Peace of Mind *and* Cash Benefits

DISABILITY INCOME PROTECTION ADVANTAGE®

SHORT-TERM DISABILITY INSURANCE

DI

Aflac®

We've got you under our wing.®

DISABILITY INCOME PROTECTION ADVANTAGE®

SHORT-TERM DISABILITY INSURANCE

Policy Series A57500

DI

The Need

Becoming disabled is often an unexpected and burdensome experience, and it can happen to anyone. What if a disability interrupted your job, your income, and your financial security? How would you make your house or rent payment, or cover day-to-day expenses? It's important to consider these questions because a disability could adversely affect your well-being and your finances at a time when you should be concentrating on recovery.

CONSIDER THESE FACTS:

- About 62 million people in the United States have some disability that affects daily activity.[1]
- Approximately two-thirds of those with disabilities are younger than 65.[1]
- Around 3-in-10 of today's 20-year-olds will become disabled before reaching age 67.[2]

When disabled, you may not only lose the ability to earn a living, but you may also lose savings, retirement funds, or even your home. The financial obligations can be overwhelming. Disability insurance plays an integral and important role in your financial planning.

[1]"Disability and Health in the United States, 2001–2005," National Center for Health Statistics, 2008.

[2]Social Security Administration Fact Sheet 2009.

HOW AFLAC CAN HELP

Aflac's Disability Income Protection Advantage benefits provide a source of income while you concentrate on getting better. Knowing that your disability coverage is backed by a market leader with more than 50 years in the insurance industry may help provide you with peace of mind.

Aflac's short-term disability insurance policy provides you with options to help meet your income and financial needs.

- Your Aflac plan stays with you even when you change or leave your job.
- We pay you a cash benefit for each day you are disabled.
- Aflac does not coordinate benefits. Regardless of any other disability insurance benefits you may have, including Social Security, we will pay you directly (unless you assign the benefits).

Aflac herein means American Family Life Assurance Company of Columbus.

WHAT IS NOT COVERED

LIMITATIONS AND EXCLUSIONS

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

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

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

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

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

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

- Pregnancy or childbirth within the first ten months of the Effective Date of coverage (complications of pregnancy will be covered to the same extent as a Sickness);
- Using any drug, narcotic, hallucinogen, or chemical substance (unless administered by a physician and taken according to the physician's instructions), or voluntarily taking any kind of poison or inhaling any kind of gas or fumes;
- Participating in any activity or event, including the operation of a vehicle, while under the influence of a controlled substance (unless administered by a physician and taken according to the physician's instructions) or while intoxicated (*intoxicated* means that condition as defined by the law of the jurisdiction in which the accident occurred);
- Participating in, or attempting to participate in, an illegal activity that is defined as a felony, whether charged or not (*felony* is defined by the law of the jurisdiction in which the activity takes place); or being incarcerated in any type penal institution;
- Intentionally self-inflicting a bodily injury, or committing or attempting suicide, while sane or insane;
- Having cosmetic surgery or other elective procedures that are not medically necessary;
- Having dental treatment except as a result of Injury;
- Being exposed to war or any act of war, declared or undeclared;
- Actively serving in any of the armed forces, or units auxiliary thereto, including the National Guard or Reserve;
- Donating an organ within the first 12 months of the Effective Date of the policy;
- Mental or emotional disorders, including but not limited to the following: bipolar affective disorder (manic-depressive syndrome), delusional (paranoid) disorders, psychotic disorders, somatoform disorders (psychosomatic illness), eating disorders, schizophrenia, anxiety disorders, depression, stress, or post-partum depression. The policy will pay, however, for covered disabilities resulting from Alzheimer's disease, or similar forms of senility or senile dementia, first manifested while coverage is in force.

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

A physician does not include you or a member of your immediate family.

The term *complications of pregnancy* does not include premature delivery without incidence, multiple gestation pregnancy, false labor, occasional spotting, prescribed rest during pregnancy, morning sickness, and similar conditions associated with the management of a difficult pregnancy not constituting a classifiably distinct pregnancy complication. Cesarean deliveries are not considered complications of pregnancy.

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

ADDITIONAL INFORMATION

FULLY PORTABLE: When you own Aflac's Disability Income Protection Advantage®, you may choose to keep your policy regardless of job changes by continuing to pay premiums.

The payroll rate may be retained after one month's premium payment on payroll deduction.

GUARANTEED-RENEWABLE TO AGE 70: You are guaranteed the right to renew the policy by payment of the premiums due on or before the renewal date. The policy is Guaranteed-Renewable to age 70, subject to Aflac's right to change premiums by class upon any renewal date. Coverage will terminate on the policy anniversary date following your 70th birthday.

PROVISIONS OF COVERAGE: Aflac reserves the right to meet with you during the pendency of a claim or to use an independent consultant and a physician's statement to determine whether you are qualified to receive disability benefits. You must be under the care and attendance of a physician for benefits to be payable. Benefits will cease on the date of your death.

If you have any other disability benefit in force with Aflac, only one disability benefit is payable.

TERMS YOU NEED TO KNOW

BASE PAY EARNINGS: your gross salary or wages for your Full-Time Job, not including variable pay such as overtime (unless contractual), bonuses, or other incentives. If you are self-employed, *Base Pay Earnings* means your business's gross income minus the allowable business deductions from that business. (For tax purposes, *Base Pay Earnings* is referred to as *net earnings*.)

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

EFFECTIVE DATE: the date coverage begins as shown in the Policy Schedule. The Effective Date is not the date you signed the application for coverage.

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

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

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

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

SICKNESS: an illness, disease, infection, or any other abnormal physical condition, independent of Injury, occurring on or after the Effective Date of coverage and while coverage is in force.

SUCCESSIVE PERIODS OF DISABILITY: separate periods of disability, if caused by the same or a related condition and not separated by 180 days or more, are considered a continuation of the prior disability. Once the maximum benefit period has been paid, you will not be eligible for a new benefit period or any disability benefits due to the same or a related condition unless you have been released by a physician from the prior disability and are no longer qualified to receive disability benefits for a period of 180 days. Separate periods of disability resulting from unrelated causes are considered a continuation of the prior disability unless they are separated by your returning to work at a Full-Time Job for 14 working days, during which you are performing the material and substantial duties of such job and are no longer qualified to receive disability benefits. Periods of disability meeting either of these separation requirements will begin a new benefit period, subject to a new elimination period.

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

TRANSITIONAL DISABILITY: being under the care and attendance of a physician due to a condition that causes you to be unable to perform the material and substantial duties of any job.

CHOOSE THE COVERAGE YOU NEED

- **Monthly Benefit: $500–$5,000 (subject to income requirements)**
- **Benefit Periods: 3, 6, 12, 18, or 24 months**
- **Elimination Periods (Injury/Sickness): 0/7, 0/14, 7/14, 14/14, 0/30, 30/30, 60/60, 90/90, 180/180**

WHAT WE WILL PAY

TOTAL DISABILITY BENEFIT: If you have a Full-Time Job and your coverage is in force at the time of your Sickness or Off-the-Job Injury, we will insure you as follows: If your covered Sickness or covered Off-the-Job Injury causes your Total Disability within 90 days of your last treatment for your covered Sickness or covered Off-the-Job Injury, we will pay you the Daily Disability Benefit for each day of your disability or your Successive Periods of Disability.

Benefits are payable up to the benefit period selected and are subject to the elimination period shown in the Policy Schedule.

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

PARTIAL DISABILITY BENEFIT: If you have a Full-Time Job and your coverage is in force at the time of your Sickness or Off-the-Job Injury, we will insure you as follows: If your covered Sickness or covered Off-the-Job Injury causes your Partial Disability within 90 days of your last treatment for your covered Sickness or covered Off-the-Job Injury, we will pay you the Daily Disability Benefit for each day of your disability or your Successive Periods of Disability.

Benefits are payable up to the benefit period selected and are subject to the elimination period shown in the Policy Schedule.

You will no longer be qualified to receive this benefit upon the earlier of your: (1) being released by your physician to perform the material and substantial duties of your Full-Time Job or (2) working at any job earning 80 percent or more of your predisability Base Pay Earnings.

TRANSITIONAL DISABILITY BENEFIT: If you do not have a Full-Time Job and your coverage is in force at the time of your Sickness or Off-the-Job Injury, we will insure you as follows: If your covered Sickness or covered Off-the-Job Injury causes your Transitional Disability within 15 days of your last treatment for your covered Sickness or covered Off-the-Job Injury, we will pay you one-half of the Daily Disability Benefit for each day you remain unable to work at any job. This benefit is payable for a maximum period of three months of disability or Successive Periods of Disability and is subject to the elimination period shown in the Policy Schedule.

You will no longer be qualified to receive this benefit upon the earlier of your: (1) being released by your physician to perform the material and substantial duties of any job or (2) working at any job. This benefit is limited to a lifetime maximum period of a total of three months, regardless of the number of disabilities or the duration of any disability.

Individual Payroll

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

❑ New
❑ Conversion
❑ Additional Units
Policy Number:

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

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

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

Driver's License Number_____ State of Issue_____ State of Birth_____

Address _____
Street or Post Office Box Apt. No.

City _____ State _____ ZIP _____

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

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

E-Mail Address (optional) _____

Payroll Account Name_____ Payroll Account No._____

Name of Employer _____ Type of Business _____

Job Duties _____

Job Title _____

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

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

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

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

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

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

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

ELIGIBILITY QUESTIONS
TO BE COMPLETED BY PROPOSED INSURED/EMPLOYEE

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

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

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

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

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

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

TO BE COMPLETED BY AFLAC ASSOCIATE/AGENT

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Height _____ (ft) _____ (in) Current Weight _____ (lbs)

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

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

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

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

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

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

ADDITIONAL UNDERWRITING MAY BE REQUIRED.

APPLICANT'S STATEMENTS AND AGREEMENTS

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

Proposed Insured's Initials _____

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

  Proposed Insured's Initials _____

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

  Proposed Insured's Initials _____

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

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

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

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

NOTICE OF INFORMATION PRACTICES

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

INFORMATION REGARDING THE MEDICAL INFORMATION BUREAU (MIB)
PRENOTICE

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

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

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

I authorize the following to give information (as defined below) to Aflac or any person or entity acting on its part: any medical professional, medical care institution, pharmacy-related service organizations, insurer (including Aflac, with respect to other Aflac coverages), reinsurer, government agency (including departments of public safety and motor vehicle departments), MIB Inc. (formerly known as the Medical Information Bureau), consumer reporting agency, or employer.

"Information" means facts or opinions relating to my past, present, or future physical or mental health or condition (excluding psychotherapy notes), employment, other insurance coverage, driving record, or any other medical or nonmedical facts that Aflac deems appropriate to determine eligibility for insurance or to evaluate a claim for benefits during the time this authorization is valid. I also authorize Aflac to give information to MIB, Inc.

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

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

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

I understand that I may revoke this authorization at any time, except to the extent that: (1) Aflac has taken action in reliance on this authorization, or (2) other law provides Aflac with the right to contest a claim under the policy or to contest the policy itself. My revocation must be submitted in writing to Aflac, Attn: Policy Service, 1932 Wynnton Road, Columbus, GA 31999.

Unless otherwise revoked, I agree that this authorization will expire on the earlier of the date Aflac notifies me of its declination of my application for coverage or, if a policy is issued, two years from the policy Effective Date.

I agree that a copy of this authorization is as valid as the original.

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

Signed and Dated at _____ on _____
City and State Date

Proposed Insured's/Employee's Signature _____

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

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

MAKE CHECK OR MONEY ORDER PAYABLE TO AFLAC.
FOR INFORMATION, CALL TOLL-FREE 1.800.99.AFLAC (1.800.992.3522).
VISIT OUR WEB SITE AT AFLAC.COM.

SPELMAN COLLEGE
PERSONAL SHORT TERM DISABILITY PREMIUM RATES

OPTION A

				Ages 18 - 49			Ages 50 - 64		
Minimum Annual Income Required	Maximum Monthly Income From Disability	Waiting Period	Benefit Period for Disability	Monthly Premium	Semi-Monthly Premium	Bi-Weekly Premium	Monthly Premium	Semi-Monthly Premium	Bi-Weekly Premium
$ 12,000	$ 700	0/7	6 months	25.48	12.74	11.76	27.30	13.65	12.6
$ 17,000	$ 800	0/7	6 months	29.12	14.56	13.44	31.12	15.60	14.4
$ 19,000	$ 900	0/7	6 months	32.76	16.38	15.12	35.10	17.55	16.20
$ 22,000	$ 1,000	0/7	6 months	36.40	18.20	16.80	39.00	19.50	18.00
$ 25,000	$ 1,100	0/7	6 months	40.04	20.02	18.48	42.90	21.45	19.80
$ 27,000	$ 1,200	0/7	6 months	43.68	21.84	20.16	46.80	23.40	21.60
$ 29,000	$ 1,300	0/7	6 months	47.32	23.66	21.84	50.70	25.35	23.40
$ 32,000	$ 1,400	0/7	6 months	50.96	25.48	23.52	54.60	27.30	25.20
$ 34,000	$ 1,500	0/7	6 months	54.60	27.30	25.20	58.50	29.25	27.00
$ 36,000	$ 1,600	0/7	6 months	58.24	29.12	26.88	62.40	37.20	28.80
$ 39,000	$ 1,700	0/7	6 months	61.88	30.94	28.56	66.30	33.15	30.60
$ 41,000	$ 1,800	0/7	6 months	65.52	32.76	30.24	70.20	35.10	32.40
$ 43,000	$ 1,900	0/7	6 months	69.16	34.58	31.92	74.10	37.05	34.20
$ 45,000	$ 2,000	0/7	6 months	72.80	36.40	33.60	78.00	39.00	36.00
$ 48,000	$ 2,100	0/7	6 months	76.44	38.22	35.28	81.90	40.95	37.80
$ 50,000	$ 2,200	0/7	6 months	80.08	40.04	36.96	85.80	42.90	39.60
$ 52,000	$ 2,300	0/7	6 months	83.72	41.86	38.64	89.70	44.85	41.40
$ 55,000	$ 2,400	0/7	6 months	87.36	43.68	40.32	93.60	46.80	43.20
$ 57,000	$ 2,500	0/7	6 months	91.00	45.50	42.00	97.50	48.75	45.00
$ 59,000	$ 2,600	0/7	6 months	94.64	47.32	43.68	101.40	50.70	46.80
$ 63,000	$ 2,700	0/7	6 months	98.28	49.14	45.36	105.30	52.65	48.60
$ 65,000	$ 2,800	0/7	6 months	101.92	50.96	47.04	109.20	54.60	50.40
$ 69,000	$ 2,900	0/7	6 months	105.56	52.78	48.72	113.10	56.55	52.20
$ 71,000	$ 3,000	0/7	6 months	109.20	54.60	50.40	117.00	58.50	54.00
$ 74,000	$ 3,100	0/7	6 months	112.84	56.42	52.08	120.90	60.45	55.80
$ 78,000	$ 3,200	0/7	6 months	116.48	58.24	53.76	124.80	62.40	57.60
$ 83,000	$ 3,300	0/7	6 months	120.12	60.06	55.44	128.70	64.35	59.40
$ 88,000	$ 3,400	0/7	6 months	123.76	61.88	57.12	132.60	66.30	61.20
$ 92,000	$ 3,500	0/7	6 months	127.40	63.70	58.80	136.50	68.25	63.00
$ 97,000	$ 3,600	0/7	6 months	131.04	65.52	60.48	140.40	70.20	64.80
$ 102,000	$ 3,700	0/7	6 months	134.68	67.34	62.16	144.30	72.15	66.60
$ 110,000	$ 3,800	0/7	6 months	138.32	69.16	63.84	148.20	74.10	68.40
$ 116,000	$ 3,900	0/7	6 months	141.96	70.98	65.52	152.10	76.05	70.20
$ 119,000	$ 4,000	0/7	6 months	145.60	72.80	67.20	156.00	78.00	72.00
$ 122,000	$ 4,100	0/7	6 months	149.24	74.62	68.88	159.90	79.95	73.80
$ 125,000	$ 4,200	0/7	6 months	152.88	76.44	70.56	163.80	81.90	75.60
$ 128,000	$ 4,300	0/7	6 months	156.52	78.26	72.24	167.70	83.85	77.40
$ 131,000	$ 4,400	0/7	6 months	160.16	80.08	73.92	171.60	85.80	79.20
$ 134,000	$ 4,500	0/7	6 months	163.80	81.90	75.60	175.50	87.75	81.00
$ 137,000	$ 4,600	0/7	6 months	167.44	83.72	77.28	179.40	89.70	82.80
$ 140,000	$ 4,700	0/7	6 months	171.08	85.54	78.96	183.30	91.65	84.60
$ 143,000	$ 4,800	0/7	6 months	174.72	87.36	80.64	187.20	93.60	86.40
$ 146,000	$ 4,900	0/7	6 months	178.36	89.18	82.32	191.10	95.55	88.20
$ 149,000	$ 5,000	0/7	6 months	182.00	91.00	84.00	195.00	97.50	90.00

SPELMAN COLLEGE
PERSONAL SHORT TERM DISABILITY PREMIUM RATES

OPTION B

				Ages 18 - 49			Ages 50 - 64		
Minimum Annual Income Required	Maximum Monthly Income From Disability	Waiting Period	Benefit Period for Disability	Monthly Premium	Semi-Monthly Premium	Bi-Weekly Premium	Monthly Premium	Semi-Monthly Premium	Bi-Weekly Premium
$ 12,000	$ 700	0/14	6 months	16.38	8.19	7.56	19.11	9.55	8.82
$ 17,000	$ 800	0/14	6 months	18.72	9.36	8.64	21.84	10.92	10.08
$ 19,000	$ 900	0/14	6 months	21.06	10.53	9.72	24.57	12.28	11.34
$ 22,000	$ 1,000	0/14	6 months	23.40	11.70	10.80	27.30	13.65	12.60
$ 25,000	$ 1,100	0/14	6 months	25.74	12.87	11.88	30.03	15.01	13.86
$ 27,000	$ 1,200	0/14	6 months	28.08	14.04	12.96	32.76	16.38	15.12
$ 29,000	$ 1,300	0/14	6 months	30.42	15.21	14.04	35.49	17.74	16.38
$ 32,000	$ 1,400	0/14	6 months	32.76	16.38	15.12	38.22	19.11	17.64
$ 34,000	$ 1,500	0/14	6 months	35.10	17.55	16.20	40.95	20.47	18.90
$ 36,000	$ 1,600	0/14	6 months	37.44	18.72	17.28	43.68	21.84	20.16
$ 39,000	$ 1,700	0/14	6 months	39.78	19.89	18.36	46.41	23.20	21.42
$ 41,000	$ 1,800	0/14	6 months	42.12	21.06	19.44	49.14	24.57	22.68
$ 43,000	$ 1,900	0/14	6 months	44.46	22.23	20.52	51.87	25.93	23.94
$ 45,000	$ 2,000	0/14	6 months	46.80	23.40	21.60	54.60	27.30	25.20
$ 48,000	$ 2,100	0/14	6 months	49.14	24.57	22.68	57.33	28.66	26.46
$ 50,000	$ 2,200	0/14	6 months	51.48	25.74	23.76	60.06	30.03	27.72
$ 52,000	$ 2,300	0/14	6 months	53.82	26.91	24.84	62.79	31.39	28.98
$ 55,000	$ 2,400	0/14	6 months	56.16	28.08	25.92	65.52	32.76	30.24
$ 57,000	$ 2,500	0/14	6 months	58.50	29.25	27.00	68.25	34.12	31.50
$ 59,000	$ 2,600	0/14	6 months	60.84	30.42	28.08	70.98	35.49	32.76
$ 63,000	$ 2,700	0/14	6 months	63.18	31.59	29.16	73.71	36.85	34.02
$ 65,000	$ 2,800	0/14	6 months	65.52	32.76	30.24	76.44	38.22	35.28
$ 69,000	$ 2,900	0/14	6 months	67.86	33.93	31.32	79.17	39.58	36.54
$ 71,000	$ 3,000	0/14	6 months	70.20	35.10	32.40	81.90	40.95	37.80
$ 74,000	$ 3,100	0/14	6 months	72.54	36.27	33.48	84.63	42.31	39.06
$ 78,000	$ 3,200	0/14	6 months	74.88	37.44	34.56	87.36	43.68	40.32
$ 83,000	$ 3,300	0/14	6 months	77.22	38.61	35.64	90.09	45.04	41.58
$ 88,000	$ 3,400	0/14	6 months	79.56	39.78	36.72	92.82	46.41	42.84
$ 92,000	$ 3,500	0/14	6 months	81.90	40.95	37.80	95.55	47.77	44.10
$ 97,000	$ 3,600	0/14	6 months	84.24	42.12	38.88	98.28	49.14	45.36
$ 102,000	$ 3,700	0/14	6 months	86.58	43.29	39.96	101.01	50.50	46.62
$ 110,000	$ 3,800	0/14	6 months	88.92	44.46	41.04	103.74	51.87	47.88
$ 116,000	$ 3,900	0/14	6 months	91.26	45.63	42.12	106.47	53.23	49.14
$ 119,000	$ 4,000	0/14	6 months	93.60	46.80	43.20	109.20	54.60	50.40
$ 122,000	$ 4,100	0/14	6 months	95.94	47.97	44.28	111.93	55.96	51.66
$ 125,000	$ 4,200	0/14	6 months	98.28	49.14	45.36	114.66	57.33	52.92
$ 128,000	$ 4,300	0/14	6 months	100.62	50.31	46.44	117.39	58.69	54.18
$ 131,000	$ 4,400	0/14	6 months	102.96	51.48	47.52	120.12	60.06	55.44
$ 134,000	$ 4,500	0/14	6 months	105.30	52.65	48.60	122.85	61.42	56.70
$ 137,000	$ 4,600	0/14	6 months	107.64	53.82	49.68	125.58	62.79	57.96
$ 140,000	$ 4,700	0/14	6 months	109.98	54.99	50.76	128.31	64.15	59.22
$ 143,000	$ 4,800	0/14	6 months	112.32	56.16	51.84	131.04	65.52	60.48
$ 146,000	$ 4,900	0/14	6 months	114.66	57.33	52.92	133.77	66.88	61.74
$ 149,000	$ 5,000	0/14	6 months	117.00	58.50	54.00	136.50	68.25	63.00

SHORT-TERM DISABILITY INSURANCE
TAX REDUCTION AGREEMENT FORM

Name: _____
Last Name First Name Middle Initial

Address: _____

_____

Social Security No: _____

Select one of the short-term disability program options listed below.

Option A: ☐ 0 day accident/7 days sickness waiting period for benefits
Option B: ☐ 0 day accident/14 days sickness waiting period for benefits

I am applying for $_____ of monthly Short Term Disability insurance.

I elect to have $_____ deducted from payroll **Bi-Weekly** for Short Term Disability coverage.

I elect to have $_____ deducted from payroll **Monthly** for Short Term Disability coverage.

I elect to have $_____ deducted from payroll **Semi-Monthly** for Short Term Disability coverage.

My pay cycle is: **Bi-Weekly** **Monthly** **Semi- Monthly**

I elect to have this deduction on a:

☐ **Pre-tax basis** ☐ **Post-tax basis**

I understand that these benefits will remain in effect until I complete and file a new election form with the Office of Human Resources during an open enrollment period. I also understand that I cannot revoke my pre-tax election before the next open enrollment.

Employee Signature: _____ Date: _____