



DENTAL INSURANCE POLICY (A81000 Series)

- Conversion options: New, Conversion

Application to: American Family Life Assurance Company of Columbus (AFLAC)
Worldwide Headquarters: Columbus, Georgia 31999

Policy Number: []

Is this a (takeover) competitive replacement? Yes No

Please Print in Black Ink -To Be Completed by Applicant

Applicant's Name Last First MI DOB Month/Day/Year Sex

Applicant's SSN Will dependent children be covered? Yes No

(Write spouse's name below if you are applying for Two-Parent Family or Named Insured/Spouse Only coverage; if no spouse or spouse is not to be covered, put N/A in space below.)

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

Spouse's SSN

Address Street or Post Office Box Apt. No.

City State ZIP

Home Telephone () Name of Employer

Name of Dental Provider (optional):

Do you have any other dental insurance coverage in force with another company?
Are you covered under any other AFLAC dental insurance?
If yes, this must be a conversion of that coverage. Please provide your current policy number.
Please read the "NOTE - IF THIS IS AN APPLICATION FOR CONVERSION" section on page 2.

Is this insurance intended to replace any other dental insurance now in force?
If yes, please read and sign the Replacement Notice provided by your agent, if applicable.

TO BE COMPLETED BY AFLAC AGENT

Check Coverage Desired: Individual One-Parent Family Two-Parent Family Named Insured/Spouse Only

Basic Policy (Series A81100) \$25 Dental Wellness
Standard Policy (Series A81200) \$50 Dental Wellness
Premier Policy (Series A81300) \$50 Dental Wellness
Orthodontic Benefit Rider (Series A81050)

Cosmetic Benefit Rider (Series A81051) After-Tax Only

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

Employee No. Dept. No. Agent's No.
Billable Premium \$ Premium Collected \$ Sit. Code

The following information must be completed on each dependent child to be covered. If additional space is needed please complete Supplemental Application Form Series A-80005.

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

NOTE – IF THIS IS AN APPLICATION FOR CONVERSION: Any increased benefit amounts resulting from the replacement of the original AFLAC coverage with this new coverage will be subject to new Waiting Periods, if any, beginning with the effective date of this new coverage. The new Waiting Periods, if any, apply only to the amount of coverage being increased. If the Waiting Period is not met on the new policy, then any benefits due will be paid under the original plan.

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.
- I understand that the policy I am applying for will not cover any person who has attained age 66 before the effective date of the policy.
- I understand that the policy I am applying for contains different Waiting Periods for benefits listed in the Schedule of Dental Procedures in the policy. This means that no benefits are payable during the listed Waiting Period. The Waiting Period begins on the effective date of the policy.
- I understand that dependent children, if any, will be covered until age 19 (23 if full-time students).
- I understand that the Orthodontic Benefit Rider (Series A81050) and the Cosmetic Benefit Rider (Series A81051) will only be issued with a 24-month Waiting Period.
- I acknowledge receipt of, if applicable:
 Replacement Notice Outline of Coverage *Guide To Health Insurance for People with Medicare*
- I understand that: (a) AFLAC is not bound by any statement made by me, the applicant, or any agent of AFLAC 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's president and secretary, and noted in or attached to the policy.

NOTICE OF INFORMATION PRACTICES

To issue an insurance policy, AFLAC may need to obtain additional information about you and any other persons proposed 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, Maine, Massachusetts, Minnesota, Nevada, New Jersey, North Carolina, Ohio, Oregon, and Virginia.

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 by my agent.

I also understand that if I am receiving any Medicaid benefits, the purchase of this coverage is not necessary.

If I am applying to replace existing 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 policy and its benefits for the benefits provided in the AFLAC 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 to the best of my knowledge and belief. I realize that any false statement or misrepresentation may result in loss of coverage under the policy.

Signed and Dated at _____ on _____
City and State Date

Applicant's Signature _____

Agent's Signature _____ Date _____
Licensed Resident 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 www.aflac.com.**