

SERFF Tracking Number: AFLA-128535377 State: Arkansas
Filing Company: American Family Life Assurance Company of Columbus State Tracking Number:
Columbus
Company Tracking Number: A90063R
TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other
Product Name: Authorization Forms
Project Name/Number: Authorization Forms 2012/Authorization Forms

Filing at a Glance

Company: American Family Life Assurance Company of Columbus

Product Name: Authorization Forms

SERFF Tr Num: AFLA-128535377 State: Arkansas

TOI: H21 Health - Other

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

Sub-TOI: H21.000 Health - Other

Co Tr Num: A90063R

State Status: Approved-Closed

Filing Type: Form

Author: Connie Gates

Reviewer(s): Rosalind Minor

Date Submitted: 07/02/2012

Disposition Date: 07/03/2012

Disposition Status: Approved-
Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: Authorization Forms 2012

Status of Filing in Domicile: Pending

Project Number: Authorization Forms

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments: Filed concurrently

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Individual Market Type: Individual

Overall Rate Impact:

Filing Status Changed: 07/03/2012

State Status Changed: 07/03/2012

Deemer Date:

Created By: Connie Gates

Submitted By: Connie Gates

Corresponding Filing Tracking Number:

PPACA: Not PPACA-Related

PPACA Notes: null

Healthcare.gov ID:

Filing Description:

See attached letter under Supporting Documentation - Flesch Certification

State Narrative:

Company and Contact

Filing Contact Information

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

Filing Company Information

American Family Life Assurance Company of Columbus CoCode: 60380 State of Domicile: Nebraska
 1932 Wynnton Road Group Code: 370 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: \$100.00
 Retaliatory? No
 Fee Explanation: 2 forms @ \$50 each
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
American Family Life Assurance Company of Columbus	\$100.00	07/02/2012	60607295

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	07/03/2012	07/03/2012

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Disposition

Disposition Date: 07/03/2012

Implementation Date:

Status: Approved-Closed

HHS Status: Not Reported

State Review: Reviewed-No Actuary

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	PPACA Uniform Compliance Summary	Approved-Closed	Yes
Form	Authorization to Obtain Information	Approved-Closed	Yes
Form	Authorization to Disclose Information	Approved-Closed	Yes

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Form Schedule

Lead Form Number: A90063R

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 07/03/2012	A90063R	Other	Authorization to Obtain Information	Initial		56.570	A90063R.pdf
Approved-Closed 07/03/2012	A90078R	Other	Authorization to Disclose Information	Initial		53.230	A90078R.pdf

AUTHORIZATION TO OBTAIN INFORMATION

MAIL TO: American Family Life Assurance Company of Columbus
[1932 Wynnton Road
Columbus, Georgia 31999-0001]

I authorize the following to give information (as defined below) to American Family Life Assurance Company of Columbus, American Family Life Assurance Company of New York, and Continental American Insurance Company (collectively, "Aflac"): 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" includes 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 are required as part of the underwriting process in order to determine eligibility for insurance or to evaluate a claim for benefits during the time this authorization is valid.

I understand that any disclosure of health information to Aflac for the purpose of determining eligibility for coverage other than health plan coverage means the information may no longer be protected by federal privacy regulations. I further understand, however, that such information may be redisclosed only in accordance with other applicable laws or regulations.

I understand that this information will be used by Aflac for enrollment or to determine eligibility for insurance or for underwriting or risk rating (where applicable) purposes and, should coverage be issued, the information may be used to contest a claim for benefits or the issuance of the policy itself during the contestability period provided in the policy.

I understand that Aflac is conditioning the issuance of coverage on the provision of this authorization, and that, while I may refuse to sign this authorization, my refusal to do so could result in coverage not being issued.

I understand that I may revoke this authorization at any time, except to the extent that (1) Aflac has taken action in reliance on this authorization, or (2) other law provides Aflac with the right to contest a claim under the policy or the policy itself. My revocation must be submitted in writing to Aflac, Policy Service, [1932 Wynnton Road, Columbus, Georgia 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 and that I or an authorized representative may request a copy of this authorization.

Printed Name of Individual Subject to Disclosure

Signature

Date

If this authorization has been signed by a personal representative on behalf of an individual, his/her authority to act on behalf of the individual must be set forth here:

Printed Name of Legal/Personal Representative

Legal Relationship
(e.g. Power of Attorney, Estate Executor)

AUTHORIZATION TO DISCLOSE INFORMATION

MAIL TO: American Family Life Assurance Company of Columbus
[1932 Wynnton Road
Columbus, Georgia 31999-0001]

I authorize American Family Life Assurance Company of Columbus, American Family Life Assurance Company of New York, and Continental American Insurance Company (collectively, "Aflac") to disclose information to MIB, Inc. (formerly known as the Medical Information Bureau). I understand that this information will be used by MIB, Inc. for the purpose of assisting the insurance industry in the accurate underwriting of insurance products as well as assisting the insurance industry in facilitating the fair pricing of insurance products through more accurate risk assessment.

"Information" includes information in Aflac's possession relating to my physical or mental health or condition (excluding psychotherapy notes, but including, for example, medical diagnosis/treatment information related to underwriting), and nonmedical financial information (including, for example, policy status).

I understand that any disclosure of health information to MIB, Inc. means the information may no longer be protected by federal privacy regulations. I further understand, however, that such information may be re-disclosed only in accordance with other applicable laws or regulations.

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 Aflac has taken action in reliance on this authorization. My revocation must be submitted in writing to Aflac, 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 and that I or an authorized representative may request a copy of this authorization.

Printed Name of Individual Subject to Disclosure

Signature

Date

If this authorization has been signed by a personal representative on behalf of an individual, his/her authority to act on behalf of the individual must be set forth here:

Printed Name of Legal/Personal Representative

Legal Relationship
(e.g. Power of Attorney, Estate Executor)

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Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	07/03/2012
Comments:			
Attachment:			
DTG ltrSERFF.pdf			
Bypassed - Item:	Application	Approved-Closed	07/03/2012
Bypass Reason:	n/a		
Comments:			
Bypassed - Item:	Health - Actuarial Justification	Approved-Closed	07/03/2012
Bypass Reason:	n/a		
Comments:			
Bypassed - Item:	Outline of Coverage	Approved-Closed	07/03/2012
Bypass Reason:	n/a		
Comments:			
Bypassed - Item:	PPACA Uniform Compliance Summary	Approved-Closed	07/03/2012
Bypass Reason:	n/a		
Comments:			



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

July 2, 2012

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

NAIC # 60380

RE: Authorization to Obtain Information Form A90063R and Authorization to Disclose Information Form A90078R.

Dear Commissioner:

The above referenced forms are being submitted for your review and approval. Previous versions of these forms were approved on January 27, 2003.

Both forms were revised to refer to the appropriate name of MIB, Inc., add signature requirements, and revise branding, Authorization to Obtain Information Form A-90063 was also revised to include pharmacy-related service organizations. The previously approved form numbers, A-90063 and A-90078 have been changed to A90063R and A90078R in order to reflect these changes.

I certify that the forms submitted herewith comply with 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;*
- *requirements of Rule and Regulation 49 of the Arkansas Insurance Department Regulations, Life and Disability Guaranty Fund Notices.*

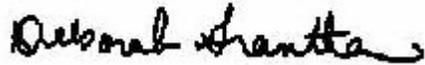
I certify that this submission meets the *Arkansas Statute Annotated Sections 23-80-201 through 23-80-208, cited as the Life and Disability Insurance Policy Language Simplification Act.* The scores for each form are as follows:

	<u>FLESH</u> <u>Score</u>	<u>Grade</u> <u>Level</u>
Authorization to Obtain Information A90063R	56.57	7.38
Authorization to Disclose Information A90078R	53.23	7.65

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. 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 the forms around the company address in the event it changes in the future.

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,

A handwritten signature in black ink that reads "Deborah T. Grantham". The signature is written in a cursive style with a prominent initial "D" and a long, sweeping tail.

Deborah T. Grantham
DTG/CG/cg
Enclosures