

SERFF Tracking Number: AFLA-128189598 State: Arkansas
Filing Company: American Family Life Assurance Company of Columbus State Tracking Number:
Company Tracking Number: VSN2012
TOI: H20I Individual Health - Vision Sub-TOI: H20I.000 Health - Vision
Product Name: VSN2012
Project Name/Number: VSN2012/VSN2012

Filing at a Glance

Company: American Family Life Assurance Company of Columbus

Product Name: VSN2012 SERFF Tr Num: AFLA-128189598 State: Arkansas
TOI: H20I Individual Health - Vision SERFF Status: Closed-Approved State Tr Num:
Sub-TOI: H20I.000 Health - Vision Co Tr Num: VSN2012 State Status: Approved-Closed
Filing Type: Form Reviewer(s): Donna Lambert
Author: Connie Gates Disposition Date: 03/29/2012
Date Submitted: 03/23/2012 Disposition Status: Approved
Implementation Date Requested: On Approval Implementation Date: 03/29/2012
State Filing Description:

General Information

Project Name: VSN2012 Status of Filing in Domicile: Pending
Project Number: VSN2012 Date Approved in Domicile:
Requested Filing Mode: Review & Approval Domicile Status Comments:
Explanation for Combination/Other: Market Type: Individual
Submission Type: New Submission Individual Market Type:
Overall Rate Impact: Filing Status Changed: 03/29/2012
State Status Changed: 03/29/2012
Deemer Date: Created By: Connie Gates
Submitted By: Connie Gates Corresponding Filing Tracking Number:
VSN2012

Filing Description:
See filing description letter attached under Supporting Documentation.

Company and Contact

Filing Contact Information

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

Filing Company Information

American Family Life Assurance Company of CoCode: 60380 State of Domicile: Nebraska

SERFF Tracking Number: AFLA-128189598 State: Arkansas
 Filing Company: American Family Life Assurance Company of Columbus State Tracking Number:
 Columbus
 Company Tracking Number: VSN2012
 TOI: H201 Individual Health - Vision Sub-TOI: H201.000 Health - Vision
 Product Name: VSN2012
 Project Name/Number: VSN2012/VSN2012
 Columbus
 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: \$350.00
 Retaliatory? No
 Fee Explanation: \$50 per form
 7 forms
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
American Family Life Assurance Company of Columbus	\$350.00	03/23/2012	57405761

SERFF Tracking Number: AFLA-128189598 State: Arkansas
Filing Company: American Family Life Assurance Company of Columbus State Tracking Number:
Company Tracking Number: VSN2012
TOI: H201 Individual Health - Vision Sub-TOI: H201.000 Health - Vision
Product Name: VSN2012
Project Name/Number: VSN2012/VSN2012

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Donna Lambert	03/29/2012	03/29/2012

SERFF Tracking Number: AFLA-128189598 *State:* Arkansas
Filing Company: American Family Life Assurance Company of Columbus *State Tracking Number:*
Company Tracking Number: VSN2012
TOI: H20I Individual Health - Vision *Sub-TOI:* H20I.000 Health - Vision
Product Name: VSN2012
Project Name/Number: VSN2012/VSN2012

Disposition

Disposition Date: 03/29/2012

Implementation Date: 03/29/2012

Status: Approved

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: AFLA-128189598 State: Arkansas
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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved	Yes
Supporting Document	Application	Approved	Yes
Supporting Document	Health - Actuarial Justification	Approved	Yes
Supporting Document	Outline of Coverage	Approved	Yes
Form	Endorsement Form	Approved	Yes
Form	Endorsement Form	Approved	Yes
Form	Endorsement Form	Approved	Yes
Form	Payroll Application Form	Approved	Yes
Form	Payroll Application Form	Approved	Yes
Form	Request for Change/Application for Reinstatement	Approved	Yes
Form	Outline of Coverage Form	Approved	Yes

SERFF Tracking Number: AFLA-128189598 State: Arkansas
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Product Name: VSN2012
Project Name/Number: VSN2012/VSN2012

Post Submission Update Request Processed On 03/26/2012

Status: Allowed
Created By: Connie Gates
Processed By: Rosalind Minor
Comments:

General Information:

Field Name	Requested Change	Prior Value
Implementation Date Requested		10/01/2012

SERFF Tracking Number: AFLA-128189598 State: Arkansas
 Filing Company: American Family Life Assurance Company of Columbus State Tracking Number:
 Company Tracking Number: VSN2012
 TOI: H201 Individual Health - Vision Sub-TOI: H201.000 Health - Vision
 Product Name: VSN2012
 Project Name/Number: VSN2012/VSN2012

Form Schedule

Lead Form Number: VSN91

Schedule Item	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
Approved 03/29/2012	VSN91	Policy/Cont Endorsement Form ract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Initial		57.840	VSN91.pdf
Approved 03/29/2012	VSN92	Policy/Cont Endorsement Form ract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Initial		54.470	VSN92.pdf
Approved 03/29/2012	VSN93	Policy/Cont Endorsement Form ract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Initial		55.110	VSN93.pdf
Approved 03/29/2012	VSN101RA R	Application/ Payroll Application Enrollment Form Form	Revised	Replaced Form #: VSN101AR Previous Filing #:	62.320	VSN101RAR. pdf

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 Product Name: VSN2012
 Project Name/Number: VSN2012/VSN2012

Approved	VSN101CR Application/ Payroll Application	Revised	Paper Filing (Vision Insurance Policy Form VSN100AR)		
03/29/2012 AR	Enrollment Form Form		Replaced Form #:	62.460	VSN101CRA R.pdf
			VSN101CAR		
			Previous Filing #:		
			Paper Filing (Vision Insurance Policy Form VSN100AR)		
Approved	VSN103RA Application/ Request for	Revised	Replaced Form #:	59.650	VSN103RAR. pdf
03/29/2012 R	Enrollment Change/Application Form for Reinstatement		VSN103AR		
			Previous Filing #:		
			Paper Filing (Vision Insurance Policy Form VSN100AR)		
Approved	VSN125RA Outline of Coverage	Revised	Replaced Form #:	58.940	VSN125RAR. pdf
03/29/2012 R	Coverage Form		VSN125AR		
			Previous Filing #:		
			Paper Filing (Vision Insurance Policy Form VSN100AR)		

AMERICAN FAMILY LIFE ASSURANCE COMPANY OF COLUMBUS
(herein referred to as Aflac)
[Worldwide Headquarters • 1932 Wynnton Road • Columbus, Georgia 31999]
A Stock Company

Benefit Increase Endorsement to Vision Insurance Policy Form VSN100
(Option 1: Policy with Vision Correction Benefit; Materials; No Waiting Period)

POLICY NUMBER:

DATE OF ISSUE: See Policy Schedule

INSURED:

ENDORSEMENT DATE: October 1, 2012,
or the Policy Effective Date, whichever is later.

**This endorsement is subject to all of the provisions of the policy to which it is attached.
No benefits have been reduced or deleted.**

The increased benefit amounts are payable for claims incurred on or after October 1, 2012, or the Policy Effective Date, whichever is later.

The BENEFITS which currently read:

A. EYE EXAMINATION BENEFIT: Aflac will pay \$35 (thirty-five dollars) when a charge is incurred for an eye examination for a covered person. This benefit is limited to one examination per covered person, per Policy Year. The eye examination must be performed by an Optometrist or Ophthalmologist. No lifetime maximum.

While this policy is in force, the following benefits will be paid, subject to Part 2, Limitations and Exclusions, and all other policy provisions.

B. VISION CORRECTION BENEFIT: Aflac will pay \$50 (fifty dollars) when a charge is incurred for prescribed Vision Correction Materials or \$100 (one hundred dollars) when a charge is incurred for Refractive Error Correction Surgery for a covered person. This benefit is payable once per covered person, per Policy Year. **NOTE: If a covered person receives a benefit for Vision Correction Materials and later receives Refractive Error Correction Surgery in the same Policy Year, we will pay \$50 (fifty dollars) for Refractive Error Correction Surgery.**

has been amended to read:

A. EYE EXAMINATION BENEFIT: Aflac will pay \$45 (forty-five dollars) when a charge is incurred for an eye examination for a covered person. This benefit is limited to one examination per covered person, per Policy Year. The eye examination must be performed by an Optometrist or Ophthalmologist. No lifetime maximum.

While this policy is in force, the following benefits will be paid, subject to Part 2, Limitations and Exclusions, and all other policy provisions.

B. VISION CORRECTION BENEFIT: Aflac will pay \$80 (eighty dollars) when a charge is incurred for prescribed Vision Correction Materials or \$130 (one hundred thirty dollars) when a charge is incurred for Refractive Error Correction Surgery for a covered person. This benefit is payable once per covered person, per Policy Year. **NOTE: If a covered person receives a benefit for Vision Correction Materials and later receives Refractive Error Correction Surgery in the same Policy Year, we will pay \$50 (fifty dollars) for Refractive Error Correction Surgery.**

This endorsement will automatically terminate with the policy.

In witness whereof, this endorsement has been executed by Aflac's Worldwide Headquarters in Columbus, Georgia, on the above stated endorsement date.



[
Paul S. Amos II, President



Joey M. Loudermilk, Secretary]

AMERICAN FAMILY LIFE ASSURANCE COMPANY OF COLUMBUS
(herein referred to as Aflac)
[Worldwide Headquarters • 1932 Wynnton Road • Columbus, Georgia 31999]
A Stock Company

Benefit Increase Endorsement to Vision Insurance Policy Form VSN100
(Option 2: Policy with Vision Correction Benefit; Materials; 12-month Waiting Period)

POLICY NUMBER:

DATE OF ISSUE: See Policy Schedule

INSURED:

ENDORSEMENT DATE: October 1, 2012,
or the Policy Effective Date, whichever is later.

**This endorsement is subject to all of the provisions of the policy to which it is attached.
No benefits have been reduced or deleted.**

The increased benefit amounts are payable for claims incurred on or after October 1, 2012, or the Policy Effective Date, whichever is later.

The BENEFITS which currently read:

A. EYE EXAMINATION BENEFIT: Aflac will pay \$35 (thirty-five dollars) when a charge is incurred for an eye examination for a covered person. This benefit is limited to one examination per covered person, per Policy Year. The eye examination must be performed by an Optometrist or Ophthalmologist. No lifetime maximum.

While this policy is in force, the following benefits will be paid, subject to Part 2, Limitations and Exclusions, and all other policy provisions.

B. VISION CORRECTION BENEFIT: After a 12-month waiting period, Aflac will pay \$120 (one hundred twenty dollars) when a charge is incurred for prescribed Vision Correction Materials or \$240 (two hundred forty dollars) when a charge is incurred for Refractive Error Correction Surgery for a covered person. This benefit is payable once per covered person during each successive 24-month period following the end of the waiting period, and applies only for charges incurred during that period. **NOTE: If a covered person receives a benefit for Vision Correction Materials and later receives Refractive Error Correction Surgery during the same 24-month period, we will pay \$120 (one hundred twenty dollars) for Refractive Error Correction Surgery.**

has been amended to read:

A. EYE EXAMINATION BENEFIT: Aflac will pay \$45 (forty-five dollars) when a charge is incurred for an eye examination for a covered person. This benefit is limited to one examination per covered person, per Policy Year. The eye examination must be performed by an Optometrist or Ophthalmologist. No lifetime maximum.

While this policy is in force, the following benefits will be paid, subject to Part 2, Limitations and Exclusions, and all other policy provisions.

B. VISION CORRECTION BENEFIT: After a 12-month waiting period, Aflac will pay \$175 (one hundred seventy-five dollars) when a charge is incurred for prescribed Vision Correction Materials or \$295 (two hundred ninety-five dollars) when a charge is incurred for Refractive Error Correction Surgery for a covered person. This benefit is payable once per covered person during each successive 24-month period following the end of the waiting period, and applies only for charges incurred during that period. **NOTE: If a covered person receives a benefit for Vision Correction Materials and later receives Refractive Error Correction Surgery during the same 24-month period, we will pay \$120 (one hundred twenty dollars) for Refractive Error Correction Surgery.**

This endorsement will automatically terminate with the policy.

In witness whereof, this endorsement has been executed by Aflac's Worldwide Headquarters in Columbus, Georgia, on the above stated endorsement date.



[
Paul S. Amos II, President



Joey M. Loudermilk, Secretary]

AMERICAN FAMILY LIFE ASSURANCE COMPANY OF COLUMBUS
(herein referred to as Aflac)
[Worldwide Headquarters • 1932 Wynnton Road • Columbus, Georgia 31999]
A Stock Company

Benefit Increase Endorsement to Vision Insurance Policy Form VSN100
(Option 3: Policy with Vision Correction Benefit; Materials; 24-month Waiting Period)

POLICY NUMBER: DATE OF ISSUE: See Policy Schedule

INSURED: ENDORSEMENT DATE: October 1, 2012,
or the Policy Effective Date, whichever is later.

This endorsement is subject to all of the provisions of the policy to which it is attached. No benefits have been reduced or deleted.

The increased benefit amounts are payable for claims incurred on or after October 1, 2012, or the Policy Effective Date, whichever is later.

The BENEFITS which currently read:

A. EYE EXAMINATION BENEFIT: Aflac will pay \$35 (thirty-five dollars) when a charge is incurred for an eye examination for a covered person. This benefit is limited to one examination per covered person, per Policy Year. The eye examination must be performed by an Optometrist or Ophthalmologist. No lifetime maximum.

While this policy is in force, the following benefits will be paid, subject to Part 2, Limitations and Exclusions, and all other policy provisions.

B. VISION CORRECTION BENEFIT: After a 24-month waiting period, Aflac will pay \$210 (two hundred ten dollars) when a charge is incurred for prescribed Vision Correction Materials or \$420 (four hundred twenty dollars) when a charge is incurred for Refractive Error Correction Surgery for a covered person. This benefit is payable once per covered person during each successive 36-month period following the end of the waiting period, and applies only for charges incurred during that period. **NOTE: If a covered person receives a benefit for Vision Correction Materials and later receives Refractive Error Correction Surgery during the same 36-month period, we will pay \$210 (two hundred ten dollars) for Refractive Error Correction Surgery.**

has been amended to read:

A. EYE EXAMINATION BENEFIT: Aflac will pay \$45 (forty-five dollars) when a charge is incurred for an eye examination for a covered person. This benefit is limited to one examination per covered person, per Policy Year. The eye examination must be performed by an Optometrist or Ophthalmologist. No lifetime maximum.

While this policy is in force, the following benefits will be paid, subject to Part 2, Limitations and Exclusions, and all other policy provisions.

B. VISION CORRECTION BENEFIT: After a 24-month waiting period, Aflac will pay \$270 (two hundred seventy dollars) when a charge is incurred for prescribed Vision Correction Materials or \$480 (four hundred eighty dollars) when a charge is incurred for Refractive Error Correction Surgery for a covered person. This benefit is payable once per covered person during each successive 36-month period following the end of the waiting period, and applies only for charges incurred during that period. **NOTE: If a covered person receives a benefit for Vision Correction Materials and later receives Refractive Error Correction Surgery during the same 36-month period, we will pay \$210 (two hundred ten dollars) for Refractive Error Correction Surgery.**

This endorsement will automatically terminate with the policy.

In witness whereof, this endorsement has been executed by Aflac's Worldwide Headquarters in Columbus, Georgia, on the above stated endorsement date.



[Paul S. Amos II, President



Joey M. Loudermilk, Secretary]



VISION INSURANCE POLICY (VSN100 Series)

New

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

Policy Number: _____

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

Proposed Insured's Name _____
Last First MI

DOB _____ Sex _____ SSN _____ - _____ - _____
Month/Day/Year

Address _____
Street or Post Office Box Apt. No.

City _____ State _____ ZIP _____

Telephone () _____
 Home Work Cell

Email Address (optional) _____

Are you applying for Dependent Child(ren) coverage? Yes No
If yes, Dependent Children must be under age 26 as of the Effective Date of coverage.

Write Spouse's name below if you are applying for Two-Parent Family or Named Insured/Spouse Only coverage; if you have no Spouse or your Spouse is not to be covered, put N/A in the space below.

Spouse's Name _____ DOB _____ Sex _____
Last First MI Month/Day/Year

Employee's Name _____ Relationship to Proposed Insured _____
(For Billing, If Employee Is Medically Ineligible for Coverage)

Name of Vision Care Provider (optional) _____

Name of Spouse's Employer (optional) _____

Account Name _____ Account No. _____

Name of Employer _____

Are you, the Proposed Insured (or Employee listed above if Employee is medically ineligible for coverage), actively working with the employer listed on the first page of this application? Yes No
If no, a policy will not be issued; therefore, do not submit this application.

Is this insurance intended to replace any other vision insurance other than eye exams and materials now in force? Yes No
If yes, please read and sign the Replacement Notice provided by your associate/agent, if applicable.

Check Coverage Desired:	<input type="checkbox"/> [Individual	<input type="checkbox"/> Named Insured/ Spouse Only	<input type="checkbox"/> One-Parent Family	<input type="checkbox"/> Two-Parent Family
<input type="checkbox"/> Option 1: Policy with Vision Correction Benefit; Materials; No waiting period - \$80 every year	<input type="checkbox"/> Pre-Tax			
<input type="checkbox"/> Option 2: Policy with Vision Correction Benefit; Materials; 12-mo. waiting period - \$175 every 2 years	or			
<input type="checkbox"/> Option 3: Policy with Vision Correction Benefit; Materials; 24-mo. waiting period - \$270 every 3 years]	<input type="checkbox"/> After-Tax			

[Billing Method:

- Payroll Deduction
 Bank Draft (B/D)
 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 or C/C Bill billing method is checked, only the following modes of payment are available: Monthly, Quarterly, Semiannual, or Annual.

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

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

ALL OF THE FOLLOWING MUST BE COMPLETED:

1. Has anyone to be covered ever been diagnosed with or treated by a member of the medical profession for any of the following? Yes No

Glaucoma, preglaucoma, and/or borderline glaucoma
 Macular degeneration
 Diabetic retinopathy
 Type I diabetes
 Cataract
 Legal blindness
 Ocular hypertension

Tumor of the eye or brain
 Detached retina
 Multiple sclerosis
 Retinitis pigmentosa
 Optic neuritis or optic neuropathy
 Total blindness
 Cancer of the eye or brain

2. Has anyone to be covered ever been diagnosed by a member of the medical profession with an ongoing visual impairment/condition that cannot be corrected by eyeglasses, contact lenses, or surgery? Yes No

3. In the last 24 months, has anyone to be covered had or been advised by a member of the medical profession to have eye surgery (other than any type of Refractive Error Correction Surgery) or diagnosed with amblyopia (lazy eye) or treated with any eye patch regimen? Yes No

If any one of Questions 1 through 3 is answered yes, was it the:

- Named Insured Spouse Child? If Child, please list the name of the child(ren).

Any person(s) so designated will not be covered under the policy. If this is the Named Insured, the Proposed Insured's Name on the first page of this application must be different.

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 I signed this application.
- I understand that if I selected Vision Correction Benefit option 2 there will be a 12-month waiting period for the Vision Correction Benefit and if I selected Vision Correction Benefit option 3, there will be a 24-month waiting period for the Vision Correction Benefit.

Proposed Insured's Initials _____

- This policy contains a 30-day waiting period. If a covered person has an eye disease or disorder, other than one caused by an Injury, diagnosed before coverage has been in force 30 days from the Effective Date of coverage shown in the Policy Schedule, benefits for treatment of that eye disease or disorder will apply only to treatment occurring after two years from the Effective Date of the policy, or, at your option, you may elect to void the policy from its beginning and receive a full refund of premium. **The 30-day waiting period for the policy does not apply to the Eye Examination Benefit or the Vision Correction Benefit.**

Proposed Insured's Initials _____

- I understand that the policy I am applying for will not cover any person who has reached their 71st birthday before the Effective Date of the policy.

The policy provides Vision benefits only. Review your policy carefully.

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

**AMERICAN FAMILY LIFE ASSURANCE COMPANY OF COLUMBUS
CLIENT SERVICES AND ADMINISTRATION
[WORLDWIDE HEADQUARTERS • 1932 WYNNTON ROAD • COLUMBUS, GEORGIA, 31999]**

**MAKE CHECK OR MONEY ORDER PAYABLE TO AFLAC.
FOR INFORMATION, CALL TOLL-FREE [1.800.99.AFLAC (1.800.992.3522)].
VISIT OUR WEBSITE 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.**

**IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE**

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance provides limited benefits if you meet the conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- * hospitalization
- * physician services
- * hospice
- * outpatient prescription drugs if you are enrolled in Medicare Part D
- * other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

- * Check the coverage in **all** health insurance policies you already have.
- * For more information about Medicare and Medicare Supplement insurance, review the *Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare*, available from the insurance company.
- * For help in understanding your health insurance, contact your state insurance department (website = www.accessarkansas.org/insurance) or state health insurance assistance program (SHIP Division of Department at 800-224-6330 or email Insurance.Seniors@Arkansas.gov).



VISION INSURANCE POLICY (VSN100 Series)

New

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

Policy Number: _____

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

Proposed Insured's Name _____
Last First MI

DOB _____ Sex _____ SSN _____ - _____ - _____
Month/Day/Year

Address _____
Street or Post Office Box Apt. No.

City _____ State _____ ZIP _____

Telephone () _____
 Home Work Cell

Email Address (optional) _____

Are you applying for Dependent Child(ren) coverage? Yes No
If yes, Dependent Children must be under age 26 as of the Effective Date of coverage.

Write Spouse's name below if you are applying for Two-Parent Family or Named Insured/Spouse Only coverage;
if you have no Spouse or your Spouse is not to be covered, put N/A in the space below.

Spouse's Name _____ DOB _____ Sex _____
Last First MI Month/Day/Year

Employee's Name _____ Relationship to Proposed Insured _____
(For Billing, If Employee Is Medically Ineligible for Coverage)

Name of Vision Care Provider (optional) _____

Name of Spouse's Employer (optional) _____

Account Name _____ Account No. _____

Name of Employer _____

Are you, the Proposed Insured (or Employee listed above if Employee is medically ineligible for coverage), actively working with the employer listed on the first page of this application? Yes No
If no, a policy will not be issued; therefore, do not submit this application.

Is this insurance intended to replace any other vision insurance other than eye exams and materials now in force? Yes No
If yes, please read and sign the Replacement Notice provided by your associate/agent, if applicable.

Check Coverage Desired:	<input type="checkbox"/> [Individual	<input type="checkbox"/> Named Insured/ Spouse Only	<input type="checkbox"/> One-Parent Family	<input type="checkbox"/> Two-Parent Family
<input type="checkbox"/> Option 1: Policy with Vision Correction Benefit; Materials; No waiting period - \$80 every year <input type="checkbox"/> Option 2: Policy with Vision Correction Benefit; Materials; 12-mo. waiting period - \$175 every 2 years <input type="checkbox"/> Option 3: Policy with Vision Correction Benefit; Materials; 24-mo. waiting period - \$270 every 3 years]				<input type="checkbox"/> Pre-Tax or <input type="checkbox"/> After-Tax

[Billing Method:

- Payroll Deduction
 Bank Draft (B/D)
 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 or C/C Bill billing method is checked, only the following modes of payment are available: Monthly, Quarterly, Semiannual, or Annual.

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

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

ALL OF THE FOLLOWING MUST BE COMPLETED:

1. Has anyone to be covered ever been diagnosed with or treated by a member of the medical profession for any of the following? Yes No

Glaucoma, preglaucoma, and/or borderline glaucoma
 Macular degeneration
 Diabetic retinopathy
 Type I diabetes
 Cataract
 Legal blindness
 Ocular hypertension

Tumor of the eye or brain
 Detached retina
 Multiple sclerosis
 Retinitis pigmentosa
 Optic neuritis or optic neuropathy
 Total blindness
 Cancer of the eye or brain

2. Has anyone to be covered ever been diagnosed by a member of the medical profession with an ongoing visual impairment/condition that cannot be corrected by eyeglasses, contact lenses, or surgery? Yes No

3. In the last 24 months, has anyone to be covered had or been advised by a member of the medical profession to have eye surgery (other than any type of Refractive Error Correction Surgery) or diagnosed with amblyopia (lazy eye) or treated with any eye patch regimen? Yes No

If any one of Questions 1 through 3 is answered yes, was it the:

- Named Insured Spouse Child? If Child, please list the name of the child(ren).

Any person(s) so designated will not be covered under the policy. If this is the Named Insured, the Proposed Insured's Name on the first page of this application must be different.

APPLICANT'S STATEMENTS AND AGREEMENTS

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- I understand that if I selected Vision Correction Benefit option 2 there will be a 12-month waiting period for the Vision Correction Benefit and if I selected Vision Correction Benefit option 3, there will be a 24-month waiting period for the Vision Correction Benefit.

Proposed Insured's Initials _____

- This policy contains a 30-day waiting period. If a covered person has an eye disease or disorder, other than one caused by an Injury, diagnosed before coverage has been in force 30 days from the Effective Date of coverage shown in the Policy Schedule, benefits for treatment of that eye disease or disorder will apply only to treatment occurring after two years from the Effective Date of the policy, or, at your option, you may elect to void the policy from its beginning and receive a full refund of premium. **The 30-day waiting period for the policy does not apply to the Eye Examination Benefit or the Vision Correction Benefit.**

Proposed Insured's Initials _____

- I understand that the policy I am applying for will not cover any person who has reached their 71st birthday before the Effective Date of the policy.

The policy provides Vision benefits only. Review your policy carefully.

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

**AMERICAN FAMILY LIFE ASSURANCE COMPANY OF COLUMBUS
CLIENT SERVICES AND ADMINISTRATION
[WORLDWIDE HEADQUARTERS • 1932 WYNNTON ROAD • COLUMBUS, GEORGIA, 31999]**

**MAKE CHECK OR MONEY ORDER PAYABLE TO AFLAC.
FOR INFORMATION, CALL TOLL-FREE [1.800.99.AFLAC (1.800.992.3522)].
VISIT OUR WEBSITE 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.**

**IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE**

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance provides limited benefits if you meet the conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- * hospitalization
- * physician services
- * hospice
- * outpatient prescription drugs if you are enrolled in Medicare Part D
- * other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

- * Check the coverage in **all** health insurance policies you already have.
- * For more information about Medicare and Medicare Supplement insurance, review the *Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare*, available from the insurance company.
- * For help in understanding your health insurance, contact your state insurance department (website = www.accessarkansas.org/insurance) or state health insurance assistance program (SHIP Division of Department at 800-224-6330 or email Insurance.Seniors@Arkansas.gov).

REQUEST FOR CHANGE/APPLICATION FOR REINSTATEMENT – VISION (VSN100 Series)

American Family Life Assurance Company of Columbus
(herein referred to as Aflac)
[Worldwide Headquarters • Columbus, GA 31999
For information, call toll-free 1.800.99.AFLAC (1.800.992.3522).
Fax number – 1.800.448.8922]

Pre-tax After-tax

Name of Policyholder _____ SSN _____

Policy Number _____ Date of Birth _____

Current Address of Policyholder _____

City _____ State _____ ZIP _____

Telephone () _____
 Home Work Cell

Email Address (optional) _____

Former Address of Policyholder _____

City _____ State _____ ZIP _____

Name of Employer _____

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

VISION CORRECTION BENEFIT OPTION CHANGE ONLY:

YOU ARE ONLY ELIGIBLE TO CHANGE YOUR VISION CORRECTION BENEFIT OPTION TO BE EFFECTIVE ON EACH POLICY ANNIVERSARY DATE.

[Change my Vision Correction Benefit to:

- Option 1: Policy with Vision Correction Benefit; Materials; No waiting period-\$80 every year
- Option 2: Policy with Vision Correction Benefit; Materials; 12-month waiting period-\$175 every 2 years
- Option 3: Policy with Vision Correction Benefit; Materials; 24-month waiting period-\$270 every 3 years]

PLEASE NOTE –The Vision Correction Benefit will be subject to new waiting periods, if any, beginning with the Effective Date of this new coverage.

REINSTATEMENT – Complete the underwriting questions

ADDITIONS – Complete applicable questions listed below. Dependent Children must be under age 26 as of the Effective Date of coverage. Spouse must be under age 71 as of the Effective Date of coverage.

Spouse to be Added _____
Last Name First Name MI

Sex Male Female

Spouse's DOB _____

Are you applying for Dependent Child(ren) coverage? Yes No

Reason for Addition Marriage Birth/Adoption within the past 31 days Request

Date of Marriage/Request _____

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

PLEASE ANSWER THE FOLLOWING UNDERWRITING QUESTIONS FOR ANY REINSTATEMENT AND/OR ANY ADDITION OTHER THAN A CHILD BORN OR ADOPTED WITHIN THE PAST 31 DAYS. IF YOU ARE ONLY ADDING A CHILD DUE TO BIRTH OR ADOPTION WITHIN THE PAST 31 DAYS, YOU DO NOT HAVE TO ANSWER THESE QUESTIONS.

FOR REINSTATEMENT, THE QUESTIONS BELOW APPLY TO ANYONE TO BE COVERED UNDER THE POLICY. FOR ADDITIONS ONLY, THE QUESTIONS BELOW APPLY ONLY TO THE PERSON(S) TO BE ADDED

1. Has anyone to be covered ever been diagnosed with or treated by a member of the medical profession for any of the following? Yes No

Glaucoma, preglaucoma, and/or borderline glaucoma
Macular degeneration
Diabetic retinopathy
Type I diabetes
Cataract
Legal blindness
Ocular hypertension

Tumor of the eye or brain
Detached retina
Multiple sclerosis
Retinitis pigmentosa
Optic neuritis or optic neuropathy
Total blindness
Cancer of the eye or brain

2. Has anyone to be covered ever been diagnosed by a member of the medical profession with an ongoing visual impairment/condition that cannot be corrected by eyeglasses, contact lenses, or surgery? Yes No

3. In the last 24 months, has anyone to be covered had or been advised by a member of the medical profession to have eye surgery (other than any type of Refractive Error Correction Surgery) or diagnosed with amblyopia (lazy eye) or treated with any eye patch regimen? Yes No

If any one of Questions 1 through 3 is answered yes, was it the:

Named Insured Spouse Child? If Child, please list the name of the child(ren) .

Any person(s) so designated will not be covered under the policy. If the named person is the policyholder, the policy will not be reinstated.

NOTICE OF INFORMATION PRACTICES

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

I understand that the reinstated policy will cover only loss resulting from covered vision treatment that begins after the date of reinstatement. I understand that the information on this form applies **ONLY** to my vision policy.

I have read, or had read to me, the completed application and realize policy reinstatement is based upon statements and answers provided herein, and they are complete and true. I understand 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 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 shall have the same rights as provided under the policy immediately before the due date of the defaulted premium, subject to the provisions herein and 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's reinstatement provision.

I understand that any covered person will be subject to new waiting periods for the Vision Correction Benefit, if any, beginning from the Effective Date of reinstatement.

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.

Policyholder's Signature (X) _____

Signed and Dated at _____ on _____
City and State Date

The policy provides Vision benefits only. Review your policy carefully.

**MAKE CHECK OR MONEY ORDER PAYABLE TO AFLAC.
FOR INFORMATION, CALL TOLL-FREE [1.800.99.AFLAC (1.800.992.3522)].
VISIT OUR WEBSITE 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**

American Family Life Assurance Company of Columbus
(herein referred to as Aflac)
[Worldwide Headquarters • 1932 Wynnton Road • Columbus, Georgia 31999]
Toll-Free [1.800.99.AFLAC (1.800.992.3522)]

LIMITED BENEFIT HEALTH COVERAGE
VISION COVERAGE
Outline of Coverage for Policy Form Series VSN100

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.

- I. 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.
- II. LIMITED BENEFIT HEALTH COVERAGE:** Policies of this category are designed to provide, to persons insured, limited or supplemental coverage.
- III. BENEFITS:** Subject to the waiting period, listed in the Benefit section (Part 5) of your policy, for the Vision Correction Benefit and the provisions in the Limitations and Exclusions section, we will pay the following benefits when a charge is incurred for covered vision treatment that occurs while coverage is in force. See your policy for the specific waiting period for the Vision Correction Benefit.
- A. EYE EXAMINATION BENEFIT:** Aflac will pay \$45 (forty-five dollars) when a charge is incurred for an eye examination for a covered person. This benefit is limited to one examination per covered person, per Policy Year. The eye examination must be performed by an Optometrist or Ophthalmologist. No lifetime maximum.

While the policy is in force, the following benefits will be paid, subject to Part 2, Limitations and Exclusions of your policy, and all other policy provisions. Please see section (IV) of this outline of coverage.

- B. VISION CORRECTION BENEFIT:** The option you have chosen on your application is indicated below by a check mark in the appropriate option box. **PLEASE NOTE: Only one Vision Correction Benefit option can be in effect at any given time.**

Option 1 VISION CORRECTION BENEFIT: Aflac will pay \$80 (eighty dollars) when a charge is incurred for prescribed Vision Correction Materials or \$130 (one hundred thirty dollars) when a charge is incurred for Refractive Error Correction Surgery for a covered person. This benefit is payable once per covered person, per Policy Year. **NOTE: If a covered person receives a benefit for Vision Correction Materials and later receives Refractive Error Correction Surgery in the same Policy Year, we will pay \$50 (fifty dollars) for Refractive Error Correction Surgery.**

Option 2 VISION CORRECTION BENEFIT: After a 12-month waiting period, Aflac will pay \$175 (one hundred seventy-five dollars) when a charge is incurred for prescribed Vision Correction Materials or \$295 (two hundred ninety-five dollars) when a charge is incurred for Refractive Error Correction Surgery for a covered person. This benefit is payable once per covered person during each successive 24-month period following the end of the waiting period, and applies only for charges incurred during that period. **NOTE: If a covered person receives a benefit for Vision Correction Materials and later receives Refractive Error Correction Surgery during the same 24-month period, we will pay \$120 (one hundred twenty dollars) for Refractive Error Correction Surgery.**

Option 3 VISION CORRECTION BENEFIT: After a 24-month waiting period, Aflac will pay \$270 (two hundred seventy dollars) when a charge is incurred for prescribed Vision Correction Materials or \$480 (four hundred eighty dollars) when a charge is incurred for Refractive Error Correction Surgery for a covered person. This benefit is payable once per covered person during each successive 36-month period following the end of the waiting period, and applies only for charges incurred during that period. **NOTE: If a covered person receives a benefit for Vision Correction Materials and later receives Refractive Error Correction Surgery during the same 36-month period, we will pay \$210 (two hundred ten dollars) for Refractive Error Correction Surgery.**

C. SPECIFIC EYE DISEASES/DISORDERS BENEFIT: Aflac will pay \$1,000 (one thousand dollars) when a covered person is first diagnosed after the Effective Date as having any of the eye diseases or disorders listed below. The eye disease or disorder must be diagnosed by an Ophthalmologist or a Physician.

Glaucoma (excluding preglaucoma and/or borderline glaucoma) Proliferative diabetic retinopathy	Retinitis pigmentosa Retinal detachment Macular degeneration
--	--

This benefit is payable only once per covered disease or disorder, per covered person, and will be paid in addition to any other benefit in this policy.

D. EYE SURGERY BENEFIT: When a surgical operation is performed on a covered person for a diagnosed eye disease or disorder, Aflac will pay the indemnity amount listed in the Schedule of Operations in your policy for the specific procedure when a charge is incurred. Surgeries must be performed by an Ophthalmologist or a Physician.

If any operation for a diagnosed eye disease or disorder is performed other than those listed, Aflac will pay an amount comparable to the amount shown in the Schedule of Operations for the operation most nearly similar in severity and gravity.

NOTE: Surgical benefits for Refractive Error Correction Surgery are payable only under the Vision Correction Benefit.

Surgical benefits are limited to surgeries of the eye, eye socket, eyelid, and tear ducts. Only one benefit is payable per 24-hour period for surgery even though more than one surgical procedure may be performed. We will pay the highest eligible benefit. No lifetime maximum.

E. PERMANENT VISUAL IMPAIRMENT BENEFIT: When a covered person is first diagnosed after the Effective Date of coverage with a Visual Impairment for which there is no medical prognosis of recovery, Aflac will pay the following indemnity amount(s) for the specific level(s) of Visual Impairment that apply to your current stage of Visual Impairment.

VISUAL IMPAIRMENT LEVEL	TOTAL PER LEVEL	MAXIMUM CUMULATIVE BENEFIT PER EYE
(Level 1) – Severe	\$750	\$750
(Level 2) – Profound	+ \$1,750	\$2,500
(Level 3) – Near-Total	+ \$2,500	\$5,000
(Level 4) – Total	+ \$5,000	\$10,000

If a covered person is diagnosed with a Level 2, 3, or 4 Visual Impairment, benefits for previously unpaid lower levels of Visual Impairment, if any, will be paid in addition to benefits for the level diagnosed. Each level of Visual Impairment is payable a maximum of once per eye, per covered person.

The permanent Visual Impairment must be diagnosed by an Ophthalmologist or a Physician. Benefits for a child born visually impaired are payable only if the visually impaired child is born after ten months from the Effective Date of this policy. Lifetime maximum of \$10,000 (ten thousand dollars) per eye, per covered person. Lifetime maximum of \$20,000 (twenty thousand dollars) per covered person.

F. CONTINUATION OF COVERAGE BENEFIT: Aflac will waive all monthly premiums due for the policy for two months if you meet all of the following conditions:

- Your policy has been in force for at least six months;
- We have received premiums for at least six consecutive months;
- Your premiums have been paid through payroll deduction;
- You or your employer has notified us in writing within 30 days of the date your premium payments ceased due to your leaving employment; and
- You re-establish premium payments through your new employer's payroll deduction process, or direct payment to Aflac.

You will again become eligible to receive this benefit after:

- You re-establish your premium payments through payroll deduction for a period of at least six months, and
- We receive premiums for at least six consecutive months.

"Payroll deduction" means your premium is remitted to Aflac for you by your employer through a payroll deduction process.

IV. EXCEPTIONS, REDUCTIONS AND LIMITATIONS OF THIS POLICY:

A. This policy contains a 30-day waiting period. If a covered person has an eye disease or disorder, other than one caused by an Injury, diagnosed before coverage has been in force 30 days from the Effective Date of coverage shown in the Policy Schedule, benefits for treatment of that eye disease or disorder will apply only to treatment occurring after two years from the Effective Date of the policy or, at your option, you may elect to void the policy from its beginning and receive a full refund of premium. **The 30-day waiting period does not apply to the Eye Examination Benefit or the Vision Correction Benefit.**

B. This policy does not cover losses caused by or resulting from:

1. Services that are not recommended by an Optometrist, Ophthalmologist, or a Physician.
2. Cosmetic surgery that is not due to eye disease, disorder, or Injury.
3. Treatment or diagnosis received while outside the territorial limits of the United States or, if outside the United States, the territorial limits of the place where your policy was issued.
4. Intentionally self-inflicting bodily Injury or attempting suicide, while sane or insane.

C. If you change your Vision Correction Benefit option, this benefit will be subject to a new waiting period, if any, beginning with the Effective Date of the new option. **YOU ARE ELIGIBLE TO CHANGE YOUR VISION CORRECTION BENEFIT OPTION ONLY ONCE EACH YEAR, WITH THE CHANGE TO BE EFFECTIVE ON YOUR NEXT POLICY ANNIVERSARY DATE.**

V. RENEWABILITY: This policy is guaranteed-renewable for your lifetime by payment of the premium in effect at the beginning of each renewal period. Premium rates may change only if changed on all policies of the same form number and class in force in your state.

RETAIN FOR YOUR RECORDS.

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

SERFF Tracking Number: AFLA-128189598 State: Arkansas
 Filing Company: American Family Life Assurance Company of Columbus State Tracking Number:
 Company Tracking Number: VSN2012
 TOI: H20I Individual Health - Vision Sub-TOI: H20I.000 Health - Vision
 Product Name: VSN2012
 Project Name/Number: VSN2012/VSN2012

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved	03/29/2012

Comments:

The attached filing letter addresses compliance with Rule & Regulation 19, Rule & Regulation 49, Flesch Certification. The Consumer Information Notice is included on the bottom of the application forms.

Attachment:

ARVSN2012dtg.pdf

		Item Status:	Status Date:
Satisfied - Item:	Application	Approved	03/29/2012

Comments:

For your convenience a copy of the previously approved applications with the March 09, 2005 stamped approval are attached below.

Attachments:

VSN101AR Stamped Approval.pdf
 VSN101CAR Stamped Approval.pdf
 VSN103AR Stamped Approval.pdf

		Item Status:	Status Date:
Bypassed - Item:	Health - Actuarial Justification	Approved	03/29/2012

Bypass Reason:

Rates previously approved with Paper Filing (Vision Insurance Policy Form VSN100AR) will not change.

The following paragraph is stated as follows in the filing description letter:

The endorsement forms will increase the EYE EXAMINATION BENEFIT and the VISION CORRECTION BENEFIT of the policy at no additional cost to the policyholder. The increased benefits will not affect premium rates currently on file with your department. There will not be any additional underwriting questions involved as a result of this increase in benefits.

Comments:

SERFF Tracking Number: AFLA-128189598 State: Arkansas
Filing Company: American Family Life Assurance Company of Columbus State Tracking Number:
Company Tracking Number: VSN2012
TOI: H201 Individual Health - Vision Sub-TOI: H201.000 Health - Vision
Product Name: VSN2012
Project Name/Number: VSN2012/VSN2012

	Item Status:	Status
Satisfied - Item: Outline of Coverage	Approved	Date: 03/29/2012

Comments:

For your convenience a copy of the previously approved Outline of Coverage Form with the March 09, 2005 stamped approval is attached below.

Attachment:

VSN125AR Stamped Approval.pdf



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

March 23, 2012

Arkansas Insurance Department
1200 West Third Street
Little Rock, AR 72201-1904

NAIC # 60380

RE: Vision Insurance Policy Endorsement Forms VSN91, VSN92, and VSN93, Payroll Application Forms VSN101RAR and VSN101CRAR, Request for Change/Application for Reinstatement Form VSN103RAR, and Outline of Coverage Form VSN125RAR

SERFF Tr Num: AFLA-128189598

Dear Commissioner:

The above referenced forms are submitted for your review and approval. Similar forms have been filed in Nebraska, our state of domicile, on March 22, 2012.

Endorsement Forms VSN91, VSN92 and VSN93 will amend Vision Insurance Policy Form VSN100AR which was approved by your department on March 09, 2005 under *Paper Filing (Vision Insurance Policy Form VSN100AR)*. Endorsement Forms VSN91, VSN92, and VSN93 will be used with policy Options 1, 2, and 3, respectively.

The endorsement forms will increase the EYE EXAMINATION BENEFIT and the VISION CORRECTION BENEFIT of the policy at no additional cost to the policyholder. The increased benefits will not affect premium rates currently on file with your department. There will not be any additional underwriting questions involved as a result of this increase in benefits.

The following forms are submitted for your review as they have been revised to reflect the increased benefits and any branding or formatting changes:

Payroll Application Forms VSN101RAR and VSN101CRAR will replace Payroll Application Forms VSN101AR and VSN101CAR, previously approved on March 09, 2005 under *Paper Filing (Vision Insurance Policy Form VSN100AR)*. These forms are self-explanatory and will be used to make application for the policy with the increased benefits. The only difference between Application Form VSN101RAR and Application Form VSN101CRAR is the addition of the agent's certification statement above the agent's signature to indicate that the agent was present at the time of application.

Request for Change/Application for Reinstatement Form VSN103RAR will replace Request for Change/Application for Reinstatement Form VSN103AR, previously approved on March 09, 2005 under *Paper Filing (Vision Insurance Policy Form VSN100AR)*. This form is self-explanatory and will be used to reinstate policies that have lapsed for non-payment of

premium. This form will also provide a section which will give the insured the opportunity to change the Vision Correction Benefit option once a year on the policy anniversary date.

Outline of Coverage Form VSN125RAR will replace Outline of Coverage Form VSN125AR, previously approved on March 09, 2005 under *Paper Filing (Vision Insurance Policy Form VSN100AR)*, and will be used with Policy Form VSN100AR. The outline is self-explanatory and will be given to the applicant at the time of application.

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 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.

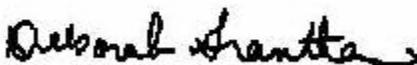
I certify that this submission meets the minimum reading ease score for the FLESCH test and that the scores for each form are provided on the Form Schedule tab in SERFF. The filing fee is submitted by EFT under the Filing Fee tab in this SERFF filing (AFLA-128189598).

Upon approval, these benefits will be made available to all policyholders effective October 1, 2012. The endorsement will be attached to policies issued on or after the implementation date, and will be mailed to policyholders who purchased their policy prior to the implementation date, for attachment to their policy.

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, website, 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/union account.

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

Sincerely,



Deborah T. Grantham
DTG/CG/cg
Enclosures



VISION INSURANCE POLICY (VSN100 Series)

New

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

Policy Number:

Please Print in Black Ink - To Be Completed by Applicant

Applicant's Name Last First MI DOB Month/Day/Year Sex

Applicant's SSN Will dependent children be covered? Yes No

(Write spouse's name below if you are applying for Two-Parent Family or Named Insured/Spouse Only coverage; if you have no spouse or your spouse is not to be covered, put N/A in space below.)

Spouse's Name Last First MI DOB Month/Day/Year Sex

Address Street or Post Office Box Apt. No.

City State ZIP

Home Telephone ()

Policy Owner's Name (If Other Than Applicant)

Relationship to Applicant

Address Street or Post Office Box Apt. No.

Policy Owner's SSN

City State ZIP

Name of Vision Care Provider (optional)

Name of Spouse's Employer (optional)

Payroll Account Name Payroll Account Number (optional)

Is this insurance intended to replace any other vision insurance other than eye exams and materials now in force? Yes No

If yes, please read and sign the Replacement Notice provided by your associate/agent, if applicable.

TO BE COMPLETED BY AFLAC ASSOCIATE/AGENT

Table with 4 columns: Check Coverage Desired, Individual, Named Insured/Spouse Only, One-Parent Family, Two-Parent Family. Includes options for Pre-Tax and After-Tax.

Billing Method: Payroll Deduction. Mode: 01 Weekly, 01 14-Day Biweekly, 01 28-Day Biweekly, 01 Semimonthly, 01 Monthly, 03 Quarterly, 06 Semiannual, 12 Annual. Includes fields for Employee No., Dept. No., Assoc./Agent's No., Billable Premium \$, Premium Collected \$, Sit. Code.



ALL OF THE FOLLOWING MUST BE COMPLETED:

1. Has anyone to be covered ever been diagnosed with or treated by a member of the medical profession for any of the following? Yes No
- | | |
|---|------------------------------------|
| Glaucoma, preglaucoma, and/or borderline glaucoma | Tumor of the eye or brain |
| Macular degeneration | Detached retina |
| Diabetic retinopathy | Multiple sclerosis |
| Type I diabetes | Retinitis pigmentosa |
| Cataract | Optic neuritis or optic neuropathy |
| Legal blindness | Total blindness |
| Ocular hypertension | Cancer of the eye or brain |
2. Has anyone to be covered ever been diagnosed by a member of the medical profession with an ongoing visual impairment/condition that cannot be corrected by eyeglasses, contact lenses, or surgery? Yes No
3. In the last 24 months, has anyone to be covered had or been advised by a member of the medical profession to have eye surgery (other than any type of Refractive Error Correction Surgery) or diagnosed with amblyopia (lazy eye) or treated with any eye patch regimen? Yes No

If any one of Questions 1 through 3 is answered yes, was it the:

- Named Insured Spouse Child? If Child, please list the name of the child(ren).

APPROVED

MAR 09 2005

LIFE AND HEALTH
ARIZONA INSURANCE DEPARTMENT

Any person(s) so designated will not be covered under the policy. If this is the Named Insured, the Name on the first page of this application must be different.

APPLICANT'S STATEMENTS AND AGREEMENTS:

1. I understand that the Effective Date of the policy will be the date recorded in the Policy Schedule by Aflac Worldwide Headquarters.
2. a. I understand that if I selected Vision Correction Benefit option 2 there will be a 12-month waiting period for the Vision Correction Benefit and if I selected Vision Correction Benefit option 3, there will be a 24-month waiting period for the Vision Correction Benefit.
- b. **The policy contains a 30-day waiting period.** If a covered person has an eye disease or disorder, other than one caused by an Injury, diagnosed before coverage has been in force 30 days from the Effective Date of coverage shown in the Policy Schedule, benefits for treatment of that eye disease or disorder will apply only to treatment occurring after two years from the Effective Date of the policy, or, at your option, you may elect to void the policy from its beginning and receive a full refund of premium. **The 30-day waiting period for the policy does not apply to the Eye Examination Benefit or the Vision Correction Benefit.**
3. I understand that the policy I am applying for will not cover any person who has attained age 71 before the Effective Date of the policy.
4. I understand that dependent children, if any, will be covered until age 25.
5. I acknowledge receipt of, if applicable:
 Replacement Notice Outline of Coverage Guide to Health Insurance for People with Medicare
6. I understand that: (a) Aflac is not bound by any statement made by me, the applicant, or any associate/agent of Aflac unless written herein. (b) The associate/agent cannot change the provisions of the policy or waive any of its provisions either orally or in writing. (c) The policy, together with this application, endorsements, benefit agreements, riders, and attached papers, if any, is the entire contract of insurance. (d) No change to the policy will be valid until approved by Aflac's president and secretary, and noted in or attached to the policy.

NOTICE OF INFORMATION PRACTICES

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

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 by my associate/agent.

I also understand that if I or anyone to be covered is receiving any Medicaid benefits, the purchase of this coverage is not necessary.

If I am applying to replace existing 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 policy and its benefits for the benefits provided in the Aflac policy. I have read, or had read to me, the completed application, and I realize that policy issuance is based upon statements and answers provided herein, and they are complete and true to the best of my knowledge and belief.

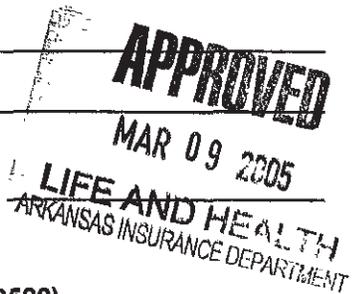
Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Signed and Dated at _____ on _____
City and State Date

Applicant's Signature _____

Policy Owner's Signature: _____
(If Different From Applicant)

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



**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.**

Writing Associate/Agent: Please complete the following - it will become part of the policy.
**AMERICAN FAMILY LIFE ASSURANCE COMPANY OF COLUMBUS (AFLAC)
CLIENT SERVICES AND ADMINISTRATION, 1932 WYNNTON ROAD, COLUMBUS, GEORGIA 31999,
TOLL-FREE 1-800-99-AFLAC (1-800-992-3522)**

Associate/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**

Payroll

VISION INSURANCE POLICY (VSN100 Series)

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

New
COPY
Policy Number: _____

Please Print in Black Ink – To Be Completed by Applicant

Applicant's Name _____ DOB _____ Sex _____
Last First MI Month/Day/Year

Applicant's SSN _____ Will dependent children be covered? Yes No

(Write spouse's name below if you are applying for Two-Parent Family or Named Insured/Spouse Only coverage; if you have no spouse or your spouse is not to be covered, put N/A in space below.)

Spouse's Name _____ DOB _____ Sex _____
Last First MI Month/Day/Year

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

City _____ State _____ ZIP _____

Home Telephone () _____

Policy Owner's Name _____ Relationship to Applicant _____
(If Other Than Applicant)

Address _____ Policy Owner's SSN _____
Street or Post Office Box Apt. No.

City _____ State _____ ZIP _____

Name of Vision Care Provider (optional) _____

Name of Spouse's Employer (optional) _____

Payroll Account Name _____ Payroll Account Number _____ (optional)

Is this insurance intended to replace any other vision insurance other than eye exams and materials now in force? Yes No

If yes, please read and sign the Replacement Notice provided by your associate/agent, if applicable.

TO BE COMPLETED BY AFLAC ASSOCIATE/AGENT

Check Coverage Desired:	<input type="checkbox"/> Individual	<input type="checkbox"/> Named Insured/Spouse Only	<input type="checkbox"/> One-Parent Family	<input type="checkbox"/> Two-Parent Family
<input type="checkbox"/> Option 1: Policy with Vision Correction Benefit; Materials; No waiting period - \$50 every year				<input type="checkbox"/> Pre-Tax
<input type="checkbox"/> Option 2: Policy with Vision Correction Benefit; Materials; 12-mo. waiting period - \$120 every 2 years				or
<input type="checkbox"/> Option 3: Policy with Vision Correction Benefit; Materials; 24-mo. waiting period - \$210 every 3 years				<input type="checkbox"/> After-Tax

Billing Method: <input checked="" type="checkbox"/> Payroll Deduction	Mode: <input type="checkbox"/> 01 Weekly <input type="checkbox"/> 01 14-Day Biweekly <input type="checkbox"/> 01 28-Day Biweekly	<input type="checkbox"/> 01 Semimonthly <input type="checkbox"/> 01 Monthly <input type="checkbox"/> 03 Quarterly	<input type="checkbox"/> 06 Semiannual <input type="checkbox"/> 12 Annual
Employee No. _____	Dept. No. _____	Assoc./Agent's No. _____	
Billable Premium \$ _____	Premium Collected \$ _____	Sit. Code _____	

ALL OF THE FOLLOWING MUST BE COMPLETED:

1. Has anyone to be covered ever been diagnosed with or treated by a member of the medical profession for any of the following? Yes No

Glaucoma, preglaucoma, and/or borderline glaucoma Macular degeneration Diabetic retinopathy Type I diabetes Cataract Legal blindness Ocular hypertension	Tumor of the eye or brain Detached retina Multiple sclerosis Retinitis pigmentosa Optic neuritis or optic neuropathy Total blindness Cancer of the eye or brain
--	---

2. Has anyone to be covered ever been diagnosed by a member of the medical profession with an ongoing visual impairment/condition that cannot be corrected by eyeglasses, contact lenses, or surgery? Yes No

3. In the last 24 months, has anyone to be covered had or been advised by a member of the medical profession to have eye surgery (other than any type of Refractive Error Correction Surgery) or diagnosed with amblyopia (lazy eye) or treated with any eye patch regimen? Yes No

If any one of Questions 1 through 3 is answered yes, was it the:

Named Insured Spouse Child? If Child, please list the name of the child(ren).

Any person(s) so designated will not be covered under the policy. If this is the Named Insured, the Applicant's Name on the first page of this application must be different.

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ARKANSAS INSURANCE DEPARTMENT

APPLICANT'S STATEMENTS AND AGREEMENTS:

1. I understand that the Effective Date of the policy will be the date recorded in the Policy Schedule by Aflac Worldwide Headquarters.
2. a. I understand that if I selected Vision Correction Benefit option 2 there will be a 12-month waiting period for the Vision Correction Benefit and if I selected Vision Correction Benefit option 3, there will be a 24-month waiting period for the Vision Correction Benefit.
b. **The policy contains a 30-day waiting period.** If a covered person has an eye disease or disorder, other than one caused by an Injury, diagnosed before coverage has been in force 30 days from the Effective Date of coverage shown in the Policy Schedule, benefits for treatment of that eye disease or disorder will apply only to treatment occurring after two years from the Effective Date of the policy, or, at your option, you may elect to void the policy from its beginning and receive a full refund of premium. **The 30-day waiting period for the policy does not apply to the Eye Examination Benefit or the Vision Correction Benefit.**
3. I understand that the policy I am applying for will not cover any person who has attained age 71 before the Effective Date of the policy.
4. I understand that dependent children, if any, will be covered until age 25.
5. I acknowledge receipt of, if applicable:
 Replacement Notice Outline of Coverage Guide to Health Insurance for People with Medicare
6. I understand that: (a) Aflac is not bound by any statement made by me, the applicant, or any associate/agent of Aflac unless written herein. (b) The associate/agent cannot change the provisions of the policy or waive any of its provisions either orally or in writing. (c) The policy, together with this application, endorsements, benefit agreements, riders, and attached papers, if any, is the entire contract of insurance. (d) No change to the policy will be valid until approved by Aflac's president and secretary, and noted in or attached to the policy.

NOTICE OF INFORMATION PRACTICES

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

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 by my associate/agent.

I also understand that if I or anyone to be covered is receiving any Medicaid benefits, the purchase of this coverage is not necessary.

If I am applying to replace existing 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 policy and its benefits for the benefits provided in the Aflac policy. I have read, or had read to me, the completed application, and I realize that policy issuance is based upon statements and answers provided herein, and they are complete and true to the best of my knowledge and belief.

Signed and Dated at _____ on _____
City and State Date

Applicant's Signature _____

Policy Owner's Signature: _____
(If Different From Applicant)

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

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

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

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LIFE AND HEALTH
ARKANSAS INSURANCE DEPARTMENT

Writing Associate/Agent: Please complete the following - it will become part of the policy.
AMERICAN FAMILY LIFE ASSURANCE COMPANY OF COLUMBUS (AFLAC)
CLIENT SERVICES AND ADMINISTRATION, 1932 WYNNTON ROAD, COLUMBUS, GEORGIA 31999,
TOLL-FREE 1-800-99-AFLAC (1-800-992-3522)

Associate/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

REQUEST FOR CHANGE/APPLICATION FOR REINSTATEMENT – VISION (VSN100 Series)
American Family Life Assurance Company of Columbus (Aflac), Worldwide Headquarters: Columbus, GA 31999
 For information, call toll-free 1-800-99-AFLAC (1-800-992-3522).

COPY

Name of Policyholder _____ SSN _____

Policy Number _____ Date of Birth _____

Current Address of Policyholder _____

City _____ State _____ ZIP _____ Home Telephone () _____

Former Address of Policyholder _____

City _____ State _____ ZIP _____

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

Licensed Resident Associate/Agent

PLEASE MAKE THE FOLLOWING CHANGES TO MY POLICY:

VISION CORRECTION BENEFIT OPTION CHANGE ONLY:

YOU ARE ONLY ELIGIBLE TO CHANGE YOUR VISION CORRECTION BENEFIT OPTION TO BE EFFECTIVE ON EACH POLICY ANNIVERSARY DATE.

Change my Vision Correction Benefit to:

- Option 1: Policy with Vision Correction Benefit; Materials; No waiting period-\$50 every year
- Option 2: Policy with Vision Correction Benefit; Materials; 12-month waiting period-\$120 every 2 years
- Option 3: Policy with Vision Correction Benefit; Materials; 24-month waiting period-\$210 every 3 years

PLEASE NOTE –The Vision Correction Benefit will be subject to new waiting periods, if any, beginning with the Effective Date of this new coverage.

TRANSFERS ONLY

Transfer From _____

To _____
 (Employer or Account Name and Number)

Amount Remitted \$ _____ Months _____

Payroll Billing Name _____

Effective Date of Transfer _____

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MAR 09 2005

LIFE AND HEALTH

ARKANSAS INSURANCE DEPARTMENT

NAME CHANGE ONLY Name Shown on Policy _____
 Change Name to _____
 Reason _____
 (Marriage/Divorce/Death/Other)
 Effective Date of Change _____

DELETIONS ONLY Person to be Deleted _____ Relationship _____
 Effective Date of Deletion _____ Reason _____
 (Divorce/Death/Other)
 New Policyholder's Full Name _____
 Birth Date of New Policyholder _____
 Type of Coverage Now Desired: Individual One-Parent Family
 Two-Parent Family Named Insured/Spouse Only

ADDITION Person(s) to Be Added _____
 Date(s) of Birth _____ Relationship(s) _____
 SSN(s) _____
 Reason(s) for Addition(s) _____
 Effective Date of Addition(s) _____
 Type of Coverage Now Desired: Two-Parent Family One-Parent Family
 Named Insured/Spouse Only

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 LIFE AND HEALTH
 ARKANSAS INSURANCE DEPARTMENT

ANSWER QUESTIONS 1 THROUGH 3 FOR REINSTATEMENTS OR ADDITIONS.

REINSTATEMENT OF OR ADDITIONS TO POLICY:

ALL OF THE FOLLOWING MUST BE COMPLETED:

1. Has anyone to be covered ever been diagnosed with or treated by a member of the medical profession for any of the following? Yes No

- | | |
|---|------------------------------------|
| Glaucoma, preglaucoma, and/or borderline glaucoma | Tumor of the eye or brain |
| Macular degeneration | Detached retina |
| Diabetic retinopathy | Multiple sclerosis |
| Type I diabetes | Retinitis pigmentosa |
| Cataract | Optic neuritis or optic neuropathy |
| Legal blindness | Total blindness |
| Ocular hypertension | Cancer of the eye or brain |

2. Has anyone to be covered ever been diagnosed by a member of the medical profession with an ongoing visual impairment/condition that cannot be corrected by eyeglasses, contact lenses, or surgery? Yes No

3. In the last 24 months, has anyone to be covered had or been advised by a member of the medical profession to have eye surgery (other than any type of Refractive Error Correction Surgery) or diagnosed with amblyopia (lazy eye) or treated with any eye patch regimen? Yes No

If any one of Questions 1 through 3 is answered yes, was it the:

Named Insured Spouse Child? If Child, please list the name of the child(ren) .

Any person(s) so designated will not be covered under the policy. If this is the Named Insured, the Applicant's Name on the first page of this application must be different.

NOTICE OF INFORMATION PRACTICES

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

I understand that the reinstated policy will cover only loss resulting from covered vision treatment that begins after the date of reinstatement. I understand that the information on this form applies ONLY to my vision policy.

I have read, or had read to me, the completed application and realize that policy reinstatement is based upon statements and answers provided herein. They are complete and true to the best of my knowledge and belief, and I understand that Aflac and I will have the same rights as provided under the policy(s) immediately before the due date of the defaulted premium, subject to any provisions endorsed on or attached to the policy(s) in connection with the reinstatement. I further understand that coverage under the reinstated policy is subject to the terms set forth in my policy(s) Reinstatement provision.

I understand that any covered person will be subject to new waiting periods for the Vision Correction Benefit, if any, beginning from the Effective Date of reinstatement.

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.

Policyholder's Signature _____ Date _____

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

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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ARKANSAS INSURANCE DEPARTMENT

FOR WORLDWIDE HEADQUARTERS USE ONLY

PTD _____
Lapsed _____
Reinstated _____
Premiums Applied From _____
Initials _____

No. of Months Dropped _____
\$ Applied _____
No. of Months _____
New PTD _____

AMERICAN FAMILY LIFE ASSURANCE COMPANY OF COLUMBUS (Aflac)
WORLDWIDE HEADQUARTERS: 1932 WYNNTON ROAD, COLUMBUS, GEORGIA 31999
TOLL-FREE 1-800-99-AFLAC (1-800-992-3522)
Visit our Web site at aflac.com.

**LIMITED BENEFIT HEALTH COVERAGE
VISION INSURANCE POLICY**

Outline of Coverage for Policy Form Series VSN100
THIS IS NOT MEDICARE SUPPLEMENT COVERAGE.

COPY

APR 10 2005

MAR 09 2005

LIFE AND HEALTH
ARKANSAS INSURANCE DEPARTMENT

Notice to Buyer: This policy provides Vision benefits only.

If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide furnished by Aflac.

- I. **READ YOUR POLICY CAREFULLY:** This Outline of Coverage provides a very brief description of some 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. Therefore, it is important that you READ YOUR POLICY CAREFULLY.
- II. **LIMITED BENEFIT HEALTH COVERAGE:** Policies of this category are designed to provide, to persons insured, limited or supplemental coverage.
- III. **BENEFITS:** Subject to the waiting period, listed in the Benefit section (Part 5) of your policy, for the Vision Correction Benefit and the provisions in the Limitations and Exclusions section, we will pay the following benefits when a charge is incurred for covered vision treatment that occurs while coverage is in force. See your policy for the specific waiting period for the Vision Correction Benefit.
 - A. **EYE EXAMINATION BENEFIT:** Aflac will pay \$35 (thirty-five dollars) when a charge is incurred for an eye examination for a covered person. This benefit is limited to one examination per covered person per Policy Year. The eye examination must be performed by an Optometrist or Ophthalmologist. No lifetime maximum.

While the policy is in force, the following benefits will be paid, subject to Part 2, Limitations and Exclusions of your policy, and all other policy provisions. Please see section (IV) of this outline of coverage.

B. VISION CORRECTION BENEFIT: The option you have chosen on your application is indicated below by a check mark in the appropriate option box. **PLEASE NOTE: Only one Vision Correction Benefit option can be in effect at any given time.**

Option 1 VISION CORRECTION BENEFIT: Aflac will pay \$50 (fifty dollars) when a charge is incurred for prescribed Vision Correction Materials or \$100 (one hundred dollars) when a charge is incurred for Refractive Error Correction Surgery for a covered person. This benefit is payable once per covered person per Policy Year. **NOTE: If a covered person receives a benefit for Vision Correction Materials and later receives Refractive Error Correction Surgery in the same Policy Year, we will pay \$50 (fifty dollars) for Refractive Error Correction Surgery.**

Option 2 VISION CORRECTION BENEFIT: After a 12-month waiting period, Aflac will pay \$120 (one hundred twenty dollars) when a charge is incurred for prescribed Vision Correction Materials or \$240 (two hundred forty dollars) when a charge is incurred for Refractive Error Correction Surgery for a covered person. This benefit is payable once per covered person during each successive 24-month period following the end of the waiting period and applies only for charges incurred during that period. **NOTE: If a covered person receives a benefit for Vision Correction Materials and later receives Refractive Error Correction Surgery during the same 24-month period, we will pay \$120 (one hundred twenty dollars) for Refractive Error Correction Surgery.**

Option 3 VISION CORRECTION BENEFIT: After a 24-month waiting period, Aflac will pay \$210 (two hundred ten dollars) when a charge is incurred for prescribed Vision Correction Materials or \$420 (four hundred twenty dollars) when a charge is incurred for Refractive Error Correction Surgery for a covered person. This benefit is payable once per covered person during each successive 36-month period following the end of the waiting period and applies only for charges incurred during that period. **NOTE: If a covered person receives a benefit for Vision Correction Materials and later receives Refractive Error Correction Surgery during the same 36-month period, we will pay \$210 (two hundred ten dollars) for Refractive Error Correction Surgery.**

C. SPECIFIC EYE DISEASES/DISORDERS BENEFIT: Aflac will pay \$1,000 (one thousand dollars) when a covered person is first diagnosed after the Effective Date as having any of the eye diseases or disorders listed below. The eye disease or disorder must be diagnosed by an Ophthalmologist or a Physician.

Glaucoma
(excluding preglaucoma and/or borderline glaucoma)
Proliferative diabetic retinopathy

Retinitis pigmentosa
Retinal detachment
Macular degeneration

This benefit is payable only once per covered disease or disorder, per covered person and will be paid in addition to any other benefit in this policy.

D. EYE SURGERY BENEFIT: When a surgical operation is performed on a covered person for a diagnosed eye disease or disorder, Aflac will pay the indemnity amount listed in the Schedule of Operations in your policy for the specific procedure when a charge is incurred. Surgeries must be performed by an Ophthalmologist or a Physician.

If any operation for a diagnosed eye disease or disorder is performed other than those listed, Aflac will pay an amount comparable to the amount shown in the Schedule of Operations for the operation most nearly similar in severity and gravity.

NOTE: Surgical benefits for Refractive Error Correction Surgery are payable only under the Vision Correction Benefit.

Surgical benefits are limited to surgeries of the eye, eye socket, eyelid, and tear ducts. Only one benefit is payable per 24-hour period for surgery even though more than one surgical procedure may be performed. We will pay the highest eligible benefit. No lifetime maximum.

E. PERMANENT VISUAL IMPAIRMENT BENEFIT: When a covered person is first diagnosed after the Effective Date of coverage with a Visual Impairment for which there is no medical prognosis of recovery, Aflac will pay the following indemnity amount(s) for the specific level(s) of Visual Impairment that apply to your current stage of Visual Impairment.

VISUAL IMPAIRMENT LEVEL	TOTAL PER LEVEL	MAXIMUM CUMULATIVE BENEFIT PER EYE
(Level 1) – Severe	\$750	\$750
(Level 2) – Profound	+ \$1,750	\$2,500
(Level 3) – Near-Total	+ \$2,500	\$5,000
(Level 4) – Total	+ \$5,000	\$10,000

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LIFE AND HEALTH
ARKANSAS INSURANCE DEPARTMENT

If a covered person is diagnosed with a Level 2, 3, or 4 Visual Impairment, benefits for previously unpaid lower levels of Visual Impairment, if any, will be paid in addition to benefits for the level diagnosed. Each level of Visual Impairment is payable a maximum of once per eye, per covered person.

The permanent Visual Impairment must be diagnosed by an Ophthalmologist or a Physician. Benefits for a child born visually impaired are payable only if the visually impaired child is born after ten months from the Effective Date of this policy. Lifetime maximum of \$10,000 (ten thousand dollars) per eye, per covered person. Lifetime maximum of \$20,000 (twenty thousand dollars) per covered person.

F. CONTINUATION OF COVERAGE BENEFIT: Aflac will waive all monthly premiums due for the policy for two months if you meet all of the following conditions:

- Your policy has been in force for at least six months;
- We have received premiums for at least six consecutive months;
- Your premiums have been paid through payroll deduction;
- You or your employer has notified us in writing within 30 days of the date your premium payments ceased due to your leaving employment; and
- You re-establish premium payments through your new employer's payroll deduction process, or direct payment to Aflac.

You will again become eligible to receive this benefit after:

- You re-establish your premium payments through payroll deduction for a period of at least six months, and
- We receive premiums for at least six consecutive months.

"Payroll deduction" means your premium is remitted to Aflac for you by your employer through a payroll deduction process.

IV. EXCEPTIONS, REDUCTIONS AND LIMITATIONS OF THIS POLICY:

A. This policy contains a 30-day waiting period. If a covered person has an eye disease or disorder, other than one caused by an Injury, diagnosed before coverage has been in force 30 days from the Effective Date of coverage shown in the Policy Schedule, benefits for treatment of that eye disease or disorder will apply only to treatment occurring after two years from the Effective Date of the policy or, at your option, you may elect to void the policy from its beginning and receive a full refund of premium. **The 30-day waiting period does not apply to the Eye Examination Benefit or the Vision Correction Benefit.**

B. This policy does not cover losses caused by or resulting from:

1. Services that are not recommended by an Optometrist, Ophthalmologist, or a Physician
2. Cosmetic surgery that is not due to eye disease, disorder, or Injury.
3. Treatment or diagnosis received while outside the territorial limits of the United States or, if outside the United States, the territorial limits of the place where your policy was issued.
4. Intentionally self-inflicting bodily Injury or attempting suicide, while sane or insane.

C. If you change your Vision Correction Benefit option, this benefit will be subject to a new waiting period, if any, beginning with the Effective Date of the new option. **YOU ARE ELIGIBLE TO CHANGE YOUR VISION CORRECTION BENEFIT OPTION ONLY ONCE EACH YEAR, WITH THE CHANGE TO BE EFFECTIVE ON YOUR NEXT POLICY ANNIVERSARY DATE.**

V. RENEWABILITY: This policy is guaranteed-renewable for your lifetime by payment of the premium in effect at the beginning of each renewal period. Premium rates may change only if changed on all policies of the same form number and class in force in your state.

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

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MAR 09 2005

**LIFE AND HEALTH
ARKANSAS INSURANCE DEPARTMENT**