Outline of Coverage Form	Initial		54.296	A57625AR.pdf
03/14/2011 Approved-Closed	A57600LBAR	Policy/Contract/Fraternal Certificate	Short-Term Disability Policy Form	Initial		56.365	A57600LBAR.pdf
03/14/2011 Approved-Closed	A57650LB	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Disability Benefit for On-the-Job Injury Rider Form	Initial		58.231	A57650LB.pdf
03/14/2011 Approved-Closed	A57625LB	Outline of Coverage	Outline of Coverage Form	Initial		54.296	A57625LB.pdf
03/14/2011							

SHORT-TERM DISABILITY POLICY

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

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

CONSIDERATION

This policy is issued in consideration of statements made in your application and the payment of the premium shown in the Policy Schedule. A copy of your application is attached and is a part of this policy. The following paragraphs set forth the definitions of terms, the limitations and exclusions, the insurance benefits, and other provisions.

YOUR RIGHT TO EXAMINE THIS POLICY

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

IMPORTANT NOTICE

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

THIS POLICY IS GUARANTEED-RENEWABLE TO AGE 75, SUBJECT TO AFLAC'S RIGHT TO CHANGE PREMIUMS BY CLASS UPON ANY RENEWAL DATE.

We agree that this policy will never be restricted by the addition of any rider without your consent, nor will renewal be refused because of any change in your health or physical condition. You are guaranteed the right to renew this policy until the policy anniversary date following your 75th birthday by the timely payment of premiums at the rate in effect at the beginning of each term, except that we may discontinue or terminate the policy if you have performed an act or practice that constitutes fraud, or have made an intentional misrepresentation of material fact, relating in any way to the policy, including claims for benefits under the policy. **Your coverage will terminate on the policy anniversary date following your 75th birthday.**

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

PRE-EXISTING CONDITION LIMITATIONS

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

AMERICAN FAMILY LIFE ASSURANCE COMPANY OF COLUMBUS
[WORLDWIDE HEADQUARTERS • 1932 WYNNTON ROAD • COLUMBUS, GEORGIA 31999
FOR ASSISTANCE OR INFORMATION ABOUT THIS POLICY, CALL 1.800.99.AFLAC (1.800.992.3522).
FOR CLAIM FORMS, VISIT OUR WEB SITE AT AFLAC.COM].
If we at Aflac, fail to provide you with reasonable and adequate service,
you should feel free to contact:
ARKANSAS INSURANCE DEPARTMENT - CONSUMER SERVICES DIVISION
1200 WEST THIRD STREET • LITTLE ROCK, ARKANSAS 72201-1904
Telephone 501.371.2640 or Toll-Free 1.800.852.5494.

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Uniform Provisions ..... Part 3

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Policy Schedule

NAMED INSURED: John A. Doe

POLICY NUMBER: 111-2222

TYPE OF COVERAGE: Individual Only

COVERAGE: XXXXXX
AAABBB

MODE OF PAYMENT: Monthly

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

BENEFIT PERIODS:
Policy:
Total Disability: 6, 12, 18, 24 Months
Partial Disability: 3 Months
On-the-Job Rider:
Total Disability: 6, 12, 18, 24 Months
Partial Disability: 3 Months
Additional Disability Rider:
Total Disability: 6, 12, 18, 24 Months
Partial Disability: 3 Months

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

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

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

[
Paul S. Amos II, President

Joey M. Loudermilk, Secretary]

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

Part 1
DEFINITIONS

A. ACTIVITIES OF DAILY LIVING (ADLs): activities used in measuring your level of personal functioning capacity. Normally, these activities are performed without Direct Personal Assistance, allowing you personal independence in everyday living.

The ADLs are:

1. Bathing: washing oneself by sponge bath or in either a tub or shower, including the task of getting into or out of the tub or shower;

2. Maintaining continence: controlling urination and bowel movements, including your ability to use ostomy supplies or other devices such as catheters;

3. Transferring: moving between a bed and a chair, or a bed and a wheelchair;

4. Dressing: putting on and taking off all necessary items of clothing;

5. Toileting: getting to and from a toilet, getting on and off a toilet, and performing associated personal hygiene; and

6. Eating: performing all major tasks of getting food into your body.

B. ANNUAL INCOME: your taxable (gross) annual income from your Full-Time Job. If you are self-employed, the term "Annual Income" means an average of the net earnings reported to the Internal Revenue Service for the past two years from your business.

C. BENEFIT PERIOD: the maximum number of days after the Elimination Period, if any, for which you can be paid benefits for any period of Disability. Each new Benefit Period is subject to a new Elimination Period. See the Policy Schedule for the Benefit Period you selected. For the purposes of this calculation, a "month" is defined as 30 days for which benefits are paid.

D. COMPLICATIONS OF PREGNANCY: (1) conditions requiring medical treatment prior to or subsequent to the termination of a pregnancy whose diagnoses are distinct from pregnancy but that are adversely affected by pregnancy or caused by pregnancy, such as acute nephritis; nephrosis; cardiac decompensation; missed abortion; disease of the vascular, hemopoietic, nervous, or endocrine systems; and similar medical and surgical conditions of comparable severity; (2) non-elective cesarean deliveries, hyperemesis gravidarum and pre-eclampsia requiring hospital confinement, ectopic pregnancy that is terminated, and spontaneous termination of pregnancy that occurs during a period of gestation in which a viable birth is not possible.

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

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E. DAILY DISABILITY BENEFIT: one-thirtieth of the applicable monthly Disability benefit shown in the Policy Schedule.

F. DIRECT PERSONAL ASSISTANCE: direct physical assistance from another party required to help you perform an ADL, each and every time you perform that activity, because of an inability to perform the entire activity alone with the supports and mechanical aids that are normally available to you.

G. DISABILITY:

1. **TOTAL DISABILITY:** being under the care and attendance of a Physician due to a condition that causes you to be unable to perform the material and substantial duties of your Full-Time Job, and not working at any job.

2. **PARTIAL DISABILITY:** being under the care and attendance of a Physician due to a condition that causes you to be unable to perform the material and substantial duties of your Full-Time Job, but able to work at any job earning less than 80 percent of your Annual Income of your Full-Time Job at the time you became disabled.

H. EFFECTIVE DATE: the date(s) coverage begins as shown in the Policy Schedule. The Effective Date of this policy **is not** the date you signed the application for coverage.

I. ELIMINATION PERIOD: the number of consecutive days at the beginning of your period of Disability for which no benefits are payable. See the Policy Schedule for the Elimination Period you selected. Each new Benefit Period is subject to a new Elimination Period.

J. FULL-TIME JOB: one job at which you work 19 or more hours per week for one employer for pay or benefits.

K. IMMEDIATE FAMILY: anyone related to you in the following manner: spouse; brothers or sisters (includes stepbrothers and stepsisters); children (includes stepchildren); parents (includes stepparents); grandchildren; father- or mother-in-law; brother- or sister-in-law; and spouses, as applicable, of any of these.

L. INJURY: a bodily injury caused directly by an accident, independent of Sickness, disease, bodily infirmity, or any other cause, occurring on or after the Effective Date of coverage and while coverage is in force.

M. MEDICALLY NECESSARY: treatment, services, or supplies necessary and appropriate for the diagnosis or treatment of a Sickness or an Injury based upon generally accepted medical practice.

N. OFF-THE-JOB INJURY: an Injury that occurs while you are not working at any job for pay or benefits.

O. ON-THE-JOB INJURY: an Injury that occurs while you are working at any job for pay or benefits.

P. PHYSICIAN: a person legally qualified to practice medicine, other than you or a member of your Immediate Family, who is licensed as a Physician by the state where treatment is received to treat the type of condition for which a claim is made.

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Q. SICKNESS: an illness, disease, infection, or any other abnormal physical condition, independent of Injury, that is first manifested and first treated more than 30 days after the Effective Date of coverage and while coverage is in force. If an illness, disease, infection, or any other physical condition is diagnosed or treated by a Physician within the first 30 days after the Effective Date of coverage, any resulting Disability will not be covered unless it begins more than 12 months after the Effective Date of coverage.

Part 2
LIMITATIONS AND EXCLUSIONS

A. Disability caused by a Pre-existing Condition or reinjuries to a Pre-existing Condition will not be covered unless it begins more than 12 months after the Effective Date of coverage.

B. Aflac will not pay benefits for an illness, disease, infection, or disorder that is diagnosed or treated by a Physician within the first 30 days after the Effective Date of coverage, unless the resulting Disability begins more than 12 months after the Effective Date of coverage.

C. Aflac will not pay benefits for a Disability that is being treated outside the territorial limits of the United States.

D. Aflac will not pay benefits whenever coverage provided by this policy is in violation of any U.S. economic or trade sanctions. If the coverage violates U.S. economic or trade sanctions, such coverage shall be null and void.

E. Aflac will not pay benefits whenever fraud is committed in making a claim under this coverage or any prior claim under any other Aflac coverage for which you received benefits that were not lawfully due and that fraudulently induced payment.

F. Aflac will not pay benefits for a Disability that is caused by or occurs as a result of any bacterial, viral, or micro-organism infection or infestation, or any condition resulting from insect, arachnid, or other arthropod bites or stings as a Disability due to an Injury; such disability will be covered to the same extent as a Disability due to Sickness.

G. Aflac will not pay benefits for a disability that is caused by or occurs as a result of your:

1. Pregnancy or childbirth within the first ten months of the Effective Date of coverage (Complications of Pregnancy will be covered to the same extent as a Sickness);

2. Using any drug, narcotic, hallucinogen, or chemical substance (unless administered by a Physician and taken according to the Physician's instructions), or voluntarily taking any kind of poison or inhaling any kind of gas or fumes;

3. Participating in any activity or event, including the operation of a vehicle, while under the influence of a controlled substance (unless administered by a Physician and taken according to the Physician's instructions) or while intoxicated ("intoxicated" means that condition as defined by the law of the jurisdiction in which the accident occurred);

4. Participating in, or attempting to participate in, an illegal activity that is defined as a felony, whether charged or not ("felony" is as defined by the law of the jurisdiction in which the activity takes place); or being incarcerated in any type penal institution;

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5. Intentionally self-inflicting a bodily injury, or committing or attempting suicide, while sane or insane;

6. Having cosmetic surgery or other elective procedures that are not Medically Necessary;

7. Having dental treatment, except as a result of Injury;

8. Being exposed to war or any act of war, declared or undeclared;

9. Actively serving in any of the armed forces, or units auxiliary thereto, including the National Guard or Reserve;

10. Donating an organ within the first 12 months of the Effective Date of this policy;

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

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

Part 3
UNIFORM PROVISIONS

A. ENTIRE CONTRACT; CHANGES: This policy, together with the application, endorsements, benefit agreements, riders, and attached papers, if any, constitutes the entire contract of insurance. No change in this policy is valid until approved in writing by the president and secretary of Aflac at our worldwide headquarters. Any such change must be noted hereon or attached hereto. No associate (duly licensed agent) has the authority to change this policy or to waive any of its provisions.

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

C. TERM: You are guaranteed the right to renew this policy until the policy anniversary date following your 75th birthday by the timely payment of premiums at the rate in effect at the beginning of each term. Your coverage will terminate on the policy anniversary date following your 75th birthday. The term of this policy begins at midnight, standard time, at the place where you reside on the Effective Date shown in the Policy Schedule. It ends at midnight, at the same standard time, on the first renewal date. Each renewal term ends at midnight, at the same standard time, on the next following renewal date. Renewal dates are determined by the mode of payment. The mode of payment for the original term of this policy is shown in the

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Policy Schedule. An annual premium will maintain this policy in force for 12 months, semiannual for six months, quarterly for three months, and monthly for one month. Premium for a term is due on the first day of that term. **If you fail to pay your premium by the end of the grace period, coverage under this policy will terminate.** If you are receiving short-term Disability benefits on the date coverage would otherwise terminate, coverage under this policy will be extended to the earlier of the date you are no longer qualified to receive Disability benefits or to the end of the Benefit Period, whichever occurs first.

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

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

F. REINSTATEMENT: You may request reinstatement of your policy from your associate (duly licensed agent) or from Aflac. If your policy has lapsed for nonpayment of premium and we accept a later payment without requiring an application, your policy will be reinstated. If we require a written application and provide you with a conditional receipt, your policy will be reinstated upon our approval of the application. If we do not notify you of our disapproval in writing within 45 days of the date your application is received at our worldwide headquarters, your policy will be deemed reinstated. The reinstated policy will cover only loss resulting from a condition that begins on or after the date of reinstatement. In all other respects, you and Aflac will have the same rights as provided under the policy immediately before the due date of the defaulted premium, subject to any provisions added in connection with the reinstatement. Any premium accepted in connection with a reinstatement will be applied to a period for which premium has not been previously paid, but not to any period more than 60 days prior to the date of reinstatement.

G. MISSTATEMENT OF OCCUPATION OR INCOME: If your occupation has been misstated, the benefits will be those that the premiums paid would have purchased for your correct occupation. If your income has been misstated, the benefit payable will be that which would have been allowed for your true income level, and any overpayment of premium will be refunded.

H. NOTICE OF CLAIM: Written notice of claim must be given within 60 days after a covered loss starts or as soon as reasonably possible. The notice can be given to Aflac at our worldwide headquarters, [1932 Wynnton Rd, Columbus, GA 31999], or to your associate (duly licensed agent). The notice of claim should include the name of the covered person and the policy number.

I. CLAIM FORMS: When we receive a notice of claim, we will send you forms for filing proof of loss. If the forms are not sent to you within ten working days after the giving of such notice, you will meet the proof-of-loss requirements by giving us a written statement of the nature and extent of the loss within the time limit stated in the Proof of Loss provision.

J. PROOF OF LOSS: Written proof of loss (written proofs, such as claim forms, medical bills, medical authorizations or other reasonable evidence of the claim that is ordinarily required) must be furnished to Aflac at our worldwide headquarters within 90 days after the date of

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such loss. Failure to furnish such proof within the time required will not invalidate or reduce any claim if it was not reasonably possible to give proof within such time. However, such proof must be furnished as soon as reasonably possible and in no event (except in the absence of legal capacity) later than 15 months from the time proof is otherwise required.

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

L. PAYMENT OF CLAIMS: All benefits will be payable to you, unless assigned by you or by operation of law. Any accrued benefits unpaid at your death will be paid to your estate.

M. LEGAL ACTIONS: No legal action may be brought to recover on this policy within 60 days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action may be brought after three years from the time written proof of loss is required to be furnished.

N. CONFORMITY WITH STATE AND FEDERAL STATUTES: Any provision of this policy that on its Effective Date is in conflict with the statutes of the state in which it was issued or with any federal statute is hereby amended to conform to the minimum requirements of such statutes.

O. PHYSICAL EXAMINATIONS AND AUTOPSY: Aflac, at its own expense, will have the right and opportunity to examine a covered person when and as often as it may be reasonably required while a claim is pending hereunder, and to make an autopsy in the case of death where autopsy is not forbidden by law.

P. ASSIGNMENT: Aflac will not assume responsibility for determining the validity of an assignment of your benefits to a provider of services. No such assignment of benefits will be recognized until we receive notice at our worldwide headquarters that you have specifically assigned the benefits of your Aflac policy.

Q. OTHER INSURANCE WITH AFLAC: If you are covered under more than one Aflac policy with Disability benefits, only one Disability benefit chosen by you or your estate, as the case may be, will be effective. Aflac will return all premiums paid for the canceled benefits from the date of duplication, less any benefits paid under these policies from such date.

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

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

Part 4
BENEFITS

Aflac will pay the following benefits, as applicable, if your Disability is caused by a covered Sickness or covered Off-the-Job Injury and occurs while this coverage is in force.

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All benefits are subject to the Limitations and Exclusions, Pre-existing Condition Limitations, and other policy terms.

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

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

A. TOTAL DISABILITY BENEFITS:

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

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

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

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

   If you are unable to perform three or more ADLs within 90 days of your last treatment that is a result of a covered Sickness or Off-the-Job Injury, as certified by a Physician, and you require Direct Personal Assistance to perform such ADLs, we will pay you the Daily Disability Benefit for each day you cannot perform such ADLs. This benefit is payable up to the Total Disability Benefit Period you selected and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled "Term," and the definition of "Benefit Period."

   You will no longer be qualified to receive this benefit upon the earlier of your: (1) being released by your Physician to perform the material and substantial duties of your Full-Time Job, (2) working at any job, or (3) Physician no longer being able to certify that you are unable to perform three or more ADLs that require Direct Personal Assistance.

Separate periods of Disability, resulting from the **same or a related condition** and not separated by 180 days or more, are considered a continuation of the prior Disability. Once the

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maximum Total Disability Benefit Period has been paid, you will not be eligible for a new Total Disability Benefit Period for Disability due to the same or a related condition, until 180 days after you: (1) have been released by a Physician from the prior Disability, (2) are no longer disabled, and (3) are no longer qualified to receive any Disability benefits under this policy.

Separate periods of Disability, resulting from **unrelated causes** and not separated by your returning to work at a Full-Time Job for 14 working days during which you are performing the material and substantial duties of such job, are considered a continuation of the prior Disability. Once the maximum Total Disability Benefit Period has been paid, you will not be eligible for a new Total Disability Benefit Period for Disability due to an unrelated cause, until 14 working days after you: (1) have been released by a Physician from a prior Disability, (2) are no longer disabled, and (3) are no longer qualified to receive any Disability benefits under this policy.

Periods of Disability meeting either of these separation requirements will begin a new Total Disability Benefit Period, subject to a new Elimination Period.

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

If your covered Sickness or covered Off-the-Job Injury causes your Partial Disability within 90 days of your last treatment for your covered Sickness or covered Off-the-Job Injury, we will pay you one-half of the Daily Disability Benefit for each day of your Partial Disability. This benefit is payable up to the Partial Disability Benefit Period (a maximum period of three months) and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled “Term,” and the definition of “Benefit Period.”

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

Separate periods of Disability, resulting from the **same or a related condition** and not separated by 180 days or more, are considered a continuation of the prior Disability. Once the maximum period of three months of Disability under this benefit has been paid, you will not be eligible for a new Partial Disability Benefit Period for Disability due to the same or a related condition, until 180 days after you: (1) have been released by a Physician from the prior Disability, (2) are no longer disabled, and (3) are no longer qualified to receive any Disability benefits under this policy.

Separate periods of Disability, resulting from **unrelated causes** and not separated by your returning to work at a Full-Time Job for 14 working days during which you are performing the material and substantial duties of such job, are considered a continuation of the prior Disability. Once the maximum Partial Disability Benefit Period has been paid, you will not be eligible for a new Partial Disability Benefit Period for Disability due to an unrelated cause, until 14 working days after you: (1) have been released by a Physician from a prior Disability, (2) are no longer disabled, and (3) are no longer qualified to receive any Disability benefits under this policy.

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Periods of Disability meeting either of these separation requirements will begin a new Partial Disability Benefit Period (a maximum period of three months), subject to a new Elimination Period.

The Partial Disability Benefit Period is not subject to the Total Disability Benefit Period.

C. WAIVER OF PREMIUM BENEFIT: If your covered Sickness or covered Off-the-Job Injury causes your Total Disability or Partial Disability for more than 90 consecutive days (or after the Elimination Period shown in the Policy Schedule, whichever is greater) while this policy is in force, Aflac will waive, from month to month, the premium for the policy and any applicable rider(s) for as long as you remain disabled, up to the applicable Benefit Period shown in the Policy Schedule.

For premiums to be waived, Aflac will require an employer's statement (or proof of your inability to perform three or more ADLs) and a Physician's statement certifying your inability to perform said duties or activities, and may each month thereafter require a Physician's statement that your inability to perform said duties or activities continues. Aflac may ask for and use an independent consultant to determine your Disability when this benefit is in force.

You must pay all premiums to keep the policy and any applicable rider(s) in force until Aflac approves your claim for this Waiver of Premium Benefit. You must also resume premium payment to keep the policy and any applicable rider(s) in force, beginning with the first premium due after you no longer qualify for Disability benefits.

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

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AMERICAN FAMILY LIFE ASSURANCE COMPANY OF COLUMBUS
(herein referred to as Aflac)
[Worldwide Headquarters • Columbus, Georgia 31999
A Stock Company]

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

Part 1
EFFECTIVE DATE

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

Part 2
TIME LIMIT ON CERTAIN DEFENSES

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

Part 3
BENEFITS

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

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

A. TOTAL DISABILITY BENEFITS:

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

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

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

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

   If you are unable to perform three or more ADLs within 90 days of your last treatment that is a result of a covered On-the-Job Injury, as certified by a Physician, and you require Direct Personal Assistance to perform such ADLs, we will pay you the Daily Disability Benefit for the On-the-Job Injury Disability Rider for each day you cannot perform such ADLs. This benefit is payable up to the Total Disability Benefit Period you selected and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled "Term," and the definition of "Benefit Period."

   You will no longer be qualified to receive this benefit upon the earlier of your: (1) being released by your Physician to perform the material and substantial duties of your Full-Time Job, (2) working at any job, or (3) Physician no longer being able to certify that you are unable to perform three or more ADLs that require Direct Personal Assistance.

Separate periods of Disability, resulting from the **same or a related condition** and not separated by 180 days or more, are considered a continuation of the prior Disability. Once the maximum Total Disability Benefit Period has been paid, you will not be eligible for a new Total Disability Benefit Period for Disability due to the same or a related condition, until 180 days after you: (1) have been released by a Physician from the prior Disability, (2) are no longer disabled, and (3) are no longer qualified to receive any Disability benefits under this policy.

Separate periods of Disability, resulting from **unrelated causes** and not separated by your returning to work at a Full-Time Job for 14 working days during which you are performing the material and substantial duties of such job, are considered a continuation of the prior Disability. Once the maximum Total Disability Benefit Period has been paid, you will not be eligible for a new Total Disability Benefit Period for Disability due to an unrelated cause, until 14 working days after you: (1) have been released by a Physician from a prior Disability, (2) are no longer disabled, and (3) are no longer qualified to receive any Disability benefits under this policy.

Periods of Disability meeting either of these separation requirements will begin a new Total Disability Benefit Period, subject to a new Elimination Period.

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

If your covered On-the-Job Injury causes your Partial Disability within 90 days of your last treatment for your covered On-the-Job Injury, we will pay you one-half of the Daily Disability Benefit for the On-the-Job Injury Disability Rider for each day of your Partial Disability. This benefit is payable up to the Partial Disability Benefit Period (a maximum period of three months) and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled "Term," and the definition of "Benefit Period."

You will no longer be qualified to receive this benefit upon the earlier of your: (1) being released by your Physician to perform the material and substantial duties of your Full-Time

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Job, or (2) working at any job earning 80 percent or more of your pre-Disability Annual Income.

Separate periods of Disability, resulting from the **same or a related condition** and not separated by 180 days or more, are considered a continuation of the prior Disability. Once the maximum period of three months of Disability under this benefit has been paid, you will not be eligible for a new Partial Disability Benefit Period for Disability due to the same or a related condition, until 180 days after you: (1) have been released by a Physician from the prior Disability, (2) are no longer disabled, and (3) are no longer qualified to receive any Disability benefits under this policy.

Separate periods of Disability, resulting from **unrelated causes** and not separated by your returning to work at a Full-Time Job for 14 working days during which you are performing the material and substantial duties of such job, are considered a continuation of the prior Disability. Once the maximum Partial Disability Benefit Period has been paid, you will not be eligible for a new Partial Disability Benefit Period for Disability due to an unrelated cause, until 14 working days after you: (1) have been released by a Physician from a prior Disability, (2) are no longer disabled, and (3) are no longer qualified to receive any Disability benefits under this policy.

Periods of Disability meeting either of these separation requirements will begin a new Partial Disability Benefit Period (a maximum period of three months), subject to a new Elimination Period.

The Partial Disability Benefit Period is not subject to the Total Disability Benefit Period.

C. WAIVER OF PREMIUM BENEFIT: If your covered On-the-Job Injury causes your Total Disability or Partial Disability for more than 90 consecutive days (or after the Elimination Period shown in the Policy Schedule, whichever is greater) while this rider is in force, Aflac will waive, from month to month, the premium for the policy and any applicable rider(s) for as long as you remain disabled, up to the applicable Benefit Period shown in the Policy Schedule.

For premiums to be waived, Aflac will require an employer's statement (or proof of your inability to perform three or more ADLs) and a Physician's statement certifying your inability to perform said duties or activities, and may each month thereafter require a Physician's statement that your inability to perform said duties or activities continues. Aflac may ask for and use an independent consultant to determine your Disability when this benefit is in force.

You must pay all premiums to keep the policy and any applicable rider(s) in force until Aflac approves your claim for this Waiver of Premium Benefit. You must also resume premium payment to keep the policy and any applicable rider(s) in force, beginning with the first premium due after you no longer qualify for Disability benefits.

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

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Part 4
TERMINATION

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

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

[
Paul S. Amos II, President

Joey M. Loudermilk, Secretary]

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AMERICAN FAMILY LIFE ASSURANCE COMPANY OF COLUMBUS
(herein referred to as Aflac)
[Worldwide Headquarters • Columbus, Georgia 31999
A Stock Company]

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

Part 1
EFFECTIVE DATE

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

Part 2
TIME LIMIT ON CERTAIN DEFENSES

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

Part 3
BENEFITS

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

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

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

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

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A. TOTAL DISABILITY BENEFITS:

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

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

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

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

   If you are unable to perform three or more ADLs within 90 days of your last treatment that is a result of a covered Sickness or Off-the-Job Injury, as certified by a Physician, and you require Direct Personal Assistance to perform such ADLs, we will pay you the Daily Disability Benefit for the Additional Units of Disability Benefit Rider for each day you cannot perform such ADLs. This benefit is payable up to the Total Disability Benefit Period you selected and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled "Term," and the definition of "Benefit Period."

   You will no longer be qualified to receive this benefit upon the earlier of your: (1) being released by your Physician to perform the material and substantial duties of your Full-Time Job, (2) working at any job, or (3) Physician no longer being able to certify that you are unable to perform three or more ADLs that require Direct Personal Assistance.

Separate periods of Disability, resulting from the **same or a related condition** and not separated by 180 days or more, are considered a continuation of the prior Disability. Once the maximum Total Disability Benefit Period has been paid, you will not be eligible for a new Total Disability Benefit Period for Disability due to the same or a related condition, until 180 days after you: (1) have been released by a Physician from the prior Disability, (2) are no longer disabled, and (3) are no longer qualified to receive any Disability benefits under this policy.

Separate periods of Disability, resulting from **unrelated causes** and not separated by your returning to work at a Full-Time Job for 14 working days during which you are performing the material and substantial duties of such job, are considered a continuation of the prior Disability. Once the maximum Total Disability Benefit Period has been paid, you will not be eligible for a new Total Disability Benefit Period for Disability due to an unrelated cause, until 14 working days after you: (1) have been released by a Physician from a prior Disability, (2) are no longer disabled, and (3) are no longer qualified to receive any Disability benefits under this policy .

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Periods of Disability meeting either of these separation requirements will begin a new Total Disability Benefit Period, subject to a new Elimination Period.

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

If your covered Sickness or covered Off-the-Job Injury causes your Partial Disability within 90 days of your last treatment for your covered Sickness or covered Off-the-Job Injury, we will pay you one-half of the Daily Disability Benefit for the Additional Units of Disability Benefit Rider for each day of your Partial Disability. This benefit is payable up to the Partial Disability Benefit Period (a maximum period of three months) and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled "Term," and the definition of "Benefit Period."

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

Separate periods of Disability, resulting from the **same or a related condition** and not separated by 180 days or more, are considered a continuation of the prior Disability. Once the maximum period of three months of Disability under this benefit has been paid, you will not be eligible for a new Partial Disability Benefit Period for Disability due to the same or a related condition, until 180 days after you: (1) have been released by a Physician from the prior Disability, (2) are no longer disabled, and (3) are no longer qualified to receive any Disability benefits under this policy.

Separate periods of Disability, resulting from the **unrelated causes** and not separated by your returning to work at a Full-Time Job for 14 working days during which you are performing the material and substantial duties of such job, are considered a continuation of the prior Disability. Once the maximum Partial Disability Benefit Period has been paid, you will not be eligible for a new Partial Disability Benefit Period for Disability due to an unrelated cause, until 14 working days after you: (1) have been released by a Physician from a prior Disability, (2) are no longer disabled, and (3) are no longer qualified to receive any Disability benefits under this policy.

Periods of Disability meeting either of these separation requirements will begin a new Partial Disability Benefit Period (a maximum period of three months), subject to a new Elimination Period.

The Partial Disability Benefit Period is not subject to the Total Disability Benefit Period.

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Part 4
TERMINATION

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

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

[
Paul S. Amos II, President

Joey M. Loudermilk, Secretary]

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Payroll

Application for Short-Term Disability Insurance (A57600 Series)
Application to: American Family Life Assurance Company of Columbus
(herein referred to as Aflac)
[Worldwide Headquarters • Columbus, Georgia 31999]

❑ New
❑ Conversion
❑ Additional Units

Policy Number:

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

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

DOB _____ Sex _____ SSN _____ - _____ - _____
Month/Day/Year (Optional)

Driver's License Number_____ State of Issue_____ State of Birth_____

Address _____
Street or Post Office Box Apt. No.

City _____ State _____ ZIP _____

Primary Telephone ( ) _____ Best Time to Call _____
❑ Home ❑ Work ❑ Cell

Secondary Telephone ( ) _____ Best Time to Call _____
❑ Home ❑ Work ❑ Cell

E-Mail Address (optional) _____

Payroll Account Name_____ Payroll Account No._____

Name of Employer _____ Type of Business _____

Job Duties _____

Job Title _____

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

Is the purchase of this coverage intended to replace any other disability insurance with another carrier? ❑ Yes ❑ No ❑ N/A

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

Do you have any other Short-Term Disability coverage with Aflac? ❑ Yes ❑ No

If Yes, this must be a conversion of that coverage. Please give current policy number and see Applicant's Statements and Agreements concerning conversions.
Policy Number: _____

Do you have any Aflac accident policies with disability benefits? ❑ Yes ❑ No

If Yes, please complete the Supplemental Notification section at the end of this application, and be aware that you cannot have this policy without canceling those disability benefits with Aflac.

ELIGIBILITY QUESTIONS
TO BE COMPLETED BY PROPOSED INSURED/EMPLOYEE

1. Are you actively working with the employer listed on the first page of this application? ❑ Yes ❑ No

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

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2. Do you work fewer than [19] hours per week with the employer listed on the first page of this application? ❑ Yes ❑ No

3. Do you have disability coverage that you purchased that will remain in force which, combined with this applied-for coverage, will exceed 72 percent of your gross monthly income? ❑ Yes ❑ No

If you answered Yes to Question 2 or 3, a policy will not be issued; therefore, do not submit this application.

4. I certify that my taxable (gross) annual income from my job with the employer listed on the first page of this application is $_____(If you are self-employed, please use an average of the **net earnings** for the past two years from the business listed on this application.) I understand that this information may require verification, to include tax records, at the time of claim. **Annual income must be [$9,000] or greater for coverage to be issued.**

TO BE COMPLETED BY AFLAC ASSOCIATE/AGENT

Billing Method:
❑ Payroll Deduction
❑ Bank Draft (B/D, ACH)
❑ Credit Card (C/C)

Mode:
❑ 01 Weekly
❑ 01 14-Day Biweekly
❑ 01 Semimonthly
❑ 01 28-Day Biweekly
❑ 01 Monthly
❑ 03 Quarterly
❑ 06 Semiannual
❑ 12 Annual

PLEASE NOTE: If B/D, ACH, or C/C billing method is checked, only the following modes of payment are available: Monthly, Quarterly, Semiannual, or Annual.

Employee No. _____ Dept. No. _____ Assoc./Agent No. _____

Billable Premium $ _____ Premium Collected $ _____ Sit. Code _____

CHECK COVERAGE DESIRED:	[Class: ☐ A ☐ B ☐ C ☐ E ☐ P

Total Disability Benefit Periods:	☐ 3 Months ☐ 6 Months ☐ 12 Months ☐ 18 Months **(maximum of 30 units)** ☐ 24 Months **(maximum of 30 units)**
Partial Disability Benefit Period:	3 Months
Elimination Periods: Injury/Sickness	☐ 0/7 Days ☐ 0/14 Days ☐ 7/7 Days ☐ 7/14 Days ☐ 14/14 Days ☐ 0/30 Days* ☐ 30/30 Days* **(*not available with 3-month Total Disability Benefit Period)** ☐ 60/60 Days** ☐ 90/90 Days** ☐ 180/180 Days** **(**not available with 3- or 6-month Total Disability Benefit Period)**

	No. of Units Purchased for this Application	**Premium**	❑ Pre-Tax or ❑ After-Tax
☐ Base Policy Series A57600			
☐ On-the-Job Injury Rider Series A57650 Are you currently covered by on-the-job disability income replacement under a collective bargaining agreement, workers' compensation or a similar law in your job with the employer listed on the first page of this application? ❑ Yes ❑ No **Similar laws include but are not limited to the following:** Railroad Retirement Act; Jones Act; Maritime Doctrine of Maintenance, Wages, or Cure; Longshore and Harbor Workers' Compensation Act			
☐ Additional Units of Disability Benefit Rider Series A57651 (applies to base policy only) **Current Units:**_____ (includes any additional units previously purchased) **(must match policy Elimination and Benefit periods)**			
NOTE: Each unit is equal to a $100 monthly benefit.	**Total Premium**]		

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PLEASE COMPLETE THE FOLLOWING UNDERWRITING QUESTIONS 1–6 IF YOUR INDUSTRY CLASS IS E OR IF YOU ARE APPLYING FOR A BENEFIT PERIOD GREATER THAN [SIX] MONTHS, MORE THAN [30] TOTAL UNITS OF COVERAGE, OR UPGRADING YOUR EXISTING AFLAC DISABILITY POLICY.

1. Are you currently disabled due to sickness or injury; or have you been out of work or disabled due to sickness or injury more than five consecutive days within the last 12 months, excluding colds, influenza, routine childbirth, appendectomy, tonsillectomy, cholecystectomy (gall bladder removal), or hysterectomy? ❑Yes ❑No

2. Do you have any condition for which any medical procedure (including but not limited to surgery, child delivery, or organ or bone marrow transplant) has been planned or the possibility of which has been discussed with medical personnel? ❑Yes ❑No

3. Within the last five years, have you been convicted of a felony, charged two or more times with operating a vehicle while under the influence of alcohol or drugs, charged three or more times with a moving violation, or are you currently on parole or incarcerated in a correctional institution? ❑Yes ❑No

For new policies:

- **If you answered Yes to any of Questions 1–3 and your Industry Class is E, a policy will not be issued; therefore, do not submit this application.**
- **If you answered Yes to any of Questions 1–3 and you belong to another Industry Class, you may only apply for the guaranteed-issue limit.**

For upgrades to existing policies, if you answered Yes to any of Questions 1–3, an upgrade will not be issued; therefore, do not submit this application.

4. Within the last six months, have you been diagnosed by a member of the medical profession with any medical condition; received any medical treatment, including injections or chiropractic adjustments; or been prescribed or taken prescription medications (other than prescription contraceptives)? ❑Yes ❑No
   If Yes, please provide descriptive information below.

Height _____ _____ Current Weight _____
ft in lbs

Medical Condition			
Onset (mo/yr)			
Method of Treatment (prescription medications, injections, surgery, physical therapy, etc.)			
Date First Prescribed/Onset of Treatment			
For Hypertension and Diabetes, List the Average Reading (for the last three months)			

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If more medical conditions exist, please use the additional chart provided:

Medical Condition			
Onset (mo/yr)			
Method of Treatment (prescription medications, injections, surgery, physical therapy, etc.)			
Date First Prescribed/Onset of Treatment			
For Hypertension and Diabetes, List the Average Reading (for the last three months)			

5. Within the last 12 months, have you used tobacco products or any other products containing nicotine? ❑ Yes ❑ No

6. a. Do you have any individual disability income coverage in force other than Aflac? ❑ Yes ❑ No
   b. Do you have any group disability income coverage in force other than Aflac? ❑ Yes ❑ No

   If you answered Yes to 6a or 6b, please list your monthly benefit amounts/percentages:_____, your Benefit Period:_____, and your Elimination Period:_____.

ADDITIONAL UNDERWRITING MAY BE REQUIRED.

APPLICANT'S STATEMENTS AND AGREEMENTS

- I understand that the Effective Date of the policy will be the date recorded in the Policy Schedule by Aflac Worldwide Headquarters. It is not the date this application was signed by me.
- I understand that (1) Aflac is not bound by any statement made by me, or any associate/agent of Aflac, unless written herein, and (2) the associate/agent cannot change the provisions of the policy or waive any of its provisions, either orally or in writing.
- I understand that (1) the policy, together with this application, and the endorsements, benefit agreements, riders, and attached papers, if any, constitutes the entire contract of insurance; and (2) no change to the policy will be valid until approved by Aflac's president and secretary, and noted in or attached to the policy.
- I understand that the premium amount listed on this application represents the premium amount that my employer will remit to Aflac on my behalf. I further understand that this amount, because of my employer's billing/payroll practices, may differ from the amount being deducted from my paycheck or the premium amount quoted to me on an online enrollment system, if applicable.
- I understand that the following conditions apply:
  - Coverage is not provided for an illness, disease, infection, disorder, or injury for which, within the 12-month period before the Effective Date of coverage, medical advice, consultation, or treatment was recommended or received, or for which symptoms existed that would ordinarily cause a prudent person to seek diagnosis, care, or treatment. Disability caused by a Pre-existing Condition or reinjuries to a Pre-existing Condition will not be covered unless it begins more than 12 months after the Effective Date of coverage;
  - Coverage is not provided for an illness, disease, infection, or any other physical condition, independent of Injury, that is diagnosed or treated by a Physician within the first 30 days after the Effective Date of coverage, unless the resulting Disability begins more than 12 months after the Effective Date of coverage; and
  - Aflac will not pay benefits for a Disability that is caused by or occurs as a result of pregnancy or childbirth within the first ten months of the Effective Date of coverage (Complications of Pregnancy will be covered to the same extent as a Sickness).

  Proposed Insured's Initials _____

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- If this is an application for a conversion of coverage, I understand that: (1) the waiting period and the Time Limit on Certain Defenses provision will run from the Effective Date of the original policy, and the original policy will be terminated as of the Effective Date of the new policy; and (2) the Pre-existing Conditions provision in the new policy will run from the original policy's Effective Date for the benefits provided under the original policy. For the increased benefit amount, the Pre-existing Conditions provision in the new policy will run from the new policy's Effective Date.

  Proposed Insured's Initials _____

- If I am applying to replace existing Aflac coverage with this policy, I acknowledge that the policies may have different benefits and that I should make a comparison to personally determine which is best for me. I understand and agree that I am terminating my current Aflac policy and its benefits for the benefits provided in this Aflac policy.

  Proposed Insured's Initials _____

- I have reviewed the statements and answers I have provided on this application. I understand that this policy is to be issued based upon these statements and answers, and any other pertinent information Aflac may require for proper underwriting. The answers are complete and true. I understand that all statements made in this application are deemed representations and not warranties but that material misrepresentations herein may result in loss of coverage under this policy.
- I acknowledge receipt of, if applicable:
  - ❑ Replacement Notice
  - ❑ Outline of Coverage
  - ❑ *Guide to Health Insurance for People With Medicare*
  - ❑ Fair Credit Reporting Notice

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

I, _____, am applying for Aflac's Short-Term Disability policy. I currently have disability benefits under Aflac Accident/Disability policy number _____. I understand that I must cancel existing Aflac disability coverage to purchase this Short-Term Disability policy.

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

NOTICE OF INFORMATION PRACTICES

To issue an insurance policy, Aflac may need to obtain additional information about you 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, Kansas, Maine, Massachusetts, Minnesota, Montana, Nevada, New Jersey, North Carolina, Ohio, Oregon, Virginia, and Wisconsin.

INFORMATION REGARDING THE MEDICAL INFORMATION BUREAU (MIB)
PRENOTICE

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

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

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AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

I authorize the following to give information (as defined below) to Aflac or any person or entity acting on its part: any medical professional, medical care institution, pharmacy-related service organizations, 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 if coverage is 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 to contest 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 would prefer to receive an electronic copy of my policy instead of a paper copy. ❑ Yes ❑ No

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

Signed and Dated at _____ on _____
City and State Date

Proposed Insured's/Employee's Signature _____

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

MAKE CHECK OR MONEY ORDER PAYABLE TO AFLAC.
AMERICAN FAMILY LIFE ASSURANCE COMPANY OF COLUMBUS (AFLAC),
CLIENT SERVICES AND ADMINISTRATION,
[WORLDWIDE HEADQUARTERS • 1932 WYNNTON ROAD • COLUMBUS, GEORGIA 31999.
FOR INFORMATION, CALL TOLL-FREE 1.800.99.AFLAC (1.800.992.3522).
VISIT OUR WEB SITE AT AFLAC.COM.]

Associate/Agent's Name_____

Associate/Agent's Address_____Telephone_____

If we at Aflac fail to provide you with reasonable and adequate service, you should feel free to contact:
ARKANSAS INSURANCE DEPARTMENT • CONSUMER SERVICES DIVISION
1200 WEST THIRD STREET•LITTLE ROCK, ARKANSAS 72201-1904
Telephone 501.371.2640 or Toll-Free 1.800.852.5494

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Payroll

Application for Short-Term Disability Insurance (A57600 Series)
Application to: American Family Life Assurance Company of Columbus
(herein referred to as Aflac)
[Worldwide Headquarters • Columbus, Georgia 31999]

❑ New
❑ Conversion ❑ Additional Units
Policy Number:

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

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

DOB _____ Sex _____ SSN _____ - _____ - _____
Month/Day/Year (Optional)

Driver's License Number_____ State of Issue_____ State of Birth_____

Address _____
Street or Post Office Box Apt. No.

City _____ State _____ ZIP _____

Primary Telephone ( ) _____ Best Time to Call _____
❑ Home ❑ Work ❑ Cell

Secondary Telephone ( ) _____ Best Time to Call _____
❑ Home ❑ Work ❑ Cell

E-Mail Address (optional) _____

Payroll Account Name_____ Payroll Account No._____

Name of Employer _____ Type of Business _____

Job Duties _____

Job Title _____

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

Is the purchase of this coverage intended to replace any other disability insurance with another carrier? ❑ Yes ❑ No ❑ N/A

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

Do you have any other Short-Term Disability coverage with Aflac? ❑ Yes ❑ No

If Yes, this must be a conversion of that coverage. Please give current policy number and see Applicant's Statements and Agreements concerning conversions.
Policy Number: _____

Do you have any Aflac accident policies with disability benefits? ❑ Yes ❑ No

If Yes, please complete the Supplemental Notification section at the end of this application, and be aware that you cannot have this policy without canceling those disability benefits with Aflac.

ELIGIBILITY QUESTIONS
TO BE COMPLETED BY PROPOSED INSURED/EMPLOYEE

1. Are you actively working with the employer listed on the first page of this application? ❑ Yes ❑ No

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

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2. Do you work fewer than [19] hours per week with the employer listed on the first page of this application? ❑ Yes ❑ No

3. Do you have disability coverage that you purchased that will remain in force which, combined with this applied-for coverage, will exceed 72 percent of your gross monthly income? ❑ Yes ❑ No

If you answered Yes to Question 2 or 3, a policy will not be issued; therefore, do not submit this application.

4. I certify that my taxable (gross) annual income from my job with the employer listed on the first page of this application is $_____(If you are self-employed, please use an average of the **net earnings** for the past two years from the business listed on this application.) I understand that this information may require verification, to include tax records, at the time of claim. **Annual income must be [$9,000] or greater for coverage to be issued.**

TO BE COMPLETED BY AFLAC ASSOCIATE/AGENT

Billing Method:
❑ Payroll Deduction
❑ Bank Draft (B/D, ACH)
❑ Credit Card (C/C)

Mode:
❑ 01 Weekly
❑ 01 14-Day Biweekly
❑ 01 Semimonthly
❑ 01 28-Day Biweekly
❑ 01 Monthly
❑ 03 Quarterly
❑ 06 Semiannual
❑ 12 Annual

PLEASE NOTE: If B/D, ACH, or C/C billing method is checked, only the following modes of payment are available: Monthly, Quarterly, Semiannual, or Annual.

Employee No. _____ Dept. No. _____ Assoc./Agent No. _____

Billable Premium $ _____ Premium Collected $ _____ Sit. Code _____

CHECK COVERAGE DESIRED:	[Class: ☐ A ☐ B ☐ C ☐ E ☐ P

Total Disability Benefit Periods:	☐ 3 Months ☐ 6 Months ☐ 12 Months ☐ 18 Months **(maximum of 30 units)** ☐ 24 Months **(maximum of 30 units)**
Partial Disability Benefit Period:	3 Months
Elimination Periods: Injury/Sickness	☐ 0/7 Days ☐ 0/14 Days ☐ 7/7 Days ☐ 7/14 Days ☐ 14/14 Days ☐ 0/30 Days* ☐ 30/30 Days* **(*not available with 3-month Total Disability Benefit Period)** ☐ 60/60 Days** ☐ 90/90 Days** ☐ 180/180 Days** **(**not available with 3- or 6-month Total Disability Benefit Period)**

	No. of Units Purchased for this Application	**Premium**	❑ Pre-Tax or ❑ After-Tax
☐ Base Policy Series A57600			
☐ On-the-Job Injury Rider Series A57650 Are you currently covered by on-the-job disability income replacement under a collective bargaining agreement, workers' compensation or a similar law in your job with the employer listed on the first page of this application? ❑ Yes ❑ No **Similar laws include but are not limited to the following:** Railroad Retirement Act; Jones Act; Maritime Doctrine of Maintenance, Wages, or Cure; Longshore and Harbor Workers' Compensation Act			
☐ Additional Units of Disability Benefit Rider Series A57651 (applies to base policy only) **Current Units:**_____ (includes any additional units previously purchased) **(must match policy Elimination and Benefit periods)**			
NOTE: Each unit is equal to a $100 monthly benefit.	**Total Premium**]		

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PLEASE COMPLETE THE FOLLOWING UNDERWRITING QUESTIONS 1–6 IF YOUR INDUSTRY CLASS IS E OR IF YOU ARE APPLYING FOR A BENEFIT PERIOD GREATER THAN [SIX] MONTHS, MORE THAN [30] TOTAL UNITS OF COVERAGE, OR UPGRADING YOUR EXISTING AFLAC DISABILITY POLICY.

1. Are you currently disabled due to sickness or injury; or have you been out of work or disabled due to sickness or injury more than five consecutive days within the last 12 months, excluding colds, influenza, routine childbirth, appendectomy, tonsillectomy, cholecystectomy (gall bladder removal), or hysterectomy? ❑Yes ❑No

2. Do you have any condition for which any medical procedure (including but not limited to surgery, child delivery, or organ or bone marrow transplant) has been planned or the possibility of which has been discussed with medical personnel? ❑Yes ❑No

3. Within the last five years, have you been convicted of a felony, charged two or more times with operating a vehicle while under the influence of alcohol or drugs, charged three or more times with a moving violation, or are you currently on parole or incarcerated in a correctional institution? ❑Yes ❑No

For new policies:

- **If you answered Yes to any of Questions 1–3 and your Industry Class is E, a policy will not be issued; therefore, do not submit this application.**
- **If you answered Yes to any of Questions 1–3 and you belong to another Industry Class, you may only apply for the guaranteed-issue limit.**

For upgrades to existing policies, if you answered Yes to any of Questions 1–3, an upgrade will not be issued; therefore, do not submit this application.

4. Within the last six months, have you been diagnosed by a member of the medical profession with any medical condition; received any medical treatment, including injections or chiropractic adjustments; or been prescribed or taken prescription medications (other than prescription contraceptives)? ❑Yes ❑No
   If Yes, please provide descriptive information below.

Height _____ _____ Current Weight _____
ft in lbs

Medical Condition			
Onset (mo/yr)			
Method of Treatment (prescription medications, injections, surgery, physical therapy, etc.)			
Date First Prescribed/Onset of Treatment			
For Hypertension and Diabetes, List the Average Reading (for the last three months)			

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If more medical conditions exist, please use the additional chart provided:

Medical Condition			
Onset (mo/yr)			
Method of Treatment (prescription medications, injections, surgery, physical therapy, etc.)			
Date First Prescribed/Onset of Treatment			
For Hypertension and Diabetes, List the Average Reading (for the last three months)			

5. Within the last 12 months, have you used tobacco products or any other products containing nicotine? ❑ Yes ❑ No

6. a. Do you have any individual disability income coverage in force other than Aflac? ❑ Yes ❑ No
   b. Do you have any group disability income coverage in force other than Aflac? ❑ Yes ❑ No

   If you answered Yes to 6a or 6b, please list your monthly benefit amounts/percentages:_____, your Benefit Period:_____, and your Elimination Period:_____.

ADDITIONAL UNDERWRITING MAY BE REQUIRED.

APPLICANT'S STATEMENTS AND AGREEMENTS

- I understand that the Effective Date of the policy will be the date recorded in the Policy Schedule by Aflac Worldwide Headquarters. It is not the date this application was signed by me.
- I understand that (1) Aflac is not bound by any statement made by me, or any associate/agent of Aflac, unless written herein, and (2) the associate/agent cannot change the provisions of the policy or waive any of its provisions, either orally or in writing.
- I understand that (1) the policy, together with this application, and the endorsements, benefit agreements, riders, and attached papers, if any, constitutes the entire contract of insurance; and (2) no change to the policy will be valid until approved by Aflac's president and secretary, and noted in or attached to the policy.
- I understand that the premium amount listed on this application represents the premium amount that my employer will remit to Aflac on my behalf. I further understand that this amount, because of my employer's billing/payroll practices, may differ from the amount being deducted from my paycheck or the premium amount quoted to me on an online enrollment system, if applicable.
- I understand that the following conditions apply:
  - Coverage is not provided for an illness, disease, infection, disorder, or injury for which, within the 12-month period before the Effective Date of coverage, medical advice, consultation, or treatment was recommended or received, or for which symptoms existed that would ordinarily cause a prudent person to seek diagnosis, care, or treatment. Disability caused by a Pre-existing Condition or reinjuries to a Pre-existing Condition will not be covered unless it begins more than 12 months after the Effective Date of coverage;
  - Coverage is not provided for an illness, disease, infection, or any other physical condition, independent of Injury, that is diagnosed or treated by a Physician within the first 30 days after the Effective Date of coverage, unless the resulting Disability begins more than 12 months after the Effective Date of coverage; and
  - Aflac will not pay benefits for a Disability that is caused by or occurs as a result of pregnancy or childbirth within the first ten months of the Effective Date of coverage (Complications of Pregnancy will be covered to the same extent as a Sickness).

Proposed Insured's Initials _____

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- If this is an application for a conversion of coverage, I understand that: (1) the waiting period and the Time Limit on Certain Defenses provision will run from the Effective Date of the original policy, and the original policy will be terminated as of the Effective Date of the new policy; and (2) the Pre-existing Conditions provision in the new policy will run from the original policy's Effective Date for the benefits provided under the original policy. For the increased benefit amount, the Pre-existing Conditions provision in the new policy will run from the new policy's Effective Date.

  Proposed Insured's Initials _____

- If I am applying to replace existing Aflac coverage with this policy, I acknowledge that the policies may have different benefits and that I should make a comparison to personally determine which is best for me. I understand and agree that I am terminating my current Aflac policy and its benefits for the benefits provided in this Aflac policy.

  Proposed Insured's Initials _____

- I have reviewed the statements and answers I have provided on this application. I understand that this policy is to be issued based upon these statements and answers, and any other pertinent information Aflac may require for proper underwriting. The answers are complete and true. I understand that all statements made in this application are deemed representations and not warranties but that material misrepresentations herein may result in loss of coverage under this policy.
- I acknowledge receipt of, if applicable:
  - ❑ Replacement Notice
  - ❑ Outline of Coverage
  - ❑ *Guide to Health Insurance for People With Medicare*
  - ❑ Fair Credit Reporting Notice

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

I, _____, am applying for Aflac's Short-Term Disability policy. I currently have disability benefits under Aflac Accident/Disability policy number _____. I understand that I must cancel existing Aflac disability coverage to purchase this Short-Term Disability policy.

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

NOTICE OF INFORMATION PRACTICES

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INFORMATION REGARDING THE MEDICAL INFORMATION BUREAU (MIB)
PRENOTICE

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

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

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AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

I authorize the following to give information (as defined below) to Aflac or any person or entity acting on its part: any medical professional, medical care institution, pharmacy-related service organizations, 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 if coverage is 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 to contest 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 would prefer to receive an electronic copy of my policy instead of a paper copy. ❑ Yes ❑ No

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

Signed and Dated at _____ on _____
City and State Date

Proposed Insured's/Employee's Signature _____

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

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

MAKE CHECK OR MONEY ORDER PAYABLE TO AFLAC.
AMERICAN FAMILY LIFE ASSURANCE COMPANY OF COLUMBUS (AFLAC),
CLIENT SERVICES AND ADMINISTRATION,
[WORLDWIDE HEADQUARTERS • 1932 WYNNTON ROAD • COLUMBUS, GEORGIA 31999.
FOR INFORMATION, CALL TOLL-FREE 1.800.99.AFLAC (1.800.992.3522).
VISIT OUR WEB SITE AT AFLAC.COM.]

Associate/Agent's Name_____

Associate/Agent's Address_____Telephone_____

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

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

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Payroll

Application for Short-Term Disability Insurance (A57600 Series)
Application to: American Family Life Assurance Company of Columbus
(herein referred to as Aflac)
[Worldwide Headquarters • Columbus, Georgia 31999]

❑ New
Policy Number:

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

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

DOB _____ Sex _____ SSN _____ - _____ - _____
Month/Day/Year (Optional)

Driver's License Number_____ State of Issue_____ State of Birth_____

Address _____
Street or Post Office Box Apt. No.

City _____ State _____ ZIP _____

Primary Telephone ( ) _____ Best Time to Call _____
❑ Home ❑ Work ❑ Cell

Secondary Telephone ( ) _____ Best Time to Call _____
❑ Home ❑ Work ❑ Cell

E-Mail Address (optional) _____

Payroll Account Name_____ Payroll Account No._____

Name of Employer _____ Type of Business _____

Job Duties _____

Job Title _____

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

Is the purchase of this coverage intended to replace any other disability insurance with another carrier? ❑ Yes ❑ No ❑ N/A

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

Do you have any other Short-Term Disability coverage with Aflac? ❑ Yes ❑ No

If Yes, then you may not use this application. **Please use Application Form Series A57601. You may be eligible to apply for additional coverage.**

Do you have any Aflac accident policies with disability benefits? ❑ Yes ❑ No

If Yes, please complete the Supplemental Notification section at the end of this application, and be aware that you cannot have this policy without canceling those disability benefits with Aflac.

ELIGIBILITY QUESTIONS
TO BE COMPLETED BY PROPOSED INSURED/EMPLOYEE

1. Are you actively working with the employer listed on the first page of this application? ❑ Yes ❑ No

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

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2. Do you work fewer than [19] hours per week with the employer listed on the first page of this application? ❑ Yes ❑ No

3. Do you have disability coverage that you purchased that will remain in force which, combined with this applied-for coverage, will exceed 72 percent of your gross monthly income? ❑ Yes ❑ No

If you answered Yes to Question 2 or 3, a policy will not be issued; therefore, do not submit this application.

4. I certify that my taxable (gross) annual income from my job with the employer listed on the first page of this application is $_____(If you are self-employed, please use an average of the **net earnings** for the past two years from the business listed on this application.) I understand that this information may require verification, to include tax records, at the time of claim. **Annual income must be [$9,000] or greater for coverage to be issued.**

TO BE COMPLETED BY AFLAC ASSOCIATE/AGENT

Billing Method:	**Mode:**	
❑ Payroll Deduction	❑ 01 Weekly	❑ 01 Monthly
❑ Bank Draft (B/D, ACH)	❑ 01 14-Day Biweekly	❑ 03 Quarterly
❑ Credit Card (C/C)	❑ 01 Semimonthly	❑ 06 Semiannual
	❑ 01 28-Day Biweekly	❑ 12 Annual

PLEASE NOTE: If B/D, ACH, or C/C billing method is checked, only the following modes of payment are available: Monthly, Quarterly, Semiannual, or Annual.

Employee No. _____ Dept. No. _____ Assoc./Agent No. _____

Billable Premium $ _____ Premium Collected $ _____ Sit. Code _____

CHECK COVERAGE DESIRED:	[Class: ☐ A ☐ B ☐ C ☐ P

Total Disability Benefit Periods:	☐ 3 Months ☐ 6 Months ☐ 12 Months ☐ 18 Months **(maximum of 30 units)** ☐ 24 Months **(maximum of 30 units)**
Partial Disability Benefit Period:	3 Months
Elimination Periods: Injury/Sickness	☐ 0/7 Days ☐ 0/14 Days ☐ 7/7 Days ☐ 7/14 Days ☐ 14/14 Days ☐ 0/30 Days* ☐ 30/30 Days* **(*not available with 3-month Total Disability Benefit Period)** ☐ 60/60 Days** ☐ 90/90 Days** ☐ 180/180 Days** **(**not available with 3- or 6-month Total Disability Benefit Period)**

	No. of Units	**Premium**	❑ Pre-Tax or ❑ After-Tax
☐ Base Policy Series A57600			
☐ On-the-Job Injury Rider Series A57650 Are you currently covered by on-the-job disability income replacement under a collective bargaining agreement, workers' compensation or a similar law in your job with the employer listed on the first page of this application? ❑ Yes ❑ No **Similar laws include but are not limited to the following:** Railroad Retirement Act; Jones Act; Maritime Doctrine of Maintenance, Wages, or Cure; Longshore and Harbor Workers' Compensation Act			
NOTE: Each unit is equal to a $100 monthly benefit.	**Total Premium**]		

APPLICANT'S STATEMENTS AND AGREEMENTS

- I understand that the Effective Date of the policy will be the date recorded in the Policy Schedule by Aflac Worldwide Headquarters. It is not the date this application was signed by me.
- I understand that (1) Aflac is not bound by any statement made by me, or any associate/agent of Aflac, unless written herein, and (2) the associate/agent cannot change the provisions of the policy or waive any of its provisions, either orally or in writing.

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- I understand that (1) the policy, together with this application, and the endorsements, benefit agreements, riders, and attached papers, if any, constitutes the entire contract of insurance; and (2) no change to the policy will be valid until approved by Aflac's president and secretary, and noted in or attached to the policy.
- I understand that the premium amount listed on this application represents the premium amount that my employer will remit to Aflac on my behalf. I further understand that this amount, because of my employer's billing/payroll practices, may differ from the amount being deducted from my paycheck or the premium amount quoted to me on an online enrollment system, if applicable.
- I understand that the following conditions apply:
  - Coverage is not provided for an illness, disease, infection, disorder, or injury for which, within the 12-month period before the Effective Date of coverage, medical advice, consultation, or treatment was recommended or received, or for which symptoms existed that would ordinarily cause a prudent person to seek diagnosis, care, or treatment. Disability caused by a Pre-existing Condition or reinjuries to a Pre-existing Condition will not be covered unless it begins more than 12 months after the Effective Date of coverage;
  - Coverage is not provided for an illness, disease, infection, or any other physical condition, independent of Injury, that is diagnosed or treated by a Physician within the first 30 days after the Effective Date of coverage, unless the resulting Disability begins more than 12 months after the Effective Date of coverage; and
  - Aflac will not pay benefits for a Disability that is caused by or occurs as a result of pregnancy or childbirth within the first ten months of the Effective Date of coverage (Complications of Pregnancy will be covered to the same extent as a Sickness).

  Proposed Insured's Initials _____
- If I am applying to replace existing Aflac coverage with this policy, I acknowledge that the policies may have different benefits and that I should make a comparison to personally determine which is best for me. I understand and agree that I am terminating my current Aflac policy and its benefits for the benefits provided in this Aflac policy.

  Proposed Insured's Initials _____
- I have reviewed the statements and answers I have provided on this application. I understand that this policy is to be issued based upon these statements and answers, and any other pertinent information Aflac may require for proper underwriting. The answers are complete and true. I understand that all statements made in this application are deemed representations and not warranties but that material misrepresentations herein may result in loss of coverage under this policy.
- I acknowledge receipt of, if applicable:
  - ❑ Replacement Notice
  - ❑ Outline of Coverage
  - ❑ *Guide to Health Insurance for People With Medicare*
  - ❑ Fair Credit Reporting Notice

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

I, _____, am applying for Aflac's Short-Term Disability policy. I currently have disability benefits under Aflac Accident/Disability policy number _____. I understand that I must cancel existing Aflac disability coverage to purchase this Short-Term Disability policy.

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

NOTICE OF INFORMATION PRACTICES

To issue an insurance policy, Aflac may need to obtain additional information about you 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, Kansas, Maine, Massachusetts, Minnesota, Montana, Nevada, New Jersey, North Carolina, Ohio, Oregon, Virginia, and Wisconsin.

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AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

I authorize the following to give information (as defined below) to Aflac or any person or entity acting on its part: any medical professional, medical care institution, pharmacy-related service organizations, 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 if coverage is 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 to contest 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 would prefer to receive an electronic copy of my policy instead of a paper copy. ❑ Yes ❑ No

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

Signed and Dated at _____ on _____
City and State Date

Proposed Insured's/Employee's Signature _____

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

MAKE CHECK OR MONEY ORDER PAYABLE TO AFLAC.
AMERICAN FAMILY LIFE ASSURANCE COMPANY OF COLUMBUS (AFLAC),
CLIENT SERVICES AND ADMINISTRATION,
[WORLDWIDE HEADQUARTERS • 1932 WYNNTON ROAD • COLUMBUS, GEORGIA 31999.
FOR INFORMATION, CALL TOLL-FREE 1.800.99.AFLAC (1.800.992.3522).
VISIT OUR WEB SITE AT AFLAC.COM.]

Associate/Agent's Name_____

Associate/Agent's Address_____Telephone_____

If we at Aflac fail to provide you with reasonable and adequate service, you should feel free to contact:
ARKANSAS INSURANCE DEPARTMENT • CONSUMER SERVICES DIVISION
1200 WEST THIRD STREET•LITTLE ROCK, ARKANSAS 72201-1904
Telephone 501.371.2640 or Toll-Free 1.800.852.5494

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Payroll

Application for Short-Term Disability Insurance (A57600 Series)
Application to: American Family Life Assurance Company of Columbus
(herein referred to as Aflac)
[Worldwide Headquarters • Columbus, Georgia 31999]

❑ New
Policy Number:

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

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

DOB _____ Sex _____ SSN _____ - _____ - _____
Month/Day/Year (Optional)

Driver's License Number_____ State of Issue_____ State of Birth_____

Address _____
Street or Post Office Box Apt. No.

City _____ State _____ ZIP _____

Primary Telephone ( ) _____ Best Time to Call _____
❑ Home ❑ Work ❑ Cell

Secondary Telephone ( ) _____ Best Time to Call _____
❑ Home ❑ Work ❑ Cell

E-Mail Address (optional) _____

Payroll Account Name_____ Payroll Account No._____

Name of Employer _____ Type of Business _____

Job Duties _____

Job Title _____

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

Is the purchase of this coverage intended to replace any other disability insurance with another carrier? ❑ Yes ❑ No ❑ N/A

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

Do you have any other Short-Term Disability coverage with Aflac? ❑ Yes ❑ No

If Yes, then you may not use this application. **Please use Application Form Series A57601c. You may be eligible to apply for additional coverage.**

Do you have any Aflac accident policies with disability benefits? ❑ Yes ❑ No

If Yes, please complete the Supplemental Notification section at the end of this application, and be aware that you cannot have this policy without canceling those disability benefits with Aflac.

ELIGIBILITY QUESTIONS
TO BE COMPLETED BY PROPOSED INSURED/EMPLOYEE

1. Are you actively working with the employer listed on the first page of this application? ❑ Yes ❑ No

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

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2. Do you work fewer than [19] hours per week with the employer listed on the first page of this application? ❑ Yes ❑ No

3. Do you have disability coverage that you purchased that will remain in force which, combined with this applied-for coverage, will exceed 72 percent of your gross monthly income? ❑ Yes ❑ No

If you answered Yes to Question 2 or 3, a policy will not be issued; therefore, do not submit this application.

4. I certify that my taxable (gross) annual income from my job with the employer listed on the first page of this application is $_____(If you are self-employed, please use an average of the **net earnings** for the past two years from the business listed on this application.) I understand that this information may require verification, to include tax records, at the time of claim. **Annual income must be [$9,000] or greater for coverage to be issued.**

TO BE COMPLETED BY AFLAC ASSOCIATE/AGENT

Billing Method:	**Mode:**	
❑ Payroll Deduction	❑ 01 Weekly	❑ 01 Monthly
❑ Bank Draft (B/D, ACH)	❑ 01 14-Day Biweekly	❑ 03 Quarterly
❑ Credit Card (C/C)	❑ 01 Semimonthly	❑ 06 Semiannual
	❑ 01 28-Day Biweekly	❑ 12 Annual

PLEASE NOTE: If B/D, ACH, or C/C billing method is checked, only the following modes of payment are available: Monthly, Quarterly, Semiannual, or Annual.

Employee No. _____ Dept. No. _____ Assoc./Agent No. _____

Billable Premium $ _____ Premium Collected $ _____ Sit. Code _____

CHECK COVERAGE DESIRED:	[Class: ☐ A ☐ B ☐ C ☐ P

Total Disability Benefit Periods:	☐ 3 Months ☐ 6 Months ☐ 12 Months ☐ 18 Months **(maximum of 30 units)** ☐ 24 Months **(maximum of 30 units)**
Partial Disability Benefit Period:	3 Months
Elimination Periods: Injury/Sickness	☐ 0/7 Days ☐ 0/14 Days ☐ 7/7 Days ☐ 7/14 Days ☐ 14/14 Days ☐ 0/30 Days* ☐ 30/30 Days* **(*not available with 3-month Total Disability Benefit Period)** ☐ 60/60 Days** ☐ 90/90 Days** ☐ 180/180 Days** **(**not available with 3- or 6-month Total Disability Benefit Period)**

	No. of Units	**Premium**	❑ Pre-Tax or ❑ After-Tax
☐ Base Policy Series A57600			
☐ On-the-Job Injury Rider Series A57650 Are you currently covered by on-the-job disability income replacement under a collective bargaining agreement, workers' compensation or a similar law in your job with the employer listed on the first page of this application? ❑ Yes ❑ No **Similar laws include but are not limited to the following:** Railroad Retirement Act; Jones Act; Maritime Doctrine of Maintenance, Wages, or Cure; Longshore and Harbor Workers' Compensation Act			
NOTE: Each unit is equal to a $100 monthly benefit.	**Total Premium**]		

APPLICANT'S STATEMENTS AND AGREEMENTS

- I understand that the Effective Date of the policy will be the date recorded in the Policy Schedule by Aflac Worldwide Headquarters. It is not the date this application was signed by me.
- I understand that (1) Aflac is not bound by any statement made by me, or any associate/agent of Aflac, unless written herein, and (2) the associate/agent cannot change the provisions of the policy or waive any of its provisions, either orally or in writing.

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- I understand that (1) the policy, together with this application, and the endorsements, benefit agreements, riders, and attached papers, if any, constitutes the entire contract of insurance; and (2) no change to the policy will be valid until approved by Aflac's president and secretary, and noted in or attached to the policy.
- I understand that the premium amount listed on this application represents the premium amount that my employer will remit to Aflac on my behalf. I further understand that this amount, because of my employer's billing/payroll practices, may differ from the amount being deducted from my paycheck or the premium amount quoted to me on an online enrollment system, if applicable.
- I understand that the following conditions apply:
  - Coverage is not provided for an illness, disease, infection, disorder, or injury for which, within the 12-month period before the Effective Date of coverage, medical advice, consultation, or treatment was recommended or received, or for which symptoms existed that would ordinarily cause a prudent person to seek diagnosis, care, or treatment. Disability caused by a Pre-existing Condition or reinjuries to a Pre-existing Condition will not be covered unless it begins more than 12 months after the Effective Date of coverage;
  - Coverage is not provided for an illness, disease, infection, or any other physical condition, independent of Injury, that is diagnosed or treated by a Physician within the first 30 days after the Effective Date of coverage, unless the resulting Disability begins more than 12 months after the Effective Date of coverage; and
  - Aflac will not pay benefits for a Disability that is caused by or occurs as a result of pregnancy or childbirth within the first ten months of the Effective Date of coverage (Complications of Pregnancy will be covered to the same extent as a Sickness).

  Proposed Insured's Initials _____
- If I am applying to replace existing Aflac coverage with this policy, I acknowledge that the policies may have different benefits and that I should make a comparison to personally determine which is best for me. I understand and agree that I am terminating my current Aflac policy and its benefits for the benefits provided in this Aflac policy.

  Proposed Insured's Initials _____
- I have reviewed the statements and answers I have provided on this application. I understand that this policy is to be issued based upon these statements and answers, and any other pertinent information Aflac may require for proper underwriting. The answers are complete and true. I understand that all statements made in this application are deemed representations and not warranties but that material misrepresentations herein may result in loss of coverage under this policy.
- I acknowledge receipt of, if applicable:
  - ❑ Replacement Notice
  - ❑ Outline of Coverage
  - ❑ *Guide to Health Insurance for People With Medicare*
  - ❑ Fair Credit Reporting Notice

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

I, _____, am applying for Aflac's Short-Term Disability policy. I currently have disability benefits under Aflac Accident/Disability policy number _____. I understand that I must cancel existing Aflac disability coverage to purchase this Short-Term Disability policy.

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

NOTICE OF INFORMATION PRACTICES

To issue an insurance policy, Aflac may need to obtain additional information about you 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, Kansas, Maine, Massachusetts, Minnesota, Montana, Nevada, New Jersey, North Carolina, Ohio, Oregon, Virginia, and Wisconsin.

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AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

I authorize the following to give information (as defined below) to Aflac or any person or entity acting on its part: any medical professional, medical care institution, pharmacy-related service organizations, 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 if coverage is 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 to contest 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 would prefer to receive an electronic copy of my policy instead of a paper copy. ❑ Yes ❑ No

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

Signed and Dated at _____ on _____
City and State Date

Proposed Insured's/Employee's Signature _____

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

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

MAKE CHECK OR MONEY ORDER PAYABLE TO AFLAC.
AMERICAN FAMILY LIFE ASSURANCE COMPANY OF COLUMBUS (AFLAC),
CLIENT SERVICES AND ADMINISTRATION,
[WORLDWIDE HEADQUARTERS • 1932 WYNNTON ROAD • COLUMBUS, GEORGIA 31999.
FOR INFORMATION, CALL TOLL-FREE 1.800.99.AFLAC (1.800.992.3522).
VISIT OUR WEB SITE AT AFLAC.COM.]

Associate/Agent's Name_____

Associate/Agent's Address_____Telephone_____

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

ARKANSAS INSURANCE DEPARTMENT • CONSUMER SERVICES DIVISION
1200 WEST THIRD STREET•LITTLE ROCK, ARKANSAS 72201-1904
Telephone (501) 371.2640 or Toll-Free 1.800.852.5494

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Associate Only

Application for Short-Term Disability Insurance (A57600 Series)
Application to: American Family Life Assurance Company of Columbus
(herein referred to as Aflac)
[Worldwide Headquarters • Columbus, Georgia 31999]

❑ New
❑ Conversion ❑ Additional Units
Policy Number:

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

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

DOB _____ Sex _____ SSN _____ - _____ - _____
Month/Day/Year (Optional)

Driver's License Number_____ State of Issue_____ State of Birth_____

Address _____
Street or Post Office Box Apt. No.

City _____ State _____ ZIP _____

Primary Telephone ( ) _____ Best Time to Call _____
❑ Home ❑ Work ❑ Cell

Secondary Telephone ( ) _____ Best Time to Call _____
❑ Home ❑ Work ❑ Cell

E-Mail Address (optional) _____

Payroll Account Name_____ Payroll Account No._____

Name of Employer _____ Type of Business _____

Job Duties _____

Job Title _____

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

Is the purchase of this coverage intended to replace any other disability insurance with another carrier? ❑ Yes ❑ No ❑ N/A

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

Do you have any other Short-Term Disability coverage with Aflac? ❑ Yes ❑ No

If Yes, this must be a conversion of that coverage. Please give current policy number and see Applicant's Statements and Agreements concerning conversions.
Policy Number: _____

Do you have any Aflac accident policies with disability benefits? ❑ Yes ❑ No

If Yes, please complete the Supplemental Notification section at the end of this application, and be aware that you cannot have this policy without canceling those disability benefits with Aflac.

ELIGIBILITY QUESTIONS
TO BE COMPLETED BY PROPOSED INSURED/EMPLOYEE

1. Are you actively working with the employer listed on the first page of this application? ❑ Yes ❑ No

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

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2. Do you work fewer than [19] hours per week with the employer listed on the first page of this application? ❑ Yes ❑ No

3. Do you have disability coverage that you purchased that will remain in force which, combined with this applied-for coverage, will exceed 72 percent of your gross monthly income? ❑ Yes ❑ No

If you answered Yes to Question 2 or 3, a policy will not be issued; therefore, do not submit this application.

4. I certify that my taxable (gross) annual income from my job with the employer listed on the first page of this application is $_____(If you are self-employed, please use an average of the **net earnings** for the past two years from the business listed on this application.) I understand that this information may require verification, to include tax records, at the time of claim. **Annual income must be [$9,000] or greater for coverage to be issued.**

TO BE COMPLETED BY AFLAC ASSOCIATE/AGENT

Billing Method:	**Mode:**	
❑ Payroll Deduction	❑ 01 Weekly	❑ 01 Monthly
❑ Bank Draft (B/D, ACH)	❑ 01 14-Day Biweekly	❑ 03 Quarterly
❑ Credit Card (C/C)	❑ 01 Semimonthly	❑ 06 Semiannual
	❑ 01 28-Day Biweekly	❑ 12 Annual

PLEASE NOTE: If B/D, ACH, or C/C billing method is checked, only the following modes of payment are available: Monthly, Quarterly, Semiannual, or Annual.

Employee No. _____ Dept. No. _____ Assoc./Agent No. _____

Billable Premium $ _____ Premium Collected $ _____ Sit. Code _____

CHECK COVERAGE DESIRED:	[Class: ☐ C

Total Disability Benefit Periods:	☐ 6 Months ☐ 12 Months
Partial Disability Benefit Period:	3 Months
Elimination Periods: Injury/Sickness	☐ 30/30 Days ☐ 60/60 Days* ☐ 90/90 Days* ☐ 180/180 Days* **(*not available with 6-month Total Disability Benefit Period)**

	No. of Units Purchased for this Application	**Premium**	After-Tax Only
☐ Base Policy Series A57600			
☐ Additional Units of Disability Benefit Rider Series A57651 (applies to base policy only) **Current Units:**_____ (includes any additional units previously purchased) **(must match policy Elimination and Benefit periods)**			
NOTE: Each unit is equal to a $100 monthly benefit.	**Total Premium**]		

PLEASE COMPLETE THE FOLLOWING UNDERWRITING QUESTIONS 1–6 IF YOU ARE APPLYING FOR A BENEFIT PERIOD GREATER THAN [SIX] MONTHS, MORE THAN [30] TOTAL UNITS OF COVERAGE, OR UPGRADING YOUR EXISTING AFLAC DISABILITY POLICY.

1. Are you currently disabled due to sickness or injury; or have you been out of work or disabled due to sickness or injury more than five consecutive days within the last 12 months, excluding colds, influenza, routine childbirth, appendectomy, tonsillectomy, cholecystectomy (gall bladder removal), or hysterectomy? ❑Yes ❑No

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2. Do you have any condition for which any medical procedure (including but not limited to surgery, child delivery, or organ or bone marrow transplant) has been planned or the possibility of which has been discussed with medical personnel? ❑Yes ❑No

3. Within the last five years, have you been convicted of a felony, charged two or more times with operating a vehicle while under the influence of alcohol or drugs, charged three or more times with a moving violation, or are you currently on parole or incarcerated in a correctional institution? ❑Yes ❑No

For new policies:
If you answered Yes to any of Questions 1–3, you may only apply for the guaranteed-issue limit.

For upgrades to existing policies, if you answered Yes to any of Questions 1–3, an upgrade will not be issued; therefore, do not submit this application.

4. Within the last six months, have you been diagnosed by a member of the medical profession with any medical condition; received any medical treatment, including injections or chiropractic adjustments; or been prescribed or taken prescription medications (other than prescription contraceptives)? ❑Yes ❑No
If Yes, please provide descriptive information below.

Height _____ _____ Current Weight _____
ft in lbs

Medical Condition			
Onset (mo/yr)			
Method of Treatment (prescription medications, injections, surgery, physical therapy, etc.)			
Date First Prescribed/Onset of Treatment			
For Hypertension and Diabetes, List the Average Reading (for the last three months)			

If more medical conditions exist, please use the additional chart provided:

Medical Condition			
Onset (mo/yr)			
Method of Treatment (prescription medications, injections, surgery, physical therapy, etc.)			
Date First Prescribed/Onset of Treatment			
For Hypertension and Diabetes, List the Average Reading (for the last three months)			

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5. Within the last 12 months, have you used tobacco products or any other products containing nicotine? ❑ Yes ❑ No

6. a. Do you have any individual disability income coverage in force other than Aflac? ❑ Yes ❑ No
   b. Do you have any group disability income coverage in force other than Aflac? ❑ Yes ❑ No

   If you answered Yes to 6a or 6b, please list your monthly benefit amounts/percentages:_____, your Benefit Period:_____, and your Elimination Period:_____.

ADDITIONAL UNDERWRITING MAY BE REQUIRED.

APPLICANT'S STATEMENTS AND AGREEMENTS

- I understand that the Effective Date of the policy will be the date recorded in the Policy Schedule by Aflac Worldwide Headquarters. It is not the date this application was signed by me.
- I understand that (1) Aflac is not bound by any statement made by me, or any associate/agent of Aflac, unless written herein, and (2) the associate/agent cannot change the provisions of the policy or waive any of its provisions, either orally or in writing.
- I understand that (1) the policy, together with this application, and the endorsements, benefit agreements, riders, and attached papers, if any, constitutes the entire contract of insurance; and (2) no change to the policy will be valid until approved by Aflac's president and secretary, and noted in or attached to the policy.
- I understand that the premium amount listed on this application represents the premium amount that my employer will remit to Aflac on my behalf. I further understand that this amount, because of my employer's billing/payroll practices, may differ from the amount being deducted from my paycheck or the premium amount quoted to me on an online enrollment system, if applicable.
- I understand that the following conditions apply:
  - Coverage is not provided for an illness, disease, infection, disorder, or injury for which, within the 12-month period before the Effective Date of coverage, medical advice, consultation, or treatment was recommended or received, or for which symptoms existed that would ordinarily cause a prudent person to seek diagnosis, care, or treatment. Disability caused by a Pre-existing Condition or reinjuries to a Pre-existing Condition will not be covered unless it begins more than 12 months after the Effective Date of coverage;
  - Coverage is not provided for an illness, disease, infection, or any other physical condition, independent of Injury, that is diagnosed or treated by a Physician within the first 30 days after the Effective Date of coverage, unless the resulting Disability begins more than 12 months after the Effective Date of coverage; and
  - Aflac will not pay benefits for a Disability that is caused by or occurs as a result of pregnancy or childbirth within the first ten months of the Effective Date of coverage (Complications of Pregnancy will be covered to the same extent as a Sickness).

  Proposed Insured's Initials _____

- If this is an application for a conversion of coverage, I understand that: (1) the waiting period and the Time Limit on Certain Defenses provision will run from the Effective Date of the original policy, and the original policy will be terminated as of the Effective Date of the new policy; and (2) the Pre-existing Conditions provision in the new policy will run from the original policy's Effective Date for the benefits provided under the original policy. For the increased benefit amount, the Pre-existing Conditions provision in the new policy will run from the new policy's Effective Date.

  Proposed Insured's Initials _____

- If I am applying to replace existing Aflac coverage with this policy, I acknowledge that the policies may have different benefits and that I should make a comparison to personally determine which is best for me. I understand and agree that I am terminating my current Aflac policy and its benefits for the benefits provided in this Aflac policy.

  Proposed Insured's Initials _____

- I have reviewed the statements and answers I have provided on this application. I understand that this policy is to be issued based upon these statements and answers, and any other pertinent information Aflac may require for proper underwriting. The answers are complete and true. I understand that all statements made in this application are deemed representations and not warranties but that material misrepresentations herein may result in loss of coverage under this policy.
- I acknowledge receipt of, if applicable:
  - ❑ Replacement Notice
  - ❑ Outline of Coverage
  - ❑ *Guide to Health Insurance for People With Medicare*
  - ❑ Fair Credit Reporting Notice

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

I, _____, am applying for Aflac's Short-Term Disability policy. I currently have disability benefits under Aflac Accident/Disability policy number _____. I understand that I must cancel existing Aflac disability coverage to purchase this Short-Term Disability policy.

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

NOTICE OF INFORMATION PRACTICES

To issue an insurance policy, Aflac may need to obtain additional information about you 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, Kansas, Maine, Massachusetts, Minnesota, Montana, Nevada, New Jersey, North Carolina, Ohio, Oregon, Virginia, and Wisconsin.

INFORMATION REGARDING THE MEDICAL INFORMATION BUREAU (MIB)
PRENOTICE

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

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

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AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

I authorize the following to give information (as defined below) to Aflac or any person or entity acting on its part: any medical professional, medical care institution, pharmacy-related service organizations, 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 if coverage is 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 to contest 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 would prefer to receive an electronic copy of my policy instead of a paper copy. ❑ Yes ❑ No

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

Signed and Dated at _____ on _____
City and State Date

Proposed Insured's/Employee's Signature _____

MAKE CHECK OR MONEY ORDER PAYABLE TO AFLAC.
AMERICAN FAMILY LIFE ASSURANCE COMPANY OF COLUMBUS (AFLAC),
CLIENT SERVICES AND ADMINISTRATION,
[WORLDWIDE HEADQUARTERS • 1932 WYNNTON ROAD • COLUMBUS, GEORGIA 31999.
FOR INFORMATION, CALL TOLL-FREE 1.800.99.AFLAC (1.800.992.3522).
VISIT OUR WEB SITE AT AFLAC.COM.]

If we at Aflac fail to provide you with reasonable and adequate service, you should feel free to contact:
ARKANSAS INSURANCE DEPARTMENT • CONSUMER SERVICES DIVISION
1200 WEST THIRD STREET•LITTLE ROCK, ARKANSAS 72201-1904
Telephone 501.371.2640 or Toll-Free 1.800.852.5494

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APPLICATION FOR REINSTATEMENT
SHORT-TERM DISABILITY INSURANCE FOR A57600 SERIES
American Family Life Assurance Company of Columbus
(herein referred to as Aflac)
[Worldwide Headquarters • 1932 Wynnton Road • Columbus, Georgia 31999
For assistance or information, call 1.800.99.AFLAC (1.800.992.3522).]

Policy Number_____

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

DOB _____ Sex _____ SSN _____ - _____ - _____
Month/Day/Year (Optional)

Driver's License Number_____ State of Issue_____ State of Birth_____

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

City _____ State _____ ZIP _____

Primary Telephone ( ) _____ Best Time to Call _____
❑ Home ❑ Work ❑ Cell

Secondary Telephone ( ) _____ Best Time to Call _____
❑ Home ❑ Work ❑ Cell

E-Mail Address (optional) _____

Former Address of Proposed Insured/Employee _____

City _____ State _____ ZIP _____

Name of Employer/Payroll Account Name_____

Payroll Account No. (if applicable) _____

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

Do you have any Aflac accident policies with disability benefits? ❑ Yes ❑ No

If Yes, please complete the Supplemental Notification section at the end of this application, and be aware that you cannot have this policy without canceling those Disability benefits with Aflac.

ELIGIBILITY QUESTIONS
TO BE COMPLETED BY PROPOSED INSURED/EMPLOYEE

1. Are you actively working with the employer listed on the first page of this application? ❑ Yes ❑ No

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

2. Do you work fewer than [19] hours per week with the employer listed on the first page of this application? ❑ Yes ❑ No

3. Do you have disability coverage that you purchased that will remain in force which, combined with this applied-for coverage, will exceed 72 percent of your gross monthly income? ❑ Yes ❑ No

If you answered Yes to Question 2 or 3, a policy will not be reinstated; therefore, do not submit this application.

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4. I certify that my taxable (gross) annual income from my job with the employer listed on the first page of this application is $_____(If you are self-employed, please use an average of the **net earnings** for the past two years from the business listed on this application.) I understand that this information may require verification, to include tax records, at the time of claim. **Annual income must be [$9,000] or greater for coverage to be issued.**

UNDERWRITING QUESTIONS REQUIRED
TO BE COMPLETED BY PROPOSED INSURED/EMPLOYEE

1. Are you the mother of a child currently conceived but as yet unborn? ❑Yes ❑No ❑ N/A

2. Are you currently disabled due to sickness or injury, or have you been out of work or disabled due to sickness or injury more than five consecutive days within the last 12 months, excluding colds, influenza, routine childbirth, appendectomy, tonsillectomy, cholecystectomy (gall bladder removal), or hysterectomy? ❑Yes ❑No

3. Within the last 12 months, have you been hospitalized more than 24 hours for reasons other than colds, influenza, routine childbirth, appendectomy, tonsillectomy, cholecystectomy (gall bladder removal), or hysterectomy? ❑Yes ❑No

4. Do you have any condition for which any medical procedure (including but not limited to surgery, or organ or bone marrow transplant) has been planned or the possibility of which has been discussed with medical personnel? ❑Yes ❑No

5. Have you been to see a member of the medical profession about a medical condition that has yet to be diagnosed? ❑Yes ❑No

6. Within the last five years, have you been convicted of a felony; charged two or more times with operating a vehicle while under the influence of alcohol or drugs; charged three or more times with a moving violation; or are you currently on parole or incarcerated in a correctional institution? ❑Yes ❑No

7. Do you currently have, or in the last 12 months have you been diagnosed with or treated by a member of the medical profession for any of the following conditions: ❑Yes ❑No

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

8. Within the last five years, have you been diagnosed with or treated by a member of the medical profession for any of the following conditions or had any of the following procedures: ❑Yes ❑No

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

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If you answered Yes to any of Questions 1–8, a policy will not be reinstated; therefore, do not submit this application.

PLEASE COMPLETE THE FOLLOWING UNDERWRITING QUESTIONS 9–11 IF YOUR INDUSTRY CLASS IS E OR IF YOU ARE REINSTATING A BENEFIT PERIOD GREATER THAN [SIX] MONTHS OR MORE THAN [30] TOTAL UNITS OF COVERAGE.
Additional underwriting may be required.

9. Within the last six months, have you been diagnosed by a member of the medical profession with any medical condition; received any medical treatment, including injections or chiropractic adjustments; or been prescribed or taken prescription medications (other than prescription contraceptives)? ❑Yes ❑No
If Yes, please provide descriptive information below.

Height _____ _____ Current Weight _____
ft in lbs

Medical Condition			
Onset (mo/yr)			
Method of Treatment (prescription medications, injections, surgery, physical therapy, etc.)			
Date First Prescribed/Onset of Treatment			
For Hypertension and Diabetes, List the Average Reading (for the last three months)			

If more medical conditions exist, please use the additional chart provided:

Medical Condition			
Onset (mo/yr)			
Method of Treatment (prescription medications, injections, surgery, physical therapy, etc.)			
Date First Prescribed/Onset of Treatment			
For Hypertension and Diabetes, List the Average Reading (for the last three months)			

10. Within the last 12 months, have you used tobacco products or any other products containing nicotine? ❑ Yes ❑ No

11. a. Do you have any individual disability income coverage in force other than Aflac? ❑ Yes ❑ No
b. Do you have any group disability income coverage in force other than Aflac? ❑ Yes ❑ No

If Yes to 11a or 11b, please list your monthly benefit amounts/percentages:_____, your Benefit Period:_____, and your Elimination Period:_____.

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

12. Are you currently covered by on-the-job disability income replacement under a collective bargaining agreement, workers' compensation or a similar law in your job with the employer listed on the first page of this application? ❑ Yes ❑ No

Similar laws include but are not limited to the following:
Railroad Retirement Act; Jones Act; Maritime Doctrine of Maintenance, Wages, or Cure; Longshore and Harbor Workers' Compensation Act

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

I, _____, am applying for Aflac's Short-Term Disability policy. I currently have disability benefits under Aflac Accident/Disability policy number _____. I understand that I must cancel existing Aflac disability coverage to purchase this Short-Term Disability policy.

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

NOTICE OF INFORMATION PRACTICES

To issue an insurance policy, Aflac may need to obtain additional information about you 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, Kansas, Maine, Massachusetts, Minnesota, Montana, Nevada, New Jersey, North Carolina, Ohio, Oregon, Virginia, and Wisconsin.

INFORMATION REGARDING THE MEDICAL INFORMATION BUREAU (MIB)
PRENOTICE

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

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

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

I authorize the following to give information (as defined below) to Aflac or any person or entity acting on its part: any medical professional, medical care institution, pharmacy-related service organizations, 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.

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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 if coverage is 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 to contest 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 Proposed Insured/Employee, 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 reviewed the statements and answers I have provided on this application, and I realize policy reinstatement is based upon these statements and answers provided herein, and any other pertinent information Aflac may require for proper underwriting. The answers are complete and true. I understand, for the purposes of the Time Limit on Certain Defenses provision of the policy, that the Effective Date of the policy shall now be the reinstatement date. I also understand that Aflac and I will have the same rights as provided under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed on or attached to the policy in connection with the reinstatement. I further understand that coverage under the reinstated policy is subject to the terms set forth in my policy Reinstatement provision.

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

Signature of Proposed Insured/Employee(X) _____

Signed and Dated at _____ on _____
City and State Date

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].

If we at Aflac fail to provide you with reasonable and adequate service, you should feel free to contact:
ARKANSAS INSURANCE DEPARTMENT • CONSUMER SERVICES DIVISION
1200 WEST THIRD STREET•LITTLE ROCK, ARKANSAS 72201-1904
Telephone 501.371.2640 or Toll-Free 1.800.852.5494

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American Family Life Assurance Company of Columbus
(herein referred to as Aflac)
[Worldwide Headquarters • 1932 Wynnton Road • Columbus, Georgia 31999
For assistance or information, call 1.800.99.AFLAC (1.800.992.3522).
For claim forms, visit our Web site at aflac.com].

SHORT-TERM DISABILITY COVERAGE
Outline of Coverage for Policy Series A57600

THIS IS NOT A MEDICARE SUPPLEMENT POLICY.

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

1. **Read Your Policy Carefully.** This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract, and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and Aflac. It is, therefore, important that you **READ YOUR POLICY CAREFULLY!**

2. Short-term Disability coverage is designed to provide, to persons insured, coverage for disabilities resulting from a covered accident or Sickness, subject to any limitations set forth in the policy. Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses.

3. **Benefits.** The following benefits are a part of the policy.

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

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

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

   A. TOTAL DISABILITY BENEFITS:

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

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

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

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

   If you are unable to perform three or more ADLs within 90 days of your last treatment that is a result of a covered Sickness or Off-the-Job Injury, as certified by a Physician, and you require Direct Personal Assistance to perform such ADLs, we will pay you the Daily Disability Benefit for each day you cannot perform such ADLs. This benefit is payable up to the Total Disability Benefit Period you selected and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled "Term," and the definition of "Benefit Period."

   You will no longer be qualified to receive this benefit upon the earlier of your: (1) being released by your Physician to perform the material and substantial duties of your Full-Time Job, (2) working at any job, or (3) Physician no longer being able to certify that you are unable to perform three or more ADLs that require Direct Personal Assistance.

Separate periods of Disability, resulting from the **same or a related condition** and not separated by 180 days or more, are considered a continuation of the prior Disability. Once the maximum Total Disability Benefit Period has been paid, you will not be eligible for a new Total Disability Benefit Period for Disability due to the same or a related condition, until 180 days after you: (1) have been released by a Physician from the prior Disability, (2) are no longer disabled, and (3) are no longer qualified to receive any Disability benefits under this policy.

Separate periods of Disability, resulting from **unrelated causes** and not separated by your returning to work at a Full-Time Job for 14 working days during which you are performing the material and substantial duties of such job, are considered a continuation of the prior Disability. Once the maximum Total Disability Benefit Period has been paid, you will not be eligible for a new Total Disability Benefit Period for Disability due to an unrelated cause, until 14 working days after you: (1) have been released by a Physician from a prior Disability, (2) are no longer disabled, and (3) are no longer qualified to receive any Disability benefits under this policy.

Periods of Disability meeting either of these separation requirements will begin a new Total Disability Benefit Period, subject to a new Elimination Period.

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

If your covered Sickness or covered Off-the-Job Injury causes your Partial Disability within 90 days of your last treatment for your covered Sickness or covered Off-the-Job Injury, we will pay you one-half of the Daily Disability Benefit for each day of your Partial Disability. This benefit is payable up to the Partial Disability Benefit Period (a maximum period of three months) and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled "Term," and the definition of "Benefit Period."

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

Separate periods of Disability, resulting from the **same or a related condition** and not separated by 180 days or more, are considered a continuation of the prior Disability. Once the maximum period of three months of Disability under this benefit has been paid, you will not be eligible for a new Partial

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Disability Benefit Period for Disability due to the same or a related condition, until 180 days after you: (1) have been released by a Physician from the prior Disability, (2) are no longer disabled, and (3) are no longer qualified to receive any Disability benefits under this policy.

Separate periods of Disability, resulting from **unrelated causes** and not separated by your returning to work at a Full-Time Job for 14 working days during which you are performing the material and substantial duties of such job, are considered a continuation of the prior Disability. Once the maximum Partial Disability Benefit Period has been paid, you will not be eligible for a new Partial Disability Benefit Period for Disability due to an unrelated cause, until 14 working days after you: (1) have been released by a Physician from a prior Disability, (2) are no longer disabled, and (3) are no longer qualified to receive any Disability benefits under this policy.

Periods of Disability meeting either of these separation requirements will begin a new Partial Disability Benefit Period (a maximum period of three months), subject to a new Elimination Period.

The Partial Disability Benefit Period is not subject to the Total Disability Benefit Period.

C. WAIVER OF PREMIUM BENEFIT: If your covered Sickness or covered Off-the-Job Injury causes your Total Disability or Partial Disability for more than 90 consecutive days (or after the Elimination Period shown in the Policy Schedule, whichever is greater) while this policy is in force, Aflac will waive, from month to month, the premium for the policy and any applicable rider(s) for as long as you remain disabled, up to the applicable Benefit Period shown in the Policy Schedule.

For premiums to be waived, Aflac will require an employer's statement (or proof of your inability to perform three or more ADLs) and a Physician's statement certifying your inability to perform said duties or activities, and may each month thereafter require a Physician's statement that your inability to perform said duties or activities continues. Aflac may ask for and use an independent consultant to determine your Disability when this benefit is in force.

You must pay all premiums to keep the policy and any applicable rider(s) in force until Aflac approves your claim for this Waiver of Premium Benefit. You must also resume premium payment to keep the policy and any applicable rider(s) in force, beginning with the first premium due after you no longer qualify for Disability benefits.

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

4. OPTIONAL BENEFITS:

Disability Benefit for On-the-Job Injury Rider: (Series A57650) Applied For: ☐ Yes ☐ No

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

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

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A. TOTAL DISABILITY BENEFITS:

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

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

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

2. **Not Working Full Time:** If you are not working at a Full-Time Job at the time of your On-the-Job Injury, we will insure you as follows while coverage is in force:

   If you are unable to perform three or more ADLs within 90 days of your last treatment that is a result of a covered On-the-Job Injury, as certified by a Physician, and you require Direct Personal Assistance to perform such ADLs, we will pay you the Daily Disability Benefit for the On-the-Job Injury Disability Rider for each day you cannot perform such ADLs. This benefit is payable up to the Total Disability Benefit Period you selected and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled "Term," and the definition of "Benefit Period."

   You will no longer be qualified to receive this benefit upon the earlier of your: (1) being released by your Physician to perform the material and substantial duties of your Full-Time Job, (2) working at any job, or (3) Physician no longer being able to certify that you are unable to perform three or more ADLs that require Direct Personal Assistance.

Separate periods of Disability, resulting from the **same or a related condition** and not separated by 180 days or more, are considered a continuation of the prior Disability. Once the maximum Total Disability Benefit Period has been paid, you will not be eligible for a new Total Disability Benefit Period for Disability due to the same or a related condition, until 180 days after you: (1) have been released by a Physician from the prior Disability, (2) are no longer disabled, and (3) are no longer qualified to receive any Disability benefits under this policy.

Separate periods of Disability, resulting from **unrelated causes** and not separated by your returning to work at a Full-Time Job for 14 working days during which you are performing the material and substantial duties of such job, are considered a continuation of the prior Disability. Once the maximum Total Disability Benefit Period has been paid, you will not be eligible for a new Total Disability Benefit Period for Disability due to an unrelated cause, until 14 working days after you: (1) have been released by a Physician from a prior Disability, (2) are no longer disabled, and (3) are no longer qualified to receive any Disability benefits under this policy.

Periods of Disability meeting either of these separation requirements will begin a new Total Disability Benefit Period, subject to a new Elimination Period.

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

If your covered On-the-Job Injury causes your Partial Disability within 90 days of your last treatment for your covered On-the-Job Injury, we will pay you one-half of the Daily Disability Benefit for the On-the-Job Injury Disability Rider for each day of your Partial Disability. This benefit is payable up to the Partial

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Disability Benefit Period (a maximum period of three months) and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled "Term," and the definition of "Benefit Period."

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

Separate periods of Disability, resulting from the **same or a related condition** and not separated by 180 days or more, are considered a continuation of the prior Disability. Once the maximum period of three months of Disability under this benefit has been paid, you will not be eligible for a new Partial Disability Benefit Period for Disability due to the same or a related condition, until 180 days after you: (1) have been released by a Physician from the prior Disability, (2) are no longer disabled, and (3) are no longer qualified to receive any Disability benefits under this policy.

Separate periods of Disability, resulting from **unrelated causes** and not separated by your returning to work at a Full-Time Job for 14 working days during which you are performing the material and substantial duties of such job, are considered a continuation of the prior Disability. Once the maximum Partial Disability Benefit Period has been paid, you will not be eligible for a new Partial Disability Benefit Period for Disability due to an unrelated cause, until 14 working days after you: (1) have been released by a Physician from a prior Disability, (2) are no longer disabled, and (3) are no longer qualified to receive any Disability benefits under this policy.

Periods of Disability meeting either of these separation requirements will begin a new Partial Disability Benefit Period (a maximum period of three months), subject to a new Elimination Period.

The Partial Disability Benefit Period is not subject to the Total Disability Benefit Period.

C. WAIVER OF PREMIUM BENEFIT: If your covered On-the-Job Injury causes your Total Disability or Partial Disability for more than 90 consecutive days (or after the Elimination Period shown in the Policy Schedule, whichever is greater) while this rider is in force, Aflac will waive, from month to month, the premium for the policy and any applicable rider(s) for as long as you remain disabled, up to the applicable Benefit Period shown in the Policy Schedule.

For premiums to be waived, Aflac will require an employer's statement (or proof of your inability to perform three of more ADLs) and a Physician's statement certifying your inability to perform said duties or activities, and may each month thereafter require a Physician's statement that your inability to perform said duties or activities continues. Aflac may ask for and use an independent consultant to determine your Disability when this benefit is in force.

You must pay all premiums to keep the policy and any applicable rider(s) in force until Aflac approves your claim for this Waiver of Premium Benefit. You must also resume premium payment to keep the policy and any applicable rider(s) in force, beginning with the first premium due after you no longer qualify for Disability benefits.

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

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Additional Units of Disability Benefit Rider: (Series A57651) Applied For: ☐ Yes ☐ No

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

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

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

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

A. TOTAL DISABILITY BENEFITS:

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

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

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

2. **Not Working Full Time:** If you are not working at a Full-Time Job at the time of your Sickness or Off-the-Job Injury, we will insure you as follows while coverage is in force:

   If you are unable to perform three or more ADLs within 90 days of your last treatment that is a result of a covered Sickness or Off-the-Job Injury, as certified by a Physician, and you require Direct Personal Assistance to perform such ADLs, we will pay you the Daily Disability Benefit for the Additional Units of Disability Benefit Rider for each day you cannot perform such ADLs. This benefit is payable up to the Total Disability Benefit Period you selected and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled "Term," and the definition of "Benefit Period."

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

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any job, or (3) Physician no longer being able to certify that you are unable to perform three or more ADLs that require Direct Personal Assistance.

Separate periods of Disability, resulting from the **same or a related condition** and not separated by 180 days or more, are considered a continuation of the prior Disability. Once the maximum Total Disability Benefit Period has been paid, you will not be eligible for a new Total Disability Benefit Period for Disability due to the same or a related condition, until 180 days after you: (1) have been released by a Physician from the prior Disability, (2) are no longer disabled, and (3) are no longer qualified to receive any Disability benefits under this policy.

Separate periods of Disability, resulting from **unrelated causes** and not separated by your returning to work at a Full-Time Job for 14 working days during which you are performing the material and substantial duties of such job, are considered a continuation of the prior Disability. Once the maximum Total Disability Benefit Period has been paid, you will not be eligible for a new Total Disability Benefit Period for Disability due to an unrelated cause, until 14 working days after you: (1) have been released by a Physician from a prior Disability, (2) are no longer disabled, and (3) are no longer qualified to receive any Disability benefits under this policy.

Periods of Disability meeting either of these separation requirements will begin a new Total Disability Benefit Period, subject to a new Elimination Period.

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

If your covered Sickness or covered Off-the-Job Injury causes your Partial Disability within 90 days of your last treatment for your covered Sickness or covered Off-the-Job Injury, we will pay you one-half of the Daily Disability Benefit for the Additional Units of Disability Benefit Rider for each day of your Partial Disability. This benefit is payable up to the Partial Disability Benefit Period (a maximum period of three months) and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled “Term,” and the definition of “Benefit Period.”

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

Separate periods of Disability, resulting from the **same or a related condition** and not separated by 180 days or more, are considered a continuation of the prior Disability. Once the maximum period of three months of Disability under this benefit has been paid, you will not be eligible for a new Partial Disability Benefit Period for Disability due to the same or a related condition, until 180 days after you: (1) have been released by a Physician from the prior Disability, (2) are no longer disabled, and (3) are no longer qualified to receive any Disability benefits under this policy.

Separate periods of Disability, resulting from **unrelated causes** and not separated by your returning to work at a Full-Time Job for 14 working days during which you are performing the material and substantial duties of such job, are considered a continuation of the prior Disability. Once the maximum Partial Disability Benefit Period has been paid, you will not be eligible for a new Partial Disability Benefit Period for Disability due to an unrelated cause, until 14 working days after you: (1) have been released by a Physician from a prior Disability, (2) are no longer disabled, and (3) are no longer qualified to receive any Disability benefits under this policy.

Periods of Disability meeting either of these separation requirements will begin a new Partial Disability Benefit Period (a maximum period of three months), subject to a new Elimination Period.

The Partial Disability Benefit Period is not subject to the Total Disability Benefit Period.

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IMPORTANT PROVISIONS OF YOUR POLICY

LIMITATIONS AND EXCLUSIONS

A. Disability caused by a Pre-existing Condition or reinjuries to a Pre-existing Condition will not be covered unless it begins more than 12 months after the Effective Date of coverage.

B. Aflac will not pay benefits for an illness, disease, infection, or disorder that is diagnosed or treated by a Physician within the first 30 days after the Effective Date of coverage, unless the resulting Disability begins more than 12 months after the Effective Date of coverage.

C. Aflac will not pay benefits for a Disability that is being treated outside the territorial limits of the United States.

D. Aflac will not pay benefits whenever coverage provided by this policy is in violation of any U.S. economic or trade sanctions. If the coverage violates U.S. economic or trade sanctions, such coverage shall be null and void.

E. Aflac will not pay benefits whenever fraud is committed in making a claim under this coverage or any prior claim under any other Aflac coverage for which you received benefits that were not lawfully due and that fraudulently induced payment.

F. Aflac will not pay benefits for a Disability that is caused by or occurs as a result of any bacterial, viral, or micro-organism infection or infestation, or any condition resulting from insect, arachnid, or other arthropod bites or stings as a Disability due to an Injury; such disability will be covered to the same extent as a Disability due to Sickness.

G. Aflac will not pay benefits for a disability that is caused by or occurs as a result of your:

1. Pregnancy or childbirth within the first ten months of the Effective Date of coverage (Complications of Pregnancy will be covered to the same extent as a Sickness);

2. Using any drug, narcotic, hallucinogen, or chemical substance (unless administered by a Physician and taken according to the Physician's instructions), or voluntarily taking any kind of poison or inhaling any kind of gas or fumes;

3. Participating in any activity or event, including the operation of a vehicle, while under the influence of a controlled substance (unless administered by a Physician and taken according to the Physician's instructions) or while intoxicated ("intoxicated" means that condition as defined by the law of the jurisdiction in which the accident occurred);

4. Participating in, or attempting to participate in, an illegal activity that is defined as a felony, whether charged or not ("felony" is as defined by the law of the jurisdiction in which the activity takes place); or being incarcerated in any type penal institution;

5. Intentionally self-inflicting a bodily injury, or committing or attempting suicide, while sane or insane;

6. Having cosmetic surgery or other elective procedures that are not Medically Necessary;

7. Having dental treatment, except as a result of Injury;

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8. Being exposed to war or any act of war, declared or undeclared;

9. Actively serving in any of the armed forces, or units auxiliary thereto, including the National Guard or Reserve;

10. Donating an organ within the first 12 months of the Effective Date of this policy;

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

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

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

Renewability. The policy is guaranteed-renewable to age 75 by payment of the premium in effect at the beginning of each renewal period. Premium rates may be changed only if changed on all policies of the same form number and class in force in your state, except that we may discontinue or terminate the policy if you have performed an act or practice that constitutes fraud, or have made an intentional misrepresentation of material fact, relating in any way to the policy, including claims for benefits under the policy.

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

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SHORT-TERM DISABILITY POLICY

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

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

CONSIDERATION

This policy is issued in consideration of statements made in your application and the payment of the premium shown in the Policy Schedule. A copy of your application is attached and is a part of this policy. The following paragraphs set forth the definitions of terms, the limitations and exclusions, the insurance benefits, and other provisions.

YOUR RIGHT TO EXAMINE THIS POLICY

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

IMPORTANT NOTICE

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

THIS POLICY IS GUARANTEED-RENEWABLE TO AGE 75, SUBJECT TO AFLAC'S RIGHT TO CHANGE PREMIUMS BY CLASS UPON ANY RENEWAL DATE.

We agree that this policy will never be restricted by the addition of any rider without your consent, nor will renewal be refused because of any change in your health or physical condition. You are guaranteed the right to renew this policy until the policy anniversary date following your 75th birthday by the timely payment of premiums at the rate in effect at the beginning of each term, except that we may discontinue or terminate the policy if you have performed an act or practice that constitutes fraud, or have made an intentional misrepresentation of material fact, relating in any way to the policy, including claims for benefits under the policy. **Your coverage will terminate on the policy anniversary date following your 75th birthday.**

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

PRE-EXISTING CONDITION LIMITATIONS

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

AMERICAN FAMILY LIFE ASSURANCE COMPANY OF COLUMBUS
[WORLDWIDE HEADQUARTERS • 1932 WYNNTON ROAD • COLUMBUS, GEORGIA 31999
FOR ASSISTANCE OR INFORMATION ABOUT THIS POLICY, CALL 1.800.99.AFLAC (1.800.992.3522).
FOR CLAIM FORMS, VISIT OUR WEB SITE AT AFLAC.COM].
If we at Aflac, fail to provide you with reasonable and adequate service,
you should feel free to contact:
ARKANSAS INSURANCE DEPARTMENT • CONSUMER SERVICES DIVISION
1200 WEST THIRD STREET • LITTLE ROCK, ARKANSAS 72201-1904
Telephone 501.371.2640 or Toll-Free 1.800.852.5494.

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Policy Schedule

NAMED INSURED: John A. Doe

POLICY NUMBER: 111-2222

TYPE OF COVERAGE: Individual Only

COVERAGE: XXXXXX
AAABBB

MODE OF PAYMENT: Monthly

ELIMINATION PERIODS:
Policy, On-the-Job Rider, and
Additional Disability Rider:
Injury: 0, 7, 14 Days
Sickness: 7, 14 Days

BENEFIT PERIODS:
Policy:
Total Disability: 3 Months
Partial Disability: 3 Months
On-the-Job Rider:
Total Disability: 3 Months
Partial Disability: 3 Months
Additional Disability Rider:
Total Disability: 3 Months
Partial Disability: 3 Months

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

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

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

[
Paul S. Amos II, President

Joey M. Loudermilk, Secretary]

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

Part 1
DEFINITIONS

A. ACTIVITIES OF DAILY LIVING (ADLs): activities used in measuring your level of personal functioning capacity. Normally, these activities are performed without Direct Personal Assistance, allowing you personal independence in everyday living.

The ADLs are:

1. Bathing: washing oneself by sponge bath or in either a tub or shower, including the task of getting into or out of the tub or shower;

2. Maintaining continence: controlling urination and bowel movements, including your ability to use ostomy supplies or other devices such as catheters;

3. Transferring: moving between a bed and a chair, or a bed and a wheelchair;

4. Dressing: putting on and taking off all necessary items of clothing;

5. Toileting: getting to and from a toilet, getting on and off a toilet, and performing associated personal hygiene; and

6. Eating: performing all major tasks of getting food into your body.

B. ANNUAL INCOME: your taxable (gross) annual income from your Full-Time Job. If you are self-employed, the term "Annual Income" means an average of the net earnings reported to the Internal Revenue Service for the past two years from your business.

C. BENEFIT PERIOD: the maximum number of days after the Elimination Period, if any, for which you can be paid benefits for any period of Disability. Each new Benefit Period is subject to a new Elimination Period. See the Policy Schedule for the Benefit Period you selected. For the purposes of this calculation, a "month" is defined as 30 days for which benefits are paid.

D. COMPLICATIONS OF PREGNANCY: (1) conditions requiring medical treatment prior to or subsequent to the termination of a pregnancy whose diagnoses are distinct from pregnancy but that are adversely affected by pregnancy or caused by pregnancy, such as acute nephritis; nephrosis; cardiac decompensation; missed abortion; disease of the vascular, hemopoietic, nervous, or endocrine systems; and similar medical and surgical conditions of comparable severity; (2) non-elective cesarean deliveries, hyperemesis gravidarum and pre-eclampsia requiring hospital confinement, ectopic pregnancy that is terminated, and spontaneous termination of pregnancy that occurs during a period of gestation in which a viable birth is not possible.

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

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E. DAILY DISABILITY BENEFIT: one-thirtieth of the applicable monthly Disability benefit shown in the Policy Schedule.

F. DIRECT PERSONAL ASSISTANCE: direct physical assistance from another party required to help you perform an ADL, each and every time you perform that activity, because of an inability to perform the entire activity alone with the supports and mechanical aids that are normally available to you.

G. DISABILITY:

1. **TOTAL DISABILITY:** being under the care and attendance of a Physician due to a condition that causes you to be unable to perform the material and substantial duties of your Full-Time Job, and not working at any job.

2. **PARTIAL DISABILITY:** being under the care and attendance of a Physician due to a condition that causes you to be unable to perform the material and substantial duties of your Full-Time Job, but able to work at any job earning less than 80 percent of your Annual Income of your Full-Time Job at the time you became disabled.

H. EFFECTIVE DATE: the date(s) coverage begins as shown in the Policy Schedule. The Effective Date of this policy **is not** the date you signed the application for coverage.

I. ELIMINATION PERIOD: the number of consecutive days at the beginning of your period of Disability for which no benefits are payable. See the Policy Schedule for the Elimination Period you selected. Each new Benefit Period is subject to a new Elimination Period.

J. FULL-TIME JOB: one job at which you work 19 or more hours per week for one employer for pay or benefits.

K. IMMEDIATE FAMILY: anyone related to you in the following manner: spouse; brothers or sisters (includes stepbrothers and stepsisters); children (includes stepchildren); parents (includes stepparents); grandchildren; father- or mother-in-law; brother- or sister-in-law; and spouses, as applicable, of any of these.

L. INJURY: a bodily injury caused directly by an accident, independent of Sickness, disease, bodily infirmity, or any other cause, occurring on or after the Effective Date of coverage and while coverage is in force.

M. MEDICALLY NECESSARY: treatment, services, or supplies necessary and appropriate for the diagnosis or treatment of a Sickness or an Injury based upon generally accepted medical practice.

N. OFF-THE-JOB INJURY: an Injury that occurs while you are not working at any job for pay or benefits.

O. ON-THE-JOB INJURY: an Injury that occurs while you are working at any job for pay or benefits.

P. PHYSICIAN: a person legally qualified to practice medicine, other than you or a member of your Immediate Family, who is licensed as a Physician by the state where treatment is received to treat the type of condition for which a claim is made.

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Q. SICKNESS: an illness, disease, infection, or any other abnormal physical condition, independent of Injury, that is first manifested and first treated more than 30 days after the Effective Date of coverage and while coverage is in force. If an illness, disease, infection, or any other physical condition is diagnosed or treated by a Physician within the first 30 days after the Effective Date of coverage, any resulting Disability will not be covered unless it begins more than 12 months after the Effective Date of coverage.

Part 2
LIMITATIONS AND EXCLUSIONS

A. Disability caused by a Pre-existing Condition or reinjuries to a Pre-existing Condition will not be covered unless it begins more than 12 months after the Effective Date of coverage.

B. Aflac will not pay benefits for an illness, disease, infection, or disorder that is diagnosed or treated by a Physician within the first 30 days after the Effective Date of coverage, unless the resulting Disability begins more than 12 months after the Effective Date of coverage.

C. Aflac will not pay benefits for a Disability that is being treated outside the territorial limits of the United States.

D. Aflac will not pay benefits whenever coverage provided by this policy is in violation of any U.S. economic or trade sanctions. If the coverage violates U.S. economic or trade sanctions, such coverage shall be null and void.

E. Aflac will not pay benefits whenever fraud is committed in making a claim under this coverage or any prior claim under any other Aflac coverage for which you received benefits that were not lawfully due and that fraudulently induced payment.

F. Aflac will not pay benefits for a Disability that is caused by or occurs as a result of any bacterial, viral, or micro-organism infection or infestation, or any condition resulting from insect, arachnid, or other arthropod bites or stings as a Disability due to an Injury; such disability will be covered to the same extent as a Disability due to Sickness.

G. Aflac will not pay benefits for a disability that is caused by or occurs as a result of your:

1. Pregnancy or childbirth within the first ten months of the Effective Date of coverage (Complications of Pregnancy will be covered to the same extent as a Sickness);

2. Using any drug, narcotic, hallucinogen, or chemical substance (unless administered by a Physician and taken according to the Physician's instructions), or voluntarily taking any kind of poison or inhaling any kind of gas or fumes;

3. Participating in any activity or event, including the operation of a vehicle, while under the influence of a controlled substance (unless administered by a Physician and taken according to the Physician's instructions) or while intoxicated ("intoxicated" means that condition as defined by the law of the jurisdiction in which the accident occurred);

4. Participating in, or attempting to participate in, an illegal activity that is defined as a felony, whether charged or not ("felony" is as defined by the law of the jurisdiction in which the activity takes place); or being incarcerated in any type penal institution;

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5. Intentionally self-inflicting a bodily injury, or committing or attempting suicide, while sane or insane;

6. Having cosmetic surgery or other elective procedures that are not Medically Necessary;

7. Having dental treatment, except as a result of Injury;

8. Being exposed to war or any act of war, declared or undeclared;

9. Actively serving in any of the armed forces, or units auxiliary thereto, including the National Guard or Reserve;

10. Donating an organ within the first 12 months of the Effective Date of this policy;

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

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

Part 3
UNIFORM PROVISIONS

A. ENTIRE CONTRACT; CHANGES: This policy, together with the application, endorsements, benefit agreements, riders, and attached papers, if any, constitutes the entire contract of insurance. No change in this policy is valid until approved in writing by the president and secretary of Aflac at our worldwide headquarters. Any such change must be noted hereon or attached hereto. No associate (duly licensed agent) has the authority to change this policy or to waive any of its provisions.

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

C. TERM: You are guaranteed the right to renew this policy until the policy anniversary date following your 75th birthday by the timely payment of premiums at the rate in effect at the beginning of each term. Your coverage will terminate on the policy anniversary date following your 75th birthday. The term of this policy begins at midnight, standard time, at the place where you reside on the Effective Date shown in the Policy Schedule. It ends at midnight, at the same standard time, on the first renewal date. Each renewal term ends at midnight, at the same standard time, on the next following renewal date. Renewal dates are determined by the mode of payment. The mode of payment for the original term of this policy is shown in the

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Policy Schedule. An annual premium will maintain this policy in force for 12 months, semiannual for six months, quarterly for three months, and monthly for one month. Premium for a term is due on the first day of that term. **If you fail to pay your premium by the end of the grace period, coverage under this policy will terminate.** If you are receiving short-term Disability benefits on the date coverage would otherwise terminate, coverage under this policy will be extended to the earlier of the date you are no longer qualified to receive Disability benefits or to the end of the Benefit Period, whichever occurs first.

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

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

F. REINSTATEMENT: You may request reinstatement of your policy from your associate (duly licensed agent) or from Aflac. If your policy has lapsed for nonpayment of premium and we accept a later payment without requiring an application, your policy will be reinstated. If we require a written application and provide you with a conditional receipt, your policy will be reinstated upon our approval of the application. If we do not notify you of our disapproval in writing within 45 days of the date your application is received at our worldwide headquarters, your policy will be deemed reinstated. The reinstated policy will cover only loss resulting from a condition that begins on or after the date of reinstatement. In all other respects, you and Aflac will have the same rights as provided under the policy immediately before the due date of the defaulted premium, subject to any provisions added in connection with the reinstatement. Any premium accepted in connection with a reinstatement will be applied to a period for which premium has not been previously paid, but not to any period more than 60 days prior to the date of reinstatement.

G. MISSTATEMENT OF OCCUPATION OR INCOME: If your occupation has been misstated, the benefits will be those that the premiums paid would have purchased for your correct occupation. If your income has been misstated, the benefit payable will be that which would have been allowed for your true income level, and any overpayment of premium will be refunded.

H. NOTICE OF CLAIM: Written notice of claim must be given within 60 days after a covered loss starts or as soon as reasonably possible. The notice can be given to Aflac at our worldwide headquarters, [1932 Wynnton Rd, Columbus, GA 31999], or to your associate (duly licensed agent). The notice of claim should include the name of the covered person and the policy number.

I. CLAIM FORMS: When we receive a notice of claim, we will send you forms for filing proof of loss. If the forms are not sent to you within ten working days after the giving of such notice, you will meet the proof-of-loss requirements by giving us a written statement of the nature and extent of the loss within the time limit stated in the Proof of Loss provision.

J. PROOF OF LOSS: Written proof of loss (written proofs, such as claim forms, medical bills, medical authorizations or other reasonable evidence of the claim that is ordinarily required) must be furnished to Aflac at our worldwide headquarters within 90 days after the date of

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such loss. Failure to furnish such proof within the time required will not invalidate or reduce any claim if it was not reasonably possible to give proof within such time. However, such proof must be furnished as soon as reasonably possible and in no event (except in the absence of legal capacity) later than 15 months from the time proof is otherwise required.

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

L. PAYMENT OF CLAIMS: All benefits will be payable to you, unless assigned by you or by operation of law. Any accrued benefits unpaid at your death will be paid to your estate.

M. LEGAL ACTIONS: No legal action may be brought to recover on this policy within 60 days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action may be brought after three years from the time written proof of loss is required to be furnished.

N. CONFORMITY WITH STATE AND FEDERAL STATUTES: Any provision of this policy that on its Effective Date is in conflict with the statutes of the state in which it was issued or with any federal statute is hereby amended to conform to the minimum requirements of such statutes.

O. PHYSICAL EXAMINATIONS AND AUTOPSY: Aflac, at its own expense, will have the right and opportunity to examine a covered person when and as often as it may be reasonably required while a claim is pending hereunder, and to make an autopsy in the case of death where autopsy is not forbidden by law.

P. ASSIGNMENT: Aflac will not assume responsibility for determining the validity of an assignment of your benefits to a provider of services. No such assignment of benefits will be recognized until we receive notice at our worldwide headquarters that you have specifically assigned the benefits of your Aflac policy.

Q. OTHER INSURANCE WITH AFLAC: If you are covered under more than one Aflac policy with Disability benefits, only one Disability benefit chosen by you or your estate, as the case may be, will be effective. Aflac will return all premiums paid for the canceled benefits from the date of duplication, less any benefits paid under these policies from such date.

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

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

Part 4
BENEFITS

Aflac will pay the following benefits, as applicable, if your Disability is caused by a covered Sickness or covered Off-the-Job Injury and occurs while this coverage is in force.

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All benefits are subject to the Limitations and Exclusions, Pre-existing Condition Limitations, and other policy terms.

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

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

A. TOTAL DISABILITY BENEFITS:

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

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

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

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

   If you are unable to perform three or more ADLs within 90 days of your last treatment that is a result of a covered Sickness or Off-the-Job Injury, as certified by a Physician, and you require Direct Personal Assistance to perform such ADLs, we will pay you the Daily Disability Benefit for each day you cannot perform such ADLs. This benefit is payable up to the Total Disability Benefit Period you selected and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled "Term," and the definition of "Benefit Period."

   You will no longer be qualified to receive this benefit upon the earlier of your: (1) being released by your Physician to perform the material and substantial duties of your Full-Time Job, (2) working at any job, or (3) Physician no longer being able to certify that you are unable to perform three or more ADLs that require Direct Personal Assistance.

Separate periods of Disability, resulting from the **same or a related condition** and not separated by 180 days or more, are considered a continuation of the prior Disability. Once the

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maximum Total Disability Benefit Period has been paid, you will not be eligible for a new Total Disability Benefit Period for Disability due to the same or a related condition, until 180 days after you: (1) have been released by a Physician from the prior Disability, (2) are no longer disabled, and (3) are no longer qualified to receive any Disability benefits under this policy.

Separate periods of Disability, resulting from **unrelated causes** and not separated by your returning to work at a Full-Time Job for 14 working days during which you are performing the material and substantial duties of such job, are considered a continuation of the prior Disability. Once the maximum Total Disability Benefit Period has been paid, you will not be eligible for a new Total Disability Benefit Period for Disability due to an unrelated cause, until 14 working days after you: (1) have been released by a Physician from a prior Disability, (2) are no longer disabled, and (3) are no longer qualified to receive any Disability benefits under this policy.

Periods of Disability meeting either of these separation requirements will begin a new Total Disability Benefit Period, subject to a new Elimination Period.

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

If your covered Sickness or covered Off-the-Job Injury causes your Partial Disability within 90 days of your last treatment for your covered Sickness or covered Off-the-Job Injury, we will pay you one-half of the Daily Disability Benefit for each day of your Partial Disability. This benefit is payable up to the Partial Disability Benefit Period (a maximum period of three months) and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled “Term,” and the definition of “Benefit Period.”

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

Separate periods of Disability, resulting from the **same or a related condition** and not separated by 180 days or more, are considered a continuation of the prior Disability. Once the maximum period of three months of Disability under this benefit has been paid, you will not be eligible for a new Partial Disability Benefit Period for Disability due to the same or a related condition, until 180 days after you: (1) have been released by a Physician from the prior Disability, (2) are no longer disabled, and (3) are no longer qualified to receive any Disability benefits under this policy.

Separate periods of Disability, resulting from **unrelated causes** and not separated by your returning to work at a Full-Time Job for 14 working days during which you are performing the material and substantial duties of such job, are considered a continuation of the prior Disability. Once the maximum Partial Disability Benefit Period has been paid, you will not be eligible for a new Partial Disability Benefit Period for Disability due to an unrelated cause, until 14 working days after you: (1) have been released by a Physician from a prior Disability, (2) are no longer disabled, and (3) are no longer qualified to receive any Disability benefits under this policy.

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Periods of Disability meeting either of these separation requirements will begin a new Partial Disability Benefit Period (a maximum period of three months), subject to a new Elimination Period.

The Partial Disability Benefit Period is not subject to the Total Disability Benefit Period.

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

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AMERICAN FAMILY LIFE ASSURANCE COMPANY OF COLUMBUS
(herein referred to as Aflac)
[Worldwide Headquarters • Columbus, Georgia 31999
A Stock Company]

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

Part 1
EFFECTIVE DATE

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

Part 2
TIME LIMIT ON CERTAIN DEFENSES

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

Part 3
BENEFITS

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

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

A. TOTAL DISABILITY BENEFITS:

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

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

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

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

   If you are unable to perform three or more ADLs within 90 days of your last treatment that is a result of a covered On-the-Job Injury, as certified by a Physician, and you require Direct Personal Assistance to perform such ADLs, we will pay you the Daily Disability Benefit for the On-the-Job Injury Disability Rider for each day you cannot perform such ADLs. This benefit is payable up to the Total Disability Benefit Period you selected and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled "Term," and the definition of "Benefit Period."

   You will no longer be qualified to receive this benefit upon the earlier of your: (1) being released by your Physician to perform the material and substantial duties of your Full-Time Job, (2) working at any job, or (3) Physician no longer being able to certify that you are unable to perform three or more ADLs that require Direct Personal Assistance.

Separate periods of Disability, resulting from the **same or a related condition** and not separated by 180 days or more, are considered a continuation of the prior Disability. Once the maximum Total Disability Benefit Period has been paid, you will not be eligible for a new Total Disability Benefit Period for Disability due to the same or a related condition, until 180 days after you: (1) have been released by a Physician from the prior Disability, (2) are no longer disabled, and (3) are no longer qualified to receive any Disability benefits under this policy.

Separate periods of Disability, resulting from **unrelated causes** and not separated by your returning to work at a Full-Time Job for 14 working days during which you are performing the material and substantial duties of such job, are considered a continuation of the prior Disability. Once the maximum Total Disability Benefit Period has been paid, you will not be eligible for a new Total Disability Benefit Period for Disability due to an unrelated cause, until 14 working days after you: (1) have been released by a Physician from a prior Disability, (2) are no longer disabled, and (3) are no longer qualified to receive any Disability benefits under this policy.

Periods of Disability meeting either of these separation requirements will begin a new Total Disability Benefit Period, subject to a new Elimination Period.

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

If your covered On-the-Job Injury causes your Partial Disability within 90 days of your last treatment for your covered On-the-Job Injury, we will pay you one-half of the Daily Disability Benefit for the On-the-Job Injury Disability Rider for each day of your Partial Disability. This benefit is payable up to the Partial Disability Benefit Period (a maximum period of three months) and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled "Term," and the definition of "Benefit Period."

You will no longer be qualified to receive this benefit upon the earlier of your: (1) being released by your Physician to perform the material and substantial duties of your Full-Time

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Job, or (2) working at any job earning 80 percent or more of your pre-Disability Annual Income.

Separate periods of Disability, resulting from the **same or a related condition** and not separated by 180 days or more, are considered a continuation of the prior Disability. Once the maximum period of three months of Disability under this benefit has been paid, you will not be eligible for a new Partial Disability Benefit Period for Disability due to the same or a related condition, until 180 days after you: (1) have been released by a Physician from the prior Disability, (2) are no longer disabled, and (3) are no longer qualified to receive any Disability benefits under this policy.

Separate periods of Disability, resulting from **unrelated causes** and not separated by your returning to work at a Full-Time Job for 14 working days during which you are performing the material and substantial duties of such job, are considered a continuation of the prior Disability. Once the maximum Partial Disability Benefit Period has been paid, you will not be eligible for a new Partial Disability Benefit Period for Disability due to an unrelated cause, until 14 working days after you: (1) have been released by a Physician from a prior Disability, (2) are no longer disabled, and (3) are no longer qualified to receive any Disability benefits under this policy.

Periods of Disability meeting either of these separation requirements will begin a new Partial Disability Benefit Period (a maximum period of three months), subject to a new Elimination Period.

The Partial Disability Benefit Period is not subject to the Total Disability Benefit Period.

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

Part 4
TERMINATION

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

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

[
Paul S. Amos II, President

Joey M. Loudermilk, Secretary]

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American Family Life Assurance Company of Columbus
(herein referred to as Aflac)
[Worldwide Headquarters • 1932 Wynnton Road • Columbus, Georgia 31999
For assistance or information, call 1.800.99.AFLAC (1.800.992.3522).
For claim forms, visit our Web site at aflac.com].

LIMITED BENEFIT HEALTH COVERAGE

SHORT-TERM DISABILITY COVERAGE
Outline of Coverage for Policy Series A57600LB

THIS IS NOT A MEDICARE SUPPLEMENT POLICY.

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

1. **Read Your Policy Carefully.** This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract, and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and Aflac. It is, therefore, important that you **READ YOUR POLICY CAREFULLY!**

2. Limited benefit health coverage is designed to provide, to persons insured, limited or supplemental coverage.

3. Short-term Disability coverage is designed to provide, to persons insured, coverage for disabilities resulting from a covered accident or Sickness, subject to any limitations set forth in the policy. Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses

4. **Benefits.** The following benefits are a part of the policy.

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

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

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

   A. TOTAL DISABILITY BENEFITS:

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

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

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

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

   If you are unable to perform three or more ADLs within 90 days of your last treatment that is a result of a covered Sickness or Off-the-Job Injury, as certified by a Physician, and you require Direct Personal Assistance to perform such ADLs, we will pay you the Daily Disability Benefit for each day you cannot perform such ADLs. This benefit is payable up to the Total Disability Benefit Period you selected and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled "Term," and the definition of "Benefit Period."

   You will no longer be qualified to receive this benefit upon the earlier of your: (1) being released by your Physician to perform the material and substantial duties of your Full-Time Job, (2) working at any job, or (3) Physician no longer being able to certify that you are unable to perform three or more ADLs that require Direct Personal Assistance.

Separate periods of Disability, resulting from the **same or a related condition** and not separated by 180 days or more, are considered a continuation of the prior Disability. Once the maximum Total Disability Benefit Period has been paid, you will not be eligible for a new Total Disability Benefit Period for Disability due to the same or a related condition, until 180 days after you: (1) have been released by a Physician from the prior Disability, (2) are no longer disabled, and (3) are no longer qualified to receive any Disability benefits under this policy.

Separate periods of Disability, resulting from **unrelated causes** and not separated by your returning to work at a Full-Time Job for 14 working days during which you are performing the material and substantial duties of such job, are considered a continuation of the prior Disability. Once the maximum Total Disability Benefit Period has been paid, you will not be eligible for a new Total Disability Benefit Period for Disability due to an unrelated cause, until 14 working days after you: (1) have been released by a Physician from a prior Disability, (2) are no longer disabled, and (3) are no longer qualified to receive any Disability benefits under this policy.

Periods of Disability meeting either of these separation requirements will begin a new Total Disability Benefit Period, subject to a new Elimination Period.

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

If your covered Sickness or covered Off-the-Job Injury causes your Partial Disability within 90 days of your last treatment for your covered Sickness or covered Off-the-Job Injury, we will pay you one-half of the Daily Disability Benefit for each day of your Partial Disability. This benefit is payable up to the Partial Disability Benefit Period (a maximum period of three months) and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled "Term," and the definition of "Benefit Period."

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

Separate periods of Disability, resulting from the **same or a related condition** and not separated by 180 days or more, are considered a continuation of the prior Disability. Once the maximum period of three months of Disability under this benefit has been paid, you will not be eligible for a new Partial Disability Benefit Period for Disability due to the same or a related condition, until 180 days after you: (1) have been released by a Physician from the prior Disability, (2) are no longer disabled, and (3) are no longer qualified to receive any Disability benefits under this policy.

Separate periods of Disability, resulting from **unrelated causes** and not separated by your returning to work at a Full-Time Job for 14 working days during which you are performing the material and substantial duties of such job, are considered a continuation of the prior Disability. Once the maximum Partial Disability Benefit Period has been paid, you will not be eligible for a new Partial Disability Benefit Period for Disability due to an unrelated cause, until 14 working days after you: (1) have been released by a Physician from a prior Disability, (2) are no longer disabled, and (3) are no longer qualified to receive any Disability benefits under this policy.

Periods of Disability meeting either of these separation requirements will begin a new Partial Disability Benefit Period (a maximum period of three months), subject to a new Elimination Period.

The Partial Disability Benefit Period is not subject to the Total Disability Benefit Period.

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

5. OPTIONAL BENEFITS:

Disability Benefit for On-the-Job Injury Rider: (Series A57650LB) Applied For: ☐ Yes ☐ No

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

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

A. TOTAL DISABILITY BENEFITS:

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

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

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

2. **Not Working Full Time:** If you are not working at a Full-Time Job at the time of your On-the-Job Injury, we will insure you as follows while coverage is in force:

   If you are unable to perform three or more ADLs within 90 days of your last treatment that is a result of a covered On-the-Job Injury, as certified by a Physician, and you require Direct Personal Assistance to perform such ADLs, we will pay you the Daily Disability Benefit for the On-the-Job Injury Disability Rider for each day you cannot perform such ADLs. This benefit is payable up to the Total Disability Benefit Period you selected and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled "Term," and the definition of "Benefit Period."

   You will no longer be qualified to receive this benefit upon the earlier of your: (1) being released by your Physician to perform the material and substantial duties of your Full-Time Job, (2) working at any job, or (3) Physician no longer being able to certify that you are unable to perform three or more ADLs that require Direct Personal Assistance.

Separate periods of Disability, resulting from the **same or a related condition** and not separated by 180 days or more, are considered a continuation of the prior Disability. Once the maximum Total Disability Benefit Period has been paid, you will not be eligible for a new Total Disability Benefit Period for Disability due to the same or a related condition, until 180 days after you: (1) have been released by a Physician from the prior Disability, (2) are no longer disabled, and (3) are no longer qualified to receive any Disability benefits under this policy.

Separate periods of Disability, resulting from **unrelated causes** and not separated by your returning to work at a Full-Time Job for 14 working days during which you are performing the material and substantial duties of such job, are considered a continuation of the prior Disability. Once the maximum Total Disability Benefit Period has been paid, you will not be eligible for a new Total Disability Benefit Period for Disability due to an unrelated cause, until 14 working days after you: (1) have been released by a Physician from a prior Disability, (2) are no longer disabled, and (3) are no longer qualified to receive any Disability benefits under this policy.

Periods of Disability meeting either of these separation requirements will begin a new Total Disability Benefit Period, subject to a new Elimination Period.

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

If your covered On-the-Job Injury causes your Partial Disability within 90 days of your last treatment for your covered On-the-Job Injury, we will pay you one-half of the Daily Disability Benefit for the On-the-Job Injury Disability Rider for each day of your Partial Disability. This benefit is payable up to the Partial Disability Benefit Period (a maximum period of three months) and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled "Term," and the definition of "Benefit Period."

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

Separate periods of Disability, resulting from the **same or a related condition** and not separated by 180 days or more, are considered a continuation of the prior Disability. Once the maximum period of three months of Disability under this benefit has been paid, you will not be eligible for a new Partial

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Disability Benefit Period for Disability due to the same or a related condition, until 180 days after you: (1) have been released by a Physician from the prior Disability, (2) are no longer disabled, and (3) are no longer qualified to receive any Disability benefits under this policy.

Separate periods of Disability, resulting from **unrelated causes** and not separated by your returning to work at a Full-Time Job for 14 working days during which you are performing the material and substantial duties of such job, are considered a continuation of the prior Disability. Once the maximum Partial Disability Benefit Period has been paid, you will not be eligible for a new Partial Disability Benefit Period for Disability due to an unrelated cause, until 14 working days after you: (1) have been released by a Physician from a prior Disability, (2) are no longer disabled, and (3) are no longer qualified to receive any Disability benefits under this policy.

Periods of Disability meeting either of these separation requirements will begin a new Partial Disability Benefit Period (a maximum period of three months), subject to a new Elimination Period.

The Partial Disability Benefit Period is not subject to the Total Disability Benefit Period.

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

Additional Units of Disability Benefit Rider: (Series A57651) Applied For: ☐ Yes ☐ No

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

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

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

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

A. TOTAL DISABILITY BENEFITS:

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

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

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subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled "Term," and the definition of "Benefit Period."

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

2. **Not Working Full Time:** If you are not working at a Full-Time Job at the time of your Sickness or Off-the-Job Injury, we will insure you as follows while coverage is in force:

   If you are unable to perform three or more ADLs within 90 days of your last treatment that is a result of a covered Sickness or Off-the-Job Injury, as certified by a Physician, and you require Direct Personal Assistance to perform such ADLs, we will pay you the Daily Disability Benefit for the Additional Units of Disability Benefit Rider for each day you cannot perform such ADLs. This benefit is payable up to the Total Disability Benefit Period you selected and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled "Term," and the definition of "Benefit Period."

   You will no longer be qualified to receive this benefit upon the earlier of your: (1) being released by your Physician to perform the material and substantial duties of your Full-Time Job, (2) working at any job, or (3) Physician no longer being able to certify that you are unable to perform three or more ADLs that require Direct Personal Assistance.

Separate periods of Disability, resulting from the **same or a related condition** and not separated by 180 days or more, are considered a continuation of the prior Disability. Once the maximum Total Disability Benefit Period has been paid, you will not be eligible for a new Total Disability Benefit Period for Disability due to the same or a related condition, until 180 days after you: (1) have been released by a Physician from the prior Disability, (2) are no longer disabled, and (3) are no longer qualified to receive any Disability benefits under this policy.

Separate periods of Disability, resulting from **unrelated causes** and not separated by your returning to work at a Full-Time Job for 14 working days during which you are performing the material and substantial duties of such job, are considered a continuation of the prior Disability. Once the maximum Total Disability Benefit Period has been paid, you will not be eligible for a new Total Disability Benefit Period for Disability due to an unrelated cause, until 14 working days after you: (1) have been released by a Physician from a prior Disability, (2) are no longer disabled, and (3) are no longer qualified to receive any Disability benefits under this policy.

Periods of Disability meeting either of these separation requirements will begin a new Total Disability Benefit Period, subject to a new Elimination Period.

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

If your covered Sickness or covered Off-the-Job Injury causes your Partial Disability within 90 days of your last treatment for your covered Sickness or covered Off-the-Job Injury, we will pay you one-half of the Daily Disability Benefit for the Additional Units of Disability Benefit Rider for each day of your Partial Disability. This benefit is payable up to the Partial Disability Benefit Period (a maximum period of three months) and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled "Term," and the definition of "Benefit Period."

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

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Separate periods of Disability, resulting from the **same or a related condition** and not separated by 180 days or more, are considered a continuation of the prior Disability. Once the maximum period of three months of Disability under this benefit has been paid, you will not be eligible for a new Partial Disability Benefit Period for Disability due to the same or a related condition, until 180 days after you: (1) have been released by a Physician from the prior Disability, (2) are no longer disabled, and (3) are no longer qualified to receive any Disability benefits under this policy.

Separate periods of Disability, resulting from **unrelated causes** and not separated by your returning to work at a Full-Time Job for 14 working days during which you are performing the material and substantial duties of such job, are considered a continuation of the prior Disability. Once the maximum Partial Disability Benefit Period has been paid, you will not be eligible for a new Partial Disability Benefit Period for Disability due to an unrelated cause, until 14 working days after you: (1) have been released by a Physician from a prior Disability, (2) are no longer disabled, and (3) are no longer qualified to receive any Disability benefits under this policy.

Periods of Disability meeting either of these separation requirements will begin a new Partial Disability Benefit Period (a maximum period of three months), subject to a new Elimination Period.

The Partial Disability Benefit Period is not subject to the Total Disability Benefit Period.

IMPORTANT PROVISIONS OF YOUR POLICY

LIMITATIONS AND EXCLUSIONS

A. Disability caused by a Pre-existing Condition or reinjuries to a Pre-existing Condition will not be covered unless it begins more than 12 months after the Effective Date of coverage.

B. Aflac will not pay benefits for an illness, disease, infection, or disorder that is diagnosed or treated by a Physician within the first 30 days after the Effective Date of coverage, unless the resulting Disability begins more than 12 months after the Effective Date of coverage.

C. Aflac will not pay benefits for a Disability that is being treated outside the territorial limits of the United States.

D. Aflac will not pay benefits whenever coverage provided by this policy is in violation of any U.S. economic or trade sanctions. If the coverage violates U.S. economic or trade sanctions, such coverage shall be null and void.

E. Aflac will not pay benefits whenever fraud is committed in making a claim under this coverage or any prior claim under any other Aflac coverage for which you received benefits that were not lawfully due and that fraudulently induced payment.

F. Aflac will not pay benefits for a Disability that is caused by or occurs as a result of any bacterial, viral, or micro-organism infection or infestation, or any condition resulting from insect, arachnid, or other arthropod bites or stings as a Disability due to an Injury; such disability will be covered to the same extent as a Disability due to Sickness.

G. Aflac will not pay benefits for a disability that is caused by or occurs as a result of your:

1. Pregnancy or childbirth within the first ten months of the Effective Date of coverage (Complications of Pregnancy will be covered to the same extent as a Sickness);

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2. Using any drug, narcotic, hallucinogen, or chemical substance (unless administered by a Physician and taken according to the Physician's instructions), or voluntarily taking any kind of poison or inhaling any kind of gas or fumes;

3. Participating in any activity or event, including the operation of a vehicle, while under the influence of a controlled substance (unless administered by a Physician and taken according to the Physician's instructions) or while intoxicated ("intoxicated" means that condition as defined by the law of the jurisdiction in which the accident occurred);

4. Participating in, or attempting to participate in, an illegal activity that is defined as a felony, whether charged or not ("felony" is as defined by the law of the jurisdiction in which the activity takes place); or being incarcerated in any type penal institution;

5. Intentionally self-inflicting a bodily injury, or committing or attempting suicide, while sane or insane;

6. Having cosmetic surgery or other elective procedures that are not Medically Necessary;

7. Having dental treatment, except as a result of Injury;

8. Being exposed to war or any act of war, declared or undeclared;

9. Actively serving in any of the armed forces, or units auxiliary thereto, including the National Guard or Reserve;

10. Donating an organ within the first 12 months of the Effective Date of this policy;

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

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

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

Renewability. The policy is guaranteed-renewable to age 75 by payment of the premium in effect at the beginning of each renewal period. Premium rates may be changed only if changed on all policies of the same form number and class in force in your state, except that we may discontinue or terminate the policy if you have performed an act or practice that constitutes fraud, or have made an intentional misrepresentation of material fact, relating in any way to the policy, including claims for benefits under the policy.

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

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SERFF Tracking Number:	*AFLA-127072212*	*State:*	*Arkansas*
Filing Company:	*American Family Life Assurance Company of Columbus*	*State Tracking Number:*	*48226*
Company Tracking Number:	*A57600*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*Short Term Disability*		
Project Name/Number:	*STD/A57600*		

Rate data does NOT apply to filing.

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	03/14/2011

Comments:

A filing description letter is attached providing certification as requested signed by a company officer.

Attachment:

A576LB DTG ltrSERFF.pdf

		Item Status:	Status Date:
Bypassed - Item:	Application	Approved-Closed	03/14/2011
Bypass Reason:	Not applicable.		

Comments:

		Item Status:	Status Date:
Satisfied - Item:	Outline of Coverage	Approved-Closed	03/14/2011

Comments:

Attachments:

A57625AR.pdf

A57625LB.pdf

		Item Status:	Status Date:
Bypassed - Item:	PPACA Uniform Compliance Summary	Approved-Closed	03/14/2011
Bypass Reason:	Not a PPACA filing, bypass.		

Comments:

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

March 11, 2011

Arkansas Insurance Department
1200 West Third Street
Little Rock, AR 72201-1904 NAIC # 60380

RE: Short-Term Disability Policy Form A57600AR, Disability Benefit for On-the-Job Injury Rider Form A57650AR, Additional Units of Disability Rider Form A57651, Payroll Application Forms A57601AR, A57601cAR, A57601GAR, A57601GcAR, Associate Only Application Form A57601AAR, Application for Reinstatement Form A57603AR, and Outline of Coverage Form A57625AR.

Short-Term Disability Policy Form A57600LBAR, Disability Benefit for On-the-Job Injury Rider Form A57650LB and Outline of Coverage Form A57625LB.

Dear Commissioner:

Referenced forms are submitted for your review and approval. Limited Benefit Short-Term Disability Policy Series A57600LB was not filed in Nebraska as same was not required by the state. Nebraska, our state of domicile, has approved similar versions of these forms on March 11, 2011.

Short-Term Disability Policy Form A57600AR pays disability benefits when the insured is disabled due to a covered sickness or covered off-the-job injury. The policy will pay for total or partial disability.

Short-Term Disability Policy Form A57600LBAR pays disability benefits when the insured is disabled due to a covered sickness or covered off-the-job injury and only provides for a three month benefit period option. The policy will pay for total or partial disability.

The policies are available in unit values with the applicant having the option of choosing the unit amounts best suited for their individual needs. There are five occupational classes. The policies will be marketed through payroll deduction to applicants age 18 through 74.

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

Disability Benefit for On-the-Job Injury Rider Form A57650AR and A57650LB are optional riders and pays benefits for disabilities occurring On-the-Job only. Disability Benefit for On-the-Job Injury Rider Form A57650AR will be used with Policy Form A57600AR and Disability Benefit for On-the-Job Injury Rider Form A57650LB will be used with Policy Form A57600LBAR.

Additional Units of Disability Benefit Rider Form A57651 pays additional amounts of benefits for Sickness or Off-the-Job Injury and will be used with Policy Form A57600AR and A57600LBAR. The additional amounts will reflect the same elimination and benefit periods as those for the policy.

Payroll Application Forms A57601AR, A57601cAR, A57601GAR, and A57601GcAR will be used to make application for the policies and any applicable optional rider forms on a payroll deduction basis.

Associate Only Application Form A57601AAR will be used to make application for the policies and the optional rider on a payroll basis for our associates/agents only.

These forms differ in that the c applications contain an agent's certification statement. Forms that do NOT contain the agent's certification statement will be used in situations where the associate/agent is unable to be present at the time of application. The G applications will be used for guaranteed issue in accounts that meet the criteria for guaranteed issue.

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

Reinstatement Application Form A57603AR will be used to apply for reinstatement of policies that have lapsed for non-payment of premium.

Replacement Notice Form A-57015, previously approved with Policy Form A-57000 on August 2, 1994, will be used with Policy Form A57600AR and A57600LBAR. This form will be completed in duplicate if the applicant intends to replace existing insurance with our policy. The duplicate will be left with the applicant and the original returned to us with the application.

Outline of Coverage Forms A57625AR or A57625LB will be given to the applicant at the time of application and are self-explanatory. Outline of Coverage Form A57625AR will be used with Policy Form A57600AR and Outline of Coverage Form A57625LB will be used with Policy Form A57600LBAR.

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

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

	FLESCH Score	**Grade Level**
Short-Term Disability Policy Form A57600AR	56.365	6th
Short-Term Disability Policy Form A57600LBAR	56.365	6th
On-the-Job Disability Benefit Rider Form A57650AR	58.231	8th
On-the-Job Disability Benefit Rider Form A57650LB	58.231	8th
Additional Units Disability Benefit Rider Form A57651	55.372	8th
Payroll Application Form A57601AR	49.853	10th
Payroll Application Form A57601cAR	48.521	10th
Payroll Application Form A57601GAR	64.799	7th
Payroll Application Form A57601GcAR	60.966	7th
Associate Only Application Form A57601AAR	49.366	10th
Reinstatement Application Form A57603AR	59.422	8th
Outline of Coverage Form A57625AR	54.296	8th
Outline of Coverage Form A57625LB	54.296	8th

An actuarial memorandum and rate sheets are enclosed for your review and approval. The appropriate transmittal forms are also enclosed.

I certify that the forms submitted herewith meet the: applicable provision of Rule and Regulation 19 of the Arkansas Insurance Department Regulations as well as meeting the applicable requirements of Arkansas Insurance Department.

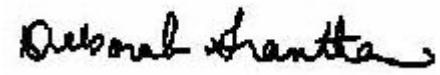
I certify that the forms submitted herewith meet the requirements of Rule and Regulation 49 of the Arkansas Insurance Department Regulations, Life and Disability Guaranty Fund Notices.

The filing fee is submitted by EFT in this SERFF filing. FLESCH certification is provided above.

Aflac reserves the right to alter the format of the forms without refiling due to future technology changes, i.e. paper size, font, font type, line ending or page ending changes. Be assured that any minimum font-size requirements will be met. When a policy is issued, the company logo will appear at the top left of page one. Any changes to wording or content would be filed for prior approval. We also reserve the right to use these forms in an electronic format, but Aflac certifies we will retain the filed final print format. 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. Other bracketed information includes language that may or may not appear based on the payroll account.

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

Sincerely,



Deborah T. Grantham
DTG/CG/cg
Enclosures

American Family Life Assurance Company of Columbus
(herein referred to as Aflac)
[Worldwide Headquarters • 1932 Wynnton Road • Columbus, Georgia 31999
For assistance or information, call 1.800.99.AFLAC (1.800.992.3522).
For claim forms, visit our Web site at aflac.com].

SHORT-TERM DISABILITY COVERAGE
Outline of Coverage for Policy Series A57600

THIS IS NOT A MEDICARE SUPPLEMENT POLICY.

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

1. **Read Your Policy Carefully.** This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract, and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and Aflac. It is, therefore, important that you **READ YOUR POLICY CAREFULLY!**

2. Short-term Disability coverage is designed to provide, to persons insured, coverage for disabilities resulting from a covered accident or Sickness, subject to any limitations set forth in the policy. Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses.

3. **Benefits.** The following benefits are a part of the policy.

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

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

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

   A. TOTAL DISABILITY BENEFITS:

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

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

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

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

   If you are unable to perform three or more ADLs within 90 days of your last treatment that is a result of a covered Sickness or Off-the-Job Injury, as certified by a Physician, and you require Direct Personal Assistance to perform such ADLs, we will pay you the Daily Disability Benefit for each day you cannot perform such ADLs. This benefit is payable up to the Total Disability Benefit Period you selected and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled "Term," and the definition of "Benefit Period."

   You will no longer be qualified to receive this benefit upon the earlier of your: (1) being released by your Physician to perform the material and substantial duties of your Full-Time Job, (2) working at any job, or (3) Physician no longer being able to certify that you are unable to perform three or more ADLs that require Direct Personal Assistance.

Separate periods of Disability, resulting from the **same or a related condition** and not separated by 180 days or more, are considered a continuation of the prior Disability. Once the maximum Total Disability Benefit Period has been paid, you will not be eligible for a new Total Disability Benefit Period for Disability due to the same or a related condition, until 180 days after you: (1) have been released by a Physician from the prior Disability, (2) are no longer disabled, and (3) are no longer qualified to receive any Disability benefits under this policy.

Separate periods of Disability, resulting from **unrelated causes** and not separated by your returning to work at a Full-Time Job for 14 working days during which you are performing the material and substantial duties of such job, are considered a continuation of the prior Disability. Once the maximum Total Disability Benefit Period has been paid, you will not be eligible for a new Total Disability Benefit Period for Disability due to an unrelated cause, until 14 working days after you: (1) have been released by a Physician from a prior Disability, (2) are no longer disabled, and (3) are no longer qualified to receive any Disability benefits under this policy.

Periods of Disability meeting either of these separation requirements will begin a new Total Disability Benefit Period, subject to a new Elimination Period.

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

If your covered Sickness or covered Off-the-Job Injury causes your Partial Disability within 90 days of your last treatment for your covered Sickness or covered Off-the-Job Injury, we will pay you one-half of the Daily Disability Benefit for each day of your Partial Disability. This benefit is payable up to the Partial Disability Benefit Period (a maximum period of three months) and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled "Term," and the definition of "Benefit Period."

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

Separate periods of Disability, resulting from the **same or a related condition** and not separated by 180 days or more, are considered a continuation of the prior Disability. Once the maximum period of three months of Disability under this benefit has been paid, you will not be eligible for a new Partial

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Disability Benefit Period for Disability due to the same or a related condition, until 180 days after you: (1) have been released by a Physician from the prior Disability, (2) are no longer disabled, and (3) are no longer qualified to receive any Disability benefits under this policy.

Separate periods of Disability, resulting from **unrelated causes** and not separated by your returning to work at a Full-Time Job for 14 working days during which you are performing the material and substantial duties of such job, are considered a continuation of the prior Disability. Once the maximum Partial Disability Benefit Period has been paid, you will not be eligible for a new Partial Disability Benefit Period for Disability due to an unrelated cause, until 14 working days after you: (1) have been released by a Physician from a prior Disability, (2) are no longer disabled, and (3) are no longer qualified to receive any Disability benefits under this policy.

Periods of Disability meeting either of these separation requirements will begin a new Partial Disability Benefit Period (a maximum period of three months), subject to a new Elimination Period.

The Partial Disability Benefit Period is not subject to the Total Disability Benefit Period.

C. WAIVER OF PREMIUM BENEFIT: If your covered Sickness or covered Off-the-Job Injury causes your Total Disability or Partial Disability for more than 90 consecutive days (or after the Elimination Period shown in the Policy Schedule, whichever is greater) while this policy is in force, Aflac will waive, from month to month, the premium for the policy and any applicable rider(s) for as long as you remain disabled, up to the applicable Benefit Period shown in the Policy Schedule.

For premiums to be waived, Aflac will require an employer's statement (or proof of your inability to perform three or more ADLs) and a Physician's statement certifying your inability to perform said duties or activities, and may each month thereafter require a Physician's statement that your inability to perform said duties or activities continues. Aflac may ask for and use an independent consultant to determine your Disability when this benefit is in force.

You must pay all premiums to keep the policy and any applicable rider(s) in force until Aflac approves your claim for this Waiver of Premium Benefit. You must also resume premium payment to keep the policy and any applicable rider(s) in force, beginning with the first premium due after you no longer qualify for Disability benefits.

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

4. OPTIONAL BENEFITS:

Disability Benefit for On-the-Job Injury Rider: (Series A57650) Applied For: ☐ Yes ☐ No

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

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

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A. TOTAL DISABILITY BENEFITS:

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

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

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

2. **Not Working Full Time:** If you are not working at a Full-Time Job at the time of your On-the-Job Injury, we will insure you as follows while coverage is in force:

   If you are unable to perform three or more ADLs within 90 days of your last treatment that is a result of a covered On-the-Job Injury, as certified by a Physician, and you require Direct Personal Assistance to perform such ADLs, we will pay you the Daily Disability Benefit for the On-the-Job Injury Disability Rider for each day you cannot perform such ADLs. This benefit is payable up to the Total Disability Benefit Period you selected and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled "Term," and the definition of "Benefit Period."

   You will no longer be qualified to receive this benefit upon the earlier of your: (1) being released by your Physician to perform the material and substantial duties of your Full-Time Job, (2) working at any job, or (3) Physician no longer being able to certify that you are unable to perform three or more ADLs that require Direct Personal Assistance.

Separate periods of Disability, resulting from the **same or a related condition** and not separated by 180 days or more, are considered a continuation of the prior Disability. Once the maximum Total Disability Benefit Period has been paid, you will not be eligible for a new Total Disability Benefit Period for Disability due to the same or a related condition, until 180 days after you: (1) have been released by a Physician from the prior Disability, (2) are no longer disabled, and (3) are no longer qualified to receive any Disability benefits under this policy.

Separate periods of Disability, resulting from **unrelated causes** and not separated by your returning to work at a Full-Time Job for 14 working days during which you are performing the material and substantial duties of such job, are considered a continuation of the prior Disability. Once the maximum Total Disability Benefit Period has been paid, you will not be eligible for a new Total Disability Benefit Period for Disability due to an unrelated cause, until 14 working days after you: (1) have been released by a Physician from a prior Disability, (2) are no longer disabled, and (3) are no longer qualified to receive any Disability benefits under this policy.

Periods of Disability meeting either of these separation requirements will begin a new Total Disability Benefit Period, subject to a new Elimination Period.

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

If your covered On-the-Job Injury causes your Partial Disability within 90 days of your last treatment for your covered On-the-Job Injury, we will pay you one-half of the Daily Disability Benefit for the On-the-Job Injury Disability Rider for each day of your Partial Disability. This benefit is payable up to the Partial

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Disability Benefit Period (a maximum period of three months) and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled "Term," and the definition of "Benefit Period."

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

Separate periods of Disability, resulting from the **same or a related condition** and not separated by 180 days or more, are considered a continuation of the prior Disability. Once the maximum period of three months of Disability under this benefit has been paid, you will not be eligible for a new Partial Disability Benefit Period for Disability due to the same or a related condition, until 180 days after you: (1) have been released by a Physician from the prior Disability, (2) are no longer disabled, and (3) are no longer qualified to receive any Disability benefits under this policy.

Separate periods of Disability, resulting from **unrelated causes** and not separated by your returning to work at a Full-Time Job for 14 working days during which you are performing the material and substantial duties of such job, are considered a continuation of the prior Disability. Once the maximum Partial Disability Benefit Period has been paid, you will not be eligible for a new Partial Disability Benefit Period for Disability due to an unrelated cause, until 14 working days after you: (1) have been released by a Physician from a prior Disability, (2) are no longer disabled, and (3) are no longer qualified to receive any Disability benefits under this policy.

Periods of Disability meeting either of these separation requirements will begin a new Partial Disability Benefit Period (a maximum period of three months), subject to a new Elimination Period.

The Partial Disability Benefit Period is not subject to the Total Disability Benefit Period.

C. WAIVER OF PREMIUM BENEFIT: If your covered On-the-Job Injury causes your Total Disability or Partial Disability for more than 90 consecutive days (or after the Elimination Period shown in the Policy Schedule, whichever is greater) while this rider is in force, Aflac will waive, from month to month, the premium for the policy and any applicable rider(s) for as long as you remain disabled, up to the applicable Benefit Period shown in the Policy Schedule.

For premiums to be waived, Aflac will require an employer's statement (or proof of your inability to perform three of more ADLs) and a Physician's statement certifying your inability to perform said duties or activities, and may each month thereafter require a Physician's statement that your inability to perform said duties or activities continues. Aflac may ask for and use an independent consultant to determine your Disability when this benefit is in force.

You must pay all premiums to keep the policy and any applicable rider(s) in force until Aflac approves your claim for this Waiver of Premium Benefit. You must also resume premium payment to keep the policy and any applicable rider(s) in force, beginning with the first premium due after you no longer qualify for Disability benefits.

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

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Additional Units of Disability Benefit Rider: (Series A57651) Applied For: ☐ Yes ☐ No

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

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

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

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

A. TOTAL DISABILITY BENEFITS:

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

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

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

2. **Not Working Full Time:** If you are not working at a Full-Time Job at the time of your Sickness or Off-the-Job Injury, we will insure you as follows while coverage is in force:

   If you are unable to perform three or more ADLs within 90 days of your last treatment that is a result of a covered Sickness or Off-the-Job Injury, as certified by a Physician, and you require Direct Personal Assistance to perform such ADLs, we will pay you the Daily Disability Benefit for the Additional Units of Disability Benefit Rider for each day you cannot perform such ADLs. This benefit is payable up to the Total Disability Benefit Period you selected and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled "Term," and the definition of "Benefit Period."

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

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any job, or (3) Physician no longer being able to certify that you are unable to perform three or more ADLs that require Direct Personal Assistance.

Separate periods of Disability, resulting from the **same or a related condition** and not separated by 180 days or more, are considered a continuation of the prior Disability. Once the maximum Total Disability Benefit Period has been paid, you will not be eligible for a new Total Disability Benefit Period for Disability due to the same or a related condition, until 180 days after you: (1) have been released by a Physician from the prior Disability, (2) are no longer disabled, and (3) are no longer qualified to receive any Disability benefits under this policy.

Separate periods of Disability, resulting from **unrelated causes** and not separated by your returning to work at a Full-Time Job for 14 working days during which you are performing the material and substantial duties of such job, are considered a continuation of the prior Disability. Once the maximum Total Disability Benefit Period has been paid, you will not be eligible for a new Total Disability Benefit Period for Disability due to an unrelated cause, until 14 working days after you: (1) have been released by a Physician from a prior Disability, (2) are no longer disabled, and (3) are no longer qualified to receive any Disability benefits under this policy.

Periods of Disability meeting either of these separation requirements will begin a new Total Disability Benefit Period, subject to a new Elimination Period.

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

If your covered Sickness or covered Off-the-Job Injury causes your Partial Disability within 90 days of your last treatment for your covered Sickness or covered Off-the-Job Injury, we will pay you one-half of the Daily Disability Benefit for the Additional Units of Disability Benefit Rider for each day of your Partial Disability. This benefit is payable up to the Partial Disability Benefit Period (a maximum period of three months) and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled “Term,” and the definition of “Benefit Period.”

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

Separate periods of Disability, resulting from the **same or a related condition** and not separated by 180 days or more, are considered a continuation of the prior Disability. Once the maximum period of three months of Disability under this benefit has been paid, you will not be eligible for a new Partial Disability Benefit Period for Disability due to the same or a related condition, until 180 days after you: (1) have been released by a Physician from the prior Disability, (2) are no longer disabled, and (3) are no longer qualified to receive any Disability benefits under this policy.

Separate periods of Disability, resulting from **unrelated causes** and not separated by your returning to work at a Full-Time Job for 14 working days during which you are performing the material and substantial duties of such job, are considered a continuation of the prior Disability. Once the maximum Partial Disability Benefit Period has been paid, you will not be eligible for a new Partial Disability Benefit Period for Disability due to an unrelated cause, until 14 working days after you: (1) have been released by a Physician from a prior Disability, (2) are no longer disabled, and (3) are no longer qualified to receive any Disability benefits under this policy.

Periods of Disability meeting either of these separation requirements will begin a new Partial Disability Benefit Period (a maximum period of three months), subject to a new Elimination Period.

The Partial Disability Benefit Period is not subject to the Total Disability Benefit Period.

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IMPORTANT PROVISIONS OF YOUR POLICY

LIMITATIONS AND EXCLUSIONS

A. Disability caused by a Pre-existing Condition or reinjuries to a Pre-existing Condition will not be covered unless it begins more than 12 months after the Effective Date of coverage.

B. Aflac will not pay benefits for an illness, disease, infection, or disorder that is diagnosed or treated by a Physician within the first 30 days after the Effective Date of coverage, unless the resulting Disability begins more than 12 months after the Effective Date of coverage.

C. Aflac will not pay benefits for a Disability that is being treated outside the territorial limits of the United States.

D. Aflac will not pay benefits whenever coverage provided by this policy is in violation of any U.S. economic or trade sanctions. If the coverage violates U.S. economic or trade sanctions, such coverage shall be null and void.

E. Aflac will not pay benefits whenever fraud is committed in making a claim under this coverage or any prior claim under any other Aflac coverage for which you received benefits that were not lawfully due and that fraudulently induced payment.

F. Aflac will not pay benefits for a Disability that is caused by or occurs as a result of any bacterial, viral, or micro-organism infection or infestation, or any condition resulting from insect, arachnid, or other arthropod bites or stings as a Disability due to an Injury; such disability will be covered to the same extent as a Disability due to Sickness.

G. Aflac will not pay benefits for a disability that is caused by or occurs as a result of your:

1. Pregnancy or childbirth within the first ten months of the Effective Date of coverage (Complications of Pregnancy will be covered to the same extent as a Sickness);

2. Using any drug, narcotic, hallucinogen, or chemical substance (unless administered by a Physician and taken according to the Physician's instructions), or voluntarily taking any kind of poison or inhaling any kind of gas or fumes;

3. Participating in any activity or event, including the operation of a vehicle, while under the influence of a controlled substance (unless administered by a Physician and taken according to the Physician's instructions) or while intoxicated ("intoxicated" means that condition as defined by the law of the jurisdiction in which the accident occurred);

4. Participating in, or attempting to participate in, an illegal activity that is defined as a felony, whether charged or not ("felony" is as defined by the law of the jurisdiction in which the activity takes place); or being incarcerated in any type penal institution;

5. Intentionally self-inflicting a bodily injury, or committing or attempting suicide, while sane or insane;

6. Having cosmetic surgery or other elective procedures that are not Medically Necessary;

7. Having dental treatment, except as a result of Injury;

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8. Being exposed to war or any act of war, declared or undeclared;

9. Actively serving in any of the armed forces, or units auxiliary thereto, including the National Guard or Reserve;

10. Donating an organ within the first 12 months of the Effective Date of this policy;

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

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

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

Renewability. The policy is guaranteed-renewable to age 75 by payment of the premium in effect at the beginning of each renewal period. Premium rates may be changed only if changed on all policies of the same form number and class in force in your state, except that we may discontinue or terminate the policy if you have performed an act or practice that constitutes fraud, or have made an intentional misrepresentation of material fact, relating in any way to the policy, including claims for benefits under the policy.

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

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American Family Life Assurance Company of Columbus
(herein referred to as Aflac)
[Worldwide Headquarters • 1932 Wynnton Road • Columbus, Georgia 31999
For assistance or information, call 1.800.99.AFLAC (1.800.992.3522).
For claim forms, visit our Web site at aflac.com].

LIMITED BENEFIT HEALTH COVERAGE

SHORT-TERM DISABILITY COVERAGE
Outline of Coverage for Policy Series A57600LB

THIS IS NOT A MEDICARE SUPPLEMENT POLICY.

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

1. **Read Your Policy Carefully.** This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract, and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and Aflac. It is, therefore, important that you **READ YOUR POLICY CAREFULLY!**

2. Limited benefit health coverage is designed to provide, to persons insured, limited or supplemental coverage.

3. Short-term Disability coverage is designed to provide, to persons insured, coverage for disabilities resulting from a covered accident or Sickness, subject to any limitations set forth in the policy. Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses

4. **Benefits.** The following benefits are a part of the policy.

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

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

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

   A. TOTAL DISABILITY BENEFITS:

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

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

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

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

   If you are unable to perform three or more ADLs within 90 days of your last treatment that is a result of a covered Sickness or Off-the-Job Injury, as certified by a Physician, and you require Direct Personal Assistance to perform such ADLs, we will pay you the Daily Disability Benefit for each day you cannot perform such ADLs. This benefit is payable up to the Total Disability Benefit Period you selected and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled "Term," and the definition of "Benefit Period."

   You will no longer be qualified to receive this benefit upon the earlier of your: (1) being released by your Physician to perform the material and substantial duties of your Full-Time Job, (2) working at any job, or (3) Physician no longer being able to certify that you are unable to perform three or more ADLs that require Direct Personal Assistance.

Separate periods of Disability, resulting from the **same or a related condition** and not separated by 180 days or more, are considered a continuation of the prior Disability. Once the maximum Total Disability Benefit Period has been paid, you will not be eligible for a new Total Disability Benefit Period for Disability due to the same or a related condition, until 180 days after you: (1) have been released by a Physician from the prior Disability, (2) are no longer disabled, and (3) are no longer qualified to receive any Disability benefits under this policy.

Separate periods of Disability, resulting from **unrelated causes** and not separated by your returning to work at a Full-Time Job for 14 working days during which you are performing the material and substantial duties of such job, are considered a continuation of the prior Disability. Once the maximum Total Disability Benefit Period has been paid, you will not be eligible for a new Total Disability Benefit Period for Disability due to an unrelated cause, until 14 working days after you: (1) have been released by a Physician from a prior Disability, (2) are no longer disabled, and (3) are no longer qualified to receive any Disability benefits under this policy.

Periods of Disability meeting either of these separation requirements will begin a new Total Disability Benefit Period, subject to a new Elimination Period.

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

If your covered Sickness or covered Off-the-Job Injury causes your Partial Disability within 90 days of your last treatment for your covered Sickness or covered Off-the-Job Injury, we will pay you one-half of the Daily Disability Benefit for each day of your Partial Disability. This benefit is payable up to the Partial Disability Benefit Period (a maximum period of three months) and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled "Term," and the definition of "Benefit Period."

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

Separate periods of Disability, resulting from the **same or a related condition** and not separated by 180 days or more, are considered a continuation of the prior Disability. Once the maximum period of three months of Disability under this benefit has been paid, you will not be eligible for a new Partial Disability Benefit Period for Disability due to the same or a related condition, until 180 days after you: (1) have been released by a Physician from the prior Disability, (2) are no longer disabled, and (3) are no longer qualified to receive any Disability benefits under this policy.

Separate periods of Disability, resulting from **unrelated causes** and not separated by your returning to work at a Full-Time Job for 14 working days during which you are performing the material and substantial duties of such job, are considered a continuation of the prior Disability. Once the maximum Partial Disability Benefit Period has been paid, you will not be eligible for a new Partial Disability Benefit Period for Disability due to an unrelated cause, until 14 working days after you: (1) have been released by a Physician from a prior Disability, (2) are no longer disabled, and (3) are no longer qualified to receive any Disability benefits under this policy.

Periods of Disability meeting either of these separation requirements will begin a new Partial Disability Benefit Period (a maximum period of three months), subject to a new Elimination Period.

The Partial Disability Benefit Period is not subject to the Total Disability Benefit Period.

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

5. OPTIONAL BENEFITS:

Disability Benefit for On-the-Job Injury Rider: (Series A57650LB) Applied For: ☐ Yes ☐ No

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

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

A. TOTAL DISABILITY BENEFITS:

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

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

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

2. **Not Working Full Time:** If you are not working at a Full-Time Job at the time of your On-the-Job Injury, we will insure you as follows while coverage is in force:

   If you are unable to perform three or more ADLs within 90 days of your last treatment that is a result of a covered On-the-Job Injury, as certified by a Physician, and you require Direct Personal Assistance to perform such ADLs, we will pay you the Daily Disability Benefit for the On-the-Job Injury Disability Rider for each day you cannot perform such ADLs. This benefit is payable up to the Total Disability Benefit Period you selected and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled "Term," and the definition of "Benefit Period."

   You will no longer be qualified to receive this benefit upon the earlier of your: (1) being released by your Physician to perform the material and substantial duties of your Full-Time Job, (2) working at any job, or (3) Physician no longer being able to certify that you are unable to perform three or more ADLs that require Direct Personal Assistance.

Separate periods of Disability, resulting from the **same or a related condition** and not separated by 180 days or more, are considered a continuation of the prior Disability. Once the maximum Total Disability Benefit Period has been paid, you will not be eligible for a new Total Disability Benefit Period for Disability due to the same or a related condition, until 180 days after you: (1) have been released by a Physician from the prior Disability, (2) are no longer disabled, and (3) are no longer qualified to receive any Disability benefits under this policy.

Separate periods of Disability, resulting from **unrelated causes** and not separated by your returning to work at a Full-Time Job for 14 working days during which you are performing the material and substantial duties of such job, are considered a continuation of the prior Disability. Once the maximum Total Disability Benefit Period has been paid, you will not be eligible for a new Total Disability Benefit Period for Disability due to an unrelated cause, until 14 working days after you: (1) have been released by a Physician from a prior Disability, (2) are no longer disabled, and (3) are no longer qualified to receive any Disability benefits under this policy.

Periods of Disability meeting either of these separation requirements will begin a new Total Disability Benefit Period, subject to a new Elimination Period.

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

If your covered On-the-Job Injury causes your Partial Disability within 90 days of your last treatment for your covered On-the-Job Injury, we will pay you one-half of the Daily Disability Benefit for the On-the-Job Injury Disability Rider for each day of your Partial Disability. This benefit is payable up to the Partial Disability Benefit Period (a maximum period of three months) and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled "Term," and the definition of "Benefit Period."

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

Separate periods of Disability, resulting from the **same or a related condition** and not separated by 180 days or more, are considered a continuation of the prior Disability. Once the maximum period of three months of Disability under this benefit has been paid, you will not be eligible for a new Partial

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Disability Benefit Period for Disability due to the same or a related condition, until 180 days after you: (1) have been released by a Physician from the prior Disability, (2) are no longer disabled, and (3) are no longer qualified to receive any Disability benefits under this policy.

Separate periods of Disability, resulting from **unrelated causes** and not separated by your returning to work at a Full-Time Job for 14 working days during which you are performing the material and substantial duties of such job, are considered a continuation of the prior Disability. Once the maximum Partial Disability Benefit Period has been paid, you will not be eligible for a new Partial Disability Benefit Period for Disability due to an unrelated cause, until 14 working days after you: (1) have been released by a Physician from a prior Disability, (2) are no longer disabled, and (3) are no longer qualified to receive any Disability benefits under this policy.

Periods of Disability meeting either of these separation requirements will begin a new Partial Disability Benefit Period (a maximum period of three months), subject to a new Elimination Period.

The Partial Disability Benefit Period is not subject to the Total Disability Benefit Period.

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

Additional Units of Disability Benefit Rider: (Series A57651) Applied For: ☐ Yes ☐ No

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

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

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

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

A. TOTAL DISABILITY BENEFITS:

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

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

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subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled "Term," and the definition of "Benefit Period."

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

2. **Not Working Full Time:** If you are not working at a Full-Time Job at the time of your Sickness or Off-the-Job Injury, we will insure you as follows while coverage is in force:

   If you are unable to perform three or more ADLs within 90 days of your last treatment that is a result of a covered Sickness or Off-the-Job Injury, as certified by a Physician, and you require Direct Personal Assistance to perform such ADLs, we will pay you the Daily Disability Benefit for the Additional Units of Disability Benefit Rider for each day you cannot perform such ADLs. This benefit is payable up to the Total Disability Benefit Period you selected and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled "Term," and the definition of "Benefit Period."

   You will no longer be qualified to receive this benefit upon the earlier of your: (1) being released by your Physician to perform the material and substantial duties of your Full-Time Job, (2) working at any job, or (3) Physician no longer being able to certify that you are unable to perform three or more ADLs that require Direct Personal Assistance.

Separate periods of Disability, resulting from the **same or a related condition** and not separated by 180 days or more, are considered a continuation of the prior Disability. Once the maximum Total Disability Benefit Period has been paid, you will not be eligible for a new Total Disability Benefit Period for Disability due to the same or a related condition, until 180 days after you: (1) have been released by a Physician from the prior Disability, (2) are no longer disabled, and (3) are no longer qualified to receive any Disability benefits under this policy.

Separate periods of Disability, resulting from **unrelated causes** and not separated by your returning to work at a Full-Time Job for 14 working days during which you are performing the material and substantial duties of such job, are considered a continuation of the prior Disability. Once the maximum Total Disability Benefit Period has been paid, you will not be eligible for a new Total Disability Benefit Period for Disability due to an unrelated cause, until 14 working days after you: (1) have been released by a Physician from a prior Disability, (2) are no longer disabled, and (3) are no longer qualified to receive any Disability benefits under this policy.

Periods of Disability meeting either of these separation requirements will begin a new Total Disability Benefit Period, subject to a new Elimination Period.

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

If your covered Sickness or covered Off-the-Job Injury causes your Partial Disability within 90 days of your last treatment for your covered Sickness or covered Off-the-Job Injury, we will pay you one-half of the Daily Disability Benefit for the Additional Units of Disability Benefit Rider for each day of your Partial Disability. This benefit is payable up to the Partial Disability Benefit Period (a maximum period of three months) and is subject to the Elimination Period shown in the Policy Schedule. Also see the Uniform Provision titled "Term," and the definition of "Benefit Period."

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

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Separate periods of Disability, resulting from the **same or a related condition** and not separated by 180 days or more, are considered a continuation of the prior Disability. Once the maximum period of three months of Disability under this benefit has been paid, you will not be eligible for a new Partial Disability Benefit Period for Disability due to the same or a related condition, until 180 days after you: (1) have been released by a Physician from the prior Disability, (2) are no longer disabled, and (3) are no longer qualified to receive any Disability benefits under this policy.

Separate periods of Disability, resulting from **unrelated causes** and not separated by your returning to work at a Full-Time Job for 14 working days during which you are performing the material and substantial duties of such job, are considered a continuation of the prior Disability. Once the maximum Partial Disability Benefit Period has been paid, you will not be eligible for a new Partial Disability Benefit Period for Disability due to an unrelated cause, until 14 working days after you: (1) have been released by a Physician from a prior Disability, (2) are no longer disabled, and (3) are no longer qualified to receive any Disability benefits under this policy.

Periods of Disability meeting either of these separation requirements will begin a new Partial Disability Benefit Period (a maximum period of three months), subject to a new Elimination Period.

The Partial Disability Benefit Period is not subject to the Total Disability Benefit Period.

IMPORTANT PROVISIONS OF YOUR POLICY

LIMITATIONS AND EXCLUSIONS

A. Disability caused by a Pre-existing Condition or reinjuries to a Pre-existing Condition will not be covered unless it begins more than 12 months after the Effective Date of coverage.

B. Aflac will not pay benefits for an illness, disease, infection, or disorder that is diagnosed or treated by a Physician within the first 30 days after the Effective Date of coverage, unless the resulting Disability begins more than 12 months after the Effective Date of coverage.

C. Aflac will not pay benefits for a Disability that is being treated outside the territorial limits of the United States.

D. Aflac will not pay benefits whenever coverage provided by this policy is in violation of any U.S. economic or trade sanctions. If the coverage violates U.S. economic or trade sanctions, such coverage shall be null and void.

E. Aflac will not pay benefits whenever fraud is committed in making a claim under this coverage or any prior claim under any other Aflac coverage for which you received benefits that were not lawfully due and that fraudulently induced payment.

F. Aflac will not pay benefits for a Disability that is caused by or occurs as a result of any bacterial, viral, or micro-organism infection or infestation, or any condition resulting from insect, arachnid, or other arthropod bites or stings as a Disability due to an Injury; such disability will be covered to the same extent as a Disability due to Sickness.

G. Aflac will not pay benefits for a disability that is caused by or occurs as a result of your:

1. Pregnancy or childbirth within the first ten months of the Effective Date of coverage (Complications of Pregnancy will be covered to the same extent as a Sickness);

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2. Using any drug, narcotic, hallucinogen, or chemical substance (unless administered by a Physician and taken according to the Physician's instructions), or voluntarily taking any kind of poison or inhaling any kind of gas or fumes;

3. Participating in any activity or event, including the operation of a vehicle, while under the influence of a controlled substance (unless administered by a Physician and taken according to the Physician's instructions) or while intoxicated ("intoxicated" means that condition as defined by the law of the jurisdiction in which the accident occurred);

4. Participating in, or attempting to participate in, an illegal activity that is defined as a felony, whether charged or not ("felony" is as defined by the law of the jurisdiction in which the activity takes place); or being incarcerated in any type penal institution;

5. Intentionally self-inflicting a bodily injury, or committing or attempting suicide, while sane or insane;

6. Having cosmetic surgery or other elective procedures that are not Medically Necessary;

7. Having dental treatment, except as a result of Injury;

8. Being exposed to war or any act of war, declared or undeclared;

9. Actively serving in any of the armed forces, or units auxiliary thereto, including the National Guard or Reserve;

10. Donating an organ within the first 12 months of the Effective Date of this policy;

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

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

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

Renewability. The policy is guaranteed-renewable to age 75 by payment of the premium in effect at the beginning of each renewal period. Premium rates may be changed only if changed on all policies of the same form number and class in force in your state, except that we may discontinue or terminate the policy if you have performed an act or practice that constitutes fraud, or have made an intentional misrepresentation of material fact, relating in any way to the policy, including claims for benefits under the policy.

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

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