



**Application for Accident Insurance (NY-34000 Series) with disability riders**  
 Application to American Family Life Assurance  
 Company of New York (AFLAC New York)  
 Albany, New York 12211

- New  
 Conversion

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 SS No. \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Dependent Children  Yes  No  
 (Write spouse's name below if you are applying for family coverage; if no spouse or if spouse is not to be covered, put N/A in space below.)

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

Applicant's Address \_\_\_\_\_ Apt. No. \_\_\_\_\_  
Street or Post Office Box

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Home Telephone ( ) \_\_\_\_\_ Business Telephone ( ) \_\_\_\_\_ Best Time to Call \_\_\_\_\_

Name of Employer \_\_\_\_\_ Type of Business \_\_\_\_\_

Job Duties \_\_\_\_\_

Job Title \_\_\_\_\_

Occupation Class \_\_\_\_\_ Industry Code \_\_\_\_\_  
(Completed by agent) (Completed by agent)

Do you have another accident policy with AFLAC New York?  Yes  No  
 If yes, is this a change of that coverage?  Yes  No If yes, give current policy number: \_\_\_\_\_  
 Is the purchase of this coverage intended to replace any other health insurance now in force?  Yes  No  
 If yes, please read and sign the Replacement Notice, if applicable, provided by your agent and provide the policy number here \_\_\_\_\_  
 Are you covered under New York's Disability Benefits Law or an equivalent state-mandated disability insurance plan?  Yes  No

**TO BE COMPLETED BY AFLAC NEW YORK AGENT**

**Billing Method:**  Payroll Deduction

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

**Disability Benefit Period:**  6 Months  12 Months

**Accident Disability Elimination Period:**  0 Days  7 Days

Employee No. \_\_\_\_\_ Dept. No. \_\_\_\_\_ Agent No. \_\_\_\_\_

Billable Premium \$ \_\_\_\_\_ Premium Collected \$ \_\_\_\_\_ Sit. Code \_\_\_\_\_

**CHECK COVERAGE DESIRED:**  Individual  Two-Parent Family  
 One-Parent Family  Named Insured/Spouse Only

Class:	Total No. of Units	Premium
<input type="checkbox"/> Level 1 Policy Series NY-34100		<input type="checkbox"/> Pre-Tax or <input type="checkbox"/> After-Tax
<input type="checkbox"/> Level 2 Policy Series NY-34200		<input type="checkbox"/> Pre-Tax or <input type="checkbox"/> After-Tax
<b>The Disability Rider shown below does not apply to your spouse or dependents.</b>		
<input type="checkbox"/> Accident Disability Rider		<input type="checkbox"/> Pre-Tax or <input type="checkbox"/> After-Tax
<b>The Disability Rider shown below applies only to your spouse.</b>		
<input type="checkbox"/> Spouse Accident Disability Rider 0 Day Elimination Period/ 6-Month Benefit Period		After-Tax Only
Total Premium		

**PLEASE COMPLETE QUESTIONS 1 THROUGH 7 IF APPLYING FOR THE DISABILITY RIDER**

1. I certify that my gross annual income (without overtime, unless contractual) for my full-time job is \$ \_\_\_\_\_.  
If you are self-employed, your gross annual income is your net earnings.  
I understand that this amount will be verified (as of this date) by my employer listed above at the time of claim.  
Annual income must be [\$10,000] or greater for coverage to be issued.
- 1a. If applying for the Spouse Disability Rider, I further certify that my spouse's gross annual income (without overtime, unless contractual, bonuses or other incentives) for his/her full-time job is \$ \_\_\_\_\_.  
If your spouse is self-employed, his/her gross annual income is his/her net earnings.  
Spouse's Employer \_\_\_\_\_ Spouse's Job Title \_\_\_\_\_
- 1b. If your Industry Class is E, have you been employed for less than 12 months with the employer listed on the front page of this application?  Yes  No
2. Do you or does anyone to be covered have a short-term disability policy with AFLAC New York?  Yes  No  
If yes, please complete the Supplemental Notification section at the end of this application and be aware that you or anyone to be covered cannot have this policy with the disability riders without canceling your short-term disability policy with AFLAC New York.
3. Do you or does anyone to be covered currently have disability coverage, that you purchased, that will remain in force which, combined with this applied-for coverage, exceeds 70% of your monthly gross (pre-tax) income?  Yes  No
4. Have you or has anyone to be covered been charged with driving under the influence of alcohol or any narcotic within the last 12 months or been charged two or more times within the last five years?  Yes  No
5. Do you or does anyone to be covered work fewer than 30 hours per week in your primary (full-time) occupation with the employer listed on the first page of the application?  Yes  No
6. Are you or is anyone to be covered currently disabled?  Yes  No

If you answered yes, to Question 1b or any one of Questions 3 through 6, you are not eligible for the disability rider coverage; and therefore, no disability rider will be issued. Please indicate to which person any "yes" answer applies.

Named Insured

Spouse

**The person indicated will not be covered by the disability rider.**

7. In the past 12 months, has a member of the medical profession diagnosed you (or anyone to be covered) with or treated you for an Injury, disease, or disorder of the back, the neck, or a joint?  Yes  No

**If you answered yes to Question 7, you must complete Item 8 and provide details in Item 9.**

8. If you are taking any prescription or over-the-counter medication please provide the name and dosage of any and all of the medication(s) and reason(s) for taking it below. If you are **not** taking any medication, check here.   Yes  No

**Please provide the name and dosage of the medication(s) you are currently taking and the reason(s) for taking it below.**

Medication Name	Dosage	Frequency	Date First Prescribed	Reason

9. Details to Question 7

	Medical Conditions	Onset (mo/yr)	Surgery Performed? (If yes, provide the type of procedure and date.)
Question 7			

**APPLICANT'S STATEMENTS AND AGREEMENTS**

10. I understand that the Effective Date of the policy will be the date recorded in the Policy Schedule by AFLAC New York's home office.
11. I acknowledge receipt of, if applicable:
- Replacement Notice
  - Disclosure Statement
  - Guide to Health Insurance for People With Medicare*
  - Fair Credit Reporting Notice
12. I understand that: (1) the policy of insurance I am now applying for will be issued based upon the written answers to the questions and information asked for in this application and any other pertinent information AFLAC New York may require for proper underwriting; (2) AFLAC New York is not bound by any statement made by me, or any agent of AFLAC New York, unless written herein; (3) the agent cannot change the provisions of the policy or waive any of its provisions either orally or in writing; (4) the policy, together with this application, endorsements, benefit agreements, riders, and attached papers, if any, constitutes the entire contract of insurance; and (5) no change to the policy will be valid until approved by AFLAC New York's secretary and president and noted in or attached to the policy.

**OTHER INSURANCE WITH AFLAC NEW YORK:** Insurance effective at any one time on a covered person under a like policy or policies with AFLAC New York is limited to the one such policy elected by the insured, his beneficiary or his estate, as the case may be, and AFLAC New York will return all premiums paid for all other such policies.

**SUPPLEMENTAL NOTIFICATION**

**COMPLETE IF YOU ARE REPLACING/TERMINATING EXISTING AFLAC NEW YORK DISABILITY COVERAGE.**

I, \_\_\_\_\_, am applying for AFLAC New York's policy with disability benefits. I currently have disability benefits under AFLAC New York short-term disability policy number \_\_\_\_\_.

I understand that I must cancel my existing AFLAC New York short-term disability policy to purchase this policy.

Please cancel my short-term disability policy so that this accident policy with disability benefits can be issued.

**AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION**

I authorize the following to give information (as defined below) to American Family Life Assurance Company of Columbus (AFLAC New York) or any person or entity acting on its part: any medical professional, medical care institution, insurer (including AFLAC New York, with respect to other AFLAC New York coverages), reinsurer, government agency (including departments of public safety and motor vehicle departments), 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 non-medical facts that AFLAC New York 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 New York to give information to the Medical Information Bureau. I understand that any disclosure of health information to AFLAC New York 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 re-disclosed only in accordance with other applicable laws or regulations.

I understand that this information will be used by AFLAC New York 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 New York 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 New York has taken action in reliance on this authorization, or (2) other law provides AFLAC New York with the right to contest a claim under the policy or the policy itself. My revocation must be submitted in writing to AFLAC New York, Policy Service, 22 Corporate Woods Boulevard, Albany, New York 12211.

Unless otherwise revoked, I agree that this authorization will expire on the earlier of the date AFLAC New York 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 understand that upon written request I will be informed whether or not AFLAC New York requested an investigative consumer report, and if such report was requested, the name and address of the consumer reporting agency to whom the request was made. I further understand that I will then have the right to inspect and receive a copy of such report by contacting such agency.**

**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 have read, or had read to me, the completed application and realize that policy issuance is based upon statements and answers provided herein. The answers are complete and true to the best of my knowledge and belief.**

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.

Signed and Dated at \_\_\_\_\_ on \_\_\_\_\_  
City and State Date

Applicant's Signature (X) \_\_\_\_\_

Beneficiary (your estate unless otherwise indicated) \_\_\_\_\_  
Relationship

**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.**

Agent Signature \_\_\_\_\_ Date  
Licensed Agent

**FOR INFORMATION, CALL TOLL-FREE 1-800-366-3436.**

### 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:
		<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Handicapped child
		<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Handicapped child
		<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Handicapped child
		<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Handicapped child
		<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Handicapped child
		<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Handicapped child
		<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Handicapped child
		<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Handicapped child

Signature of Applicant/Named Insured \_\_\_\_\_ Date \_\_\_\_\_

For policies that provide benefits for expenses incurred for an accidental injury only

**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 policy conditions, for hospital or medical expenses that result from accidental injury. 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
- \* 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 senior insurance counseling program.