Payroll

HOSPITAL CONFINEMENT INDEMNITY INSURANCE POLICY
(NY46000 Series)

Application to: American Family Life Assurance Company of New York
(Aflac New York)
22 Corporate Woods Boulevard • Suite 2
Albany, New York 12211

❑ New
❑ Conversion

Policy Number:

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

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

SSN _____ - _____ - _____ Are you applying for dependent child(ren) coverage? ❑Yes ❑No
If yes, dependent children must be under age 19 at the time of application.

(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

Address _____
Street or Post Office Box Apt. No.

City _____ State _____ ZIP _____

Home Telephone ( ) _____

Employee's Name _____ Relationship _____
(If Other Than Proposed Insured)

Payroll Account Name _____ Payroll Account No. _____
(Optional)

Do you have any other hospital indemnity coverage other than a hospital confinement sickness indemnity policy with Aflac New York? ❑ Yes ❑ No
If yes, this must be a conversion of that coverage. Provide current policy number and see Item 16.
Policy Number _____

Is this insurance intended to replace any other hospital indemnity insurance now in force? ❑ Yes ❑ No
If yes, please read and sign the Replacement Notice provided by your agent, if applicable.

TO BE COMPLETED BY AFLAC NEW YORK AGENT

Check Coverage Desired:	❑ Individual	❑ Named Insured/ Spouse Only	❑ One-Parent Family	❑ Two-Parent Family
❑ Plan 1: (Policy Series NY46100) ❑ Plan 2: (Policy Series NY46200)				❑ Pre-Tax or ❑ After-Tax

Billing Method:	**Mode:**		
☒ Payroll Deduction	❑ 01 Weekly	❑ 01 Semimonthly	❑ 06 Semiannual
	❑ 01 14-Day Biweekly	❑ 01 Monthly	❑ 12 Annual
	❑ 01 28-Day Biweekly	❑ 03 Quarterly	

Employee ID No. _____ Dept. No. _____ Agent's No. _____

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

ALL OF THE FOLLOWING MUST BE COMPLETED:

1. To the best of your knowledge and belief, is anyone to be covered the mother or father of a child currently conceived but as yet unborn? ❑ Yes ❑ No
   If yes, this policy will not be issued.

2. Is anyone to be covered currently confined in a Hospital or nursing home, or has a member of the medical profession recommended hospitalization or nursing home confinement? ❑ Yes ❑ No

3. To the best of your knowledge and belief, has anyone to be covered ever been medically treated or diagnosed by a member of the medical profession as having any of the following? ❑ Yes ❑ No

   * Alzheimer's disease
   * senile dementia
   * uncorrected congenital heart defect (excluding mitral valve prolapse)
   * kidney disease (not including kidney stones)
   * systemic lupus
   * insulin-dependent diabetes
   * end-stage renal disease

4. To the best of your knowledge and belief, has anyone to be covered ever been treated for or diagnosed by a member of the medical profession with acquired immune deficiency syndrome (AIDS)? ❑ Yes ❑ No

5. To the best of your knowledge and belief, has anyone to be covered been medically treated or diagnosed by a member of the medical profession for an internal cancer (which includes melanoma of Clark's Level III or higher, or a Breslow level greater than 1.5 mm) within the last five years? ❑ Yes ❑ No

6. To the best of your knowledge and belief, has anyone to be covered been hospitalized or missed five consecutive days of work within the last 36 months for any of the following? ❑ Yes ❑ No

   * angina (heart-related chest pain)
   * heart surgery
   * congestive heart failure
   * heart attack
   * Parkinson's disease
   * transient ischemic attack (TIA) (ministroke)
   * stroke
   * cerebral vascular insufficiency
   * peripheral vascular disease (circulatory problems)
   * Crohn's disease

7. To the best of your knowledge and belief, has anyone to be covered been confined in a Hospital or received medical treatment by a member of the medical profession in an emergency room within the last 12 months for any of the following? ❑ Yes ❑ No

   * emphysema
   * sickle cell anemia
   * Type II diabetes
   * hypertension
   * ulcerative colitis
   * liver disease or disorder (excluding Hepatitis A)
   * chronic obstructive pulmonary disease

8. To the best of your knowledge and belief, has anyone to be covered been confined in a Hospital within the last 12 months for treatment of asthma? ❑ Yes ❑ No

9. **If any one of Questions 2 through 8 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.

10. List all hospital indemnity policies you currently have in force, other than Aflac New York hospital indemnity policies, and provide the daily benefit amount. _____

_____

APPLICANT'S STATEMENTS AND AGREEMENTS:

11. I understand that the Effective Date of the policy will be the date recorded in the Policy Schedule by Aflac New York.

12. 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.

13. I understand that dependent children, if any, must be under age 19 at the time of application. Once covered, coverage will be extended until the anniversary date of the policy following their 19th birthday (23rd if a full-time student).

14. I acknowledge receipt of, if applicable:

❑ **Replacement Notice** ❑ **Disclosure Statement** ❑ ***Guide to Health Insurance for People with Medicare***

15. I understand that: (a) Aflac New York is not bound by any statement made by me, the Proposed Insured/Employee or any agent of Aflac New York unless written herein. (b) The 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 New York's president and secretary, and noted in or attached to the policy.

16. If this is an application for a conversion of coverage, the following conditions will apply: (a) If any one of Questions 2 through 8 are answered yes, the policy for which this application is made for the person(s) identified in Item 9 will be void, and coverage will continue under the terms of the previous policy, which may remain in force. Benefits that may be due any person(s) listed in Item 9 will be paid under the previous policy. (b) Any person(s) not listed in Item 9, if eligible, will be covered under the new policy. (c) 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. (d) 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.

OTHER INSURANCE WITH AFLAC NEW YORK: If any person is covered under more than one hospital confinement indemnity policy or rider with us, only the one Aflac New York policy chosen by you, your beneficiary or estate, as the case may be, will be effective. We will pay benefits under the policies for claims that may have been incurred since their respective Effective Dates. We will also return all premiums paid for the canceled policies from the date of duplication, less any benefits paid under these policies from such date.

I understand that the premium amount listed on this application represents the premium amount that my employer will remit to Aflac New York 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 agent.

I understand that the purchase of this policy is intended to supplement my existing comprehensive health care coverage. It is not intended to replace or be issued in lieu of that coverage.

If I am applying to replace existing Aflac New York hospital indemnity 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 New York policy and its benefits for the benefits provided in this Aflac New York 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. All statements made in this application are deemed representations and not warranties. I realize that any material misrepresentation therein may result in loss of coverage under the policy.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

The coverage applied for provides limited benefits health insurance only. This coverage does not meet the minimum requirements for Medicare supplement, long term care insurance, nursing home insurance only, home care insurance only, or nursing home and home care insurance in the state of New York. Purchase of this coverage may be unnecessary if you already have or intend to purchase Medicare supplement insurance or long term care insurance.

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 above are correct to the best of my knowledge.

Agent's Signature _____ Date _____
Licensed Resident Agent

MAKE CHECK OR MONEY ORDER PAYABLE TO AFLAC NEW YORK.
FOR INFORMATION, CALL TOLL-FREE 1-800-366-3436
VISIT OUR WEB SITE AT aflacny.com

For indemnity policies and other policies that pay a fixed dollar amount per day, excluding long-term care policies.

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 pays a fixed dollar amount, regardless of your expenses, for each day you meet the policy conditions. 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 *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 or state health insurance assistance program (SHIP).

Additional Information

This is part of the application and will become part of the policy.

The following information must be completed on each dependent child to be covered.

Name – Last, First, MI	Date of Birth	Sex	SSN	Check if:
		❑ M ❑ F		❑ Handicapped child
		❑ M ❑ F		❑ Handicapped child
		❑ M ❑ F		❑ Handicapped child
		❑ M ❑ F		❑ Handicapped child
		❑ M ❑ F		❑ Handicapped child
		❑ M ❑ F		❑ Handicapped child
		❑ M ❑ F		❑ Handicapped child
		❑ M ❑ F		❑ Handicapped child

Signature of Applicant/Named Insured _____ Date _____