American Family Life Assurance Company of Columbus
(herein referred to as Aflac)
Worldwide Headquarters • 1932 Wynnton Road • Columbus, Georgia 31999

ADDITIONAL COVERAGE APPLICATION
STATEMENT OF UNDERSTANDING AND AGREEMENT

I, the undersigned, understand and agree that I am adding or converting an Aflac Plus Rider (Series CIRIDER) to my existing Aflac policy shown below without making any other changes to such existing policy: (Select one – available products vary by state)

- ❑ Hospital Indemnity (Series A49000)
- ❑ Accident (Series A35000)
- ❑ Short Term Disability (Series A57600)
- ❑ Cancer (Series A78000)

Policyholder's Printed Name: _____

Address: _____

Policy Number: _____

Signature of Applicant: _____

Date Signed: _____

Signature of Associate: _____

AUTHORIZATION TO OBTAIN INFORMATION

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

Primary Policyholder's Name:	**SSN**(optional):	**Date of Birth:**
Policy Number(s):		
Address:		
Name of Individual Subject to Disclosure (if not the primary policyholder):		**Date of Birth:**
Relationship to Primary Policyholder: □ Self □ Spouse □ Domestic Partner		

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 date this authorization is signed.

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.

_____ _____

Signature of Individual Subject to Disclosure | Date Signed

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)*

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Worldwide Headquarters: Columbus, GA 31999
For information, call toll-free 1.800.99.AFLAC (1.800.992.3522)

GEORGIA
CRITICAL ILLNESS RIDER SERIES CIRIDER
ACKNOWLEDGEMENT

I am applying for Critical Illness coverage to be added to a policy by Rider. I have been furnished information regarding the benefits and limitations of the Critical Illness Coverage Rider. I understand that Critical Illness coverage is considered a limited benefit type of coverage in Georgia, and is meant to supplement, not be a substitute or replacement for major medical insurance.

I acknowledge that I am applying for a Critical Illness Rider and another form of limited benefit coverage through this application.

Applicant's Signature:_____Date:_____

This acknowledgement is made part of the application and the policy to which it is attached.