Union

Application for Short-Term Disability Insurance (NY57500 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 ❑ Additional Units
Policy Number:

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

Proposed Insured's Name _____
Last First MI

State of Birth_____DOB _____ Sex _____ SSN _____ - _____ - _____
Month/Day/Year (optional)

Address _____
Street or Post Office Box Apt. No.

City _____ State _____ ZIP _____

Home Telephone (____) _____ Business Telephone (____) _____ Best Time to Call _____

E-Mail Address (optional) _____

Account Name_____ Account No._____

Name of Employer _____ Type of Business _____

Job Duties _____

Job Title _____

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

Is the purchase of this coverage intended to replace any other disability insurance now in force? ❑ Yes ❑ No
❑ Not applicable

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

Are you covered under New York's Disability Law or an equivalent state-mandated disability insurance plan? ❑ Yes ❑ No
If no, then you are not eligible for the Continuing Disability Benefit Rider (Form NY57552).

TO BE COMPLETED BY AFLAC NEW YORK AGENT

Billing Method:
❑ Direct
❑ List Bill
❑ Bank Draft (B/D, ACH)
❑ Credit Card (C/C)

Mode:
❑ 01 Monthly
❑ 03 Quarterly
❑ 06 Semiannual
❑ 12 Annual

Agent No. _____ Sit. Code _____ Billable Premium $ _____ Premium Collected $ _____

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

Benefit Periods:	☐ 3 Months ☐ 6 Months ☐ 12 Months
Elimination Periods: Injury/Sickness	☐ 0/7 Days ☐ 7/7 Days ☐ 0/14 Days ☐ 7/14 Days ☐ 14/14 Days ☐ 0/30 Days* ☐ 30/30 Days* **(*not available with 3-month Benefit Period)** ☐ 60/60 Days** ☐ 90/90 Days** ☐ 180/180 Days** **(**not available with 3- or 6-month Benefit Period)**

	No. of Units Purchased for this Application	**Premium**	
☐ Base Policy Series NY57500			☒ After-Tax Only
☐ On-the-Job Injury Rider Series NY57550			
☐ Additional Units of Disability Benefit Rider Series NY57551 (applies to base policy only) **Current Units:**_____(includes any additional units previously purchased) **(must match policy elimination and benefit periods)**			
☐ Continuing Disability Benefit Rider Series NY57552 Not available with a 3 or 6 month Benefit Period or a 180-day Elimination Period			
NOTE: Each unit is equal to a $100 monthly benefit.	**Total Premium**		

TO BE COMPLETED BY PROPOSED INSURED

1. Do you work fewer than [19] hours per week in your primary job at which you work for pay or benefits and which is considered full time employment by your employer listed on the first page of this application? ❑ Yes ❑ No

2. Do you have disability coverage that will remain in force, which combined with this applied for coverage, will exceed 55 percent of your gross monthly income? ❑ Yes ❑ No

3. 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 ❑ N/A

4. I certify that my gross annual income (without overtime, unless contractual; bonuses; or other incentives) for my full-time job is $_____. If you are self-employed, your gross annual income is your net earnings. I understand that this information will be verified at the time of claim. **Annual income must be [$15,000 or $17,000 if covered under a state disability plan] or greater for coverage to be issued.**

If you answered Yes to any Question 1–3, a policy will not be issued; therefore, do not submit this application.

5. Do you have any of Aflac New York's 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 New York.
6. Within the last 60 days, have you had another disability insurance policy? ❑ Yes ❑ No

7. Is the purchase of this coverage intended to replace any other disability insurance now in force? ❑ Yes ❑ No
   If yes, please read and sign the replacement notice provided by your agent and provide policy number here:_____

8. Do you have any other individual disability coverage in force with another company? ❑ Yes ❑ No
   If yes, please provide name of company, benefit amount, and elimination period here:

_____

PLEASE COMPLETE THE FOLLOWING QUESTIONS

1. Is anyone to be covered currently disabled due to sickness or injury, or has anyone to be covered been out of work or disabled due to sickness or injury more than 5 consecutive days within the last 12 months (excluding routine childbirth)? ❑Yes ❑No

2. Has anyone to be covered been hospitalized more than 24 hours within the last 12 months for reasons other than routine childbirth? ❑Yes ❑No

3. To the best of your knowledge and belief, does anyone to be covered have any condition for which any medical procedure (including but not limited to surgery, child delivery, organ or bone marrow transplant) has been planned or the possibility of which has been discussed with medical personnel? ❑Yes ❑No

4. To the best of your knowledge and belief, has anyone to be covered been to see a member of the medical profession about a medical condition that has yet to be diagnosed? ❑Yes ❑No

5. To the best of your knowledge and belief, has anyone to be covered, within the last five years: been convicted of a felony; been charged two or more times with operating a vehicle while under the influence of alcohol or drugs; been charged three or more times with a moving violation; or is currently on parole or incarcerated in a correctional institution? ❑Yes ❑No

6. To the best of your knowledge and belief, does anyone to be covered currently have or in the last 12 months, has anyone to be covered been diagnosed with or treated for any of the following conditions or had any of the following procedures: ❑Yes ❑No

AIDS
sciatica
Systemic lupus
muscular dystrophy
Parkinson's Disease
cystic fibrosis
pulmonary hypertension
renal hypertension
Crohn's disease
Ileitis
regional enteritis
ulcerative colitis
ulcerative proctitis
vascular insufficiency (circulatory problems)
diabetes (Type II) diagnosed prior to age 30
any sort of back, neck, or joint disorder
carpal tunnel syndrome
psoriatic arthritis
rheumatoid arthritis

7. To the best of your knowledge and belief, within the last 5 years, has anyone to be covered been diagnosed with or treated for any of the following conditions or had any of the following procedures: ❑Yes ❑No

heart attack
cardiomyopathy
bypass/stents/angioplasty
atrial fibrillation
implant of pacemaker/defibrillator
heart surgery (including valve replacement or correction)
congestive heart failure
stroke/TIA
chronic obstructive pulmonary disease (COPD)
emphysema
pulmonary fibrosis
diabetes and used tobacco after diagnosis
diabetes treated with insulin
diabetes with complications to include nephropathy; neuropathy; or retinopathy
kidney disease or disorder (not including stones)
liver disease or disorder (excluding Hepatitis A)
fibromyalgia
chronic fatigue syndrome
sarcoidosis
multiple sclerosis
alcohol or drug abuse
internal cancer (to include myelodysplastic blood disorder and myeloproliferative blood disorder)
melanoma (Clark's Level III or higher, or a Breslow Level greater than 1.5 mm)

If you answered Yes to any question 1 - 7, you are not eligible for any disability coverage; therefore, do not submit this application.

PLEASE COMPLETE THE FOLLOWING QUESTIONS IF YOU ARE APPLYING FOR MORE THAN 20 UNITS OF COVERAGE OR A BENEFIT PERIOD GREATER THAN 12 MONTHS.
Additional underwriting may be required.

8. During the last 6 months, have you received any medical treatment, including injections, or been prescribed or taken medications (other than prescription contraceptives)? ❑Yes ❑No
If yes, please provide descriptive information below.

Medical Conditions/Treatments	Onset (mo/yr)	Surgery Performed? (If yes, provide the type of procedure and date)	Date Last Treated	Released by Physician	For Hypertension and Diabetes, List the Average Reading (for the last three months)
				❑Yes ❑No	
				❑Yes ❑No	
				❑Yes ❑No	
				❑Yes ❑No	
				❑Yes ❑No	
				❑Yes ❑No	

Medication Name	Dosage	Date First Prescribed	Medical Condition

9. To the best of your knowledge and belief, has anyone to be covered used tobacco products or products containing nicotine of any type in the last 12 months? ❑ Yes ❑ No

10. a. Do you have any individual disability income coverage in force? ❑ Yes ❑ No
b. Do you have any group disability income coverage in force? ❑ Yes ❑ No

If yes to 10a or 10b, please list your monthly benefit amounts/percentages:_____, your benefit period:_____, and your Elimination Period:_____.

PLEASE COMPLETE THE FOLLOWING QUESTION IF YOU ARE APPLYING FOR THE ON-THE-JOB INJURY RIDER.

11. Are you covered by worker's compensation or a similar law in your full-time job? ❑ Yes ❑ No
Similar laws include but are not limited to the following:
Railroad Retirement Act
Jones Act
Maritime Doctrine of Maintenance
Wages or Cure
Longshoremen's and Harbor Worker's Acts

Form NYuwallR

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 New York. It is not the date this application was signed by me.
- I understand that coverage is not provided for an illness, disease, infection, condition, disorder, or injury for which, within the 12-month period before the Effective Date of coverage, medical advice or treatment was recommended by a Physician or received from a Physician, 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, including deliveries for children conceived prior to the Effective Date of coverage, or reinjuries to a Pre-existing Condition will not be covered unless it begins more than 12 months after the Effective Date of coverage.
- I acknowledge receipt of, if applicable:
  - ❑ Replacement Notice
  - ❑ Disclosure Statement
  - ❑ *Guide to Health Insurance for People With Medicare*
  - ❑ Fair Credit Reporting Notice
- 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) the policy, together with this application, endorsements, benefit agreements, riders, and attached papers, if any, constitutes the entire contract of insurance; and (3) 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.
- I understand that (1) Aflac New York is not bound by any statement made by me, or any agent of Aflac New York, unless written herein and (2) the agent cannot change the provisions of the policy or waive any of its provisions either orally or in writing.
- 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 on an online enrollment system, if applicable.
- If I am applying to replace existing Aflac New York 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 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 New York 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 material misrepresentations herein may result in loss of coverage under this policy. I further understand that I am signing this application one time even though I may have used it to apply for more than one policy.
- **OTHER INSURANCE WITH AFLAC NEW YORK:** If you are covered under more than one Aflac New York policy with disability benefits, only one disability benefit chosen by you or your estate, as the case may be, will be effective. Aflac New York will return all premiums paid for the canceled benefits from the date of duplication, less any benefits paid under these policies from such date.

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

I, _____, am applying for Aflac New York's short-term disability policy. I currently have disability benefits under Aflac New York accident/disability Policy Number _____. I understand that I must cancel existing Aflac New York 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.

INFORMATION REGARDING THE MEDICAL INFORMATION BUREAU (MIB)
PRENOTICE

Information regarding your insurability will be treated as confidential. Aflac New York 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, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted 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 New York 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 www.mib.com.

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

I authorize the following to give information (as defined below) to American Family Life Assurance Company of New York (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), 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 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 MIB, Inc.

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 redisclosed 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, Attn: Policy Service, 22 Corporate Woods Boulevard, Suite 2, 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.

Form NY575UAPP

I, the undersigned Proposed Insured/Employee, agree that by signing below I am submitting an application to Aflac New York for the following insurance policy(ies).

❑ Specified Disease/Lump Sum Critical Illness	❑ Short Term Disability Income	❑ Vision
❑ Specified Disease/Lump Sum Cancer	❑ Hospital Confinement	❑ Dental
❑ Specified Disease/Cancer	❑ Accident	❑ Hospital Intensive Care

- I would prefer to receive an electronic copy of my policy(ies) instead of paper. ❑ Yes ❑ No

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

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.

Form NYsignc