AFLAC
MEDICARE SUPPLEMENT

You lead a strong, active, healthy life …
Make sure a gap in your Medicare coverage doesn't slow you down.

Aflac®

We've got you under our wing.®

GEORGIA | 2013

A19MS75GA

RC(7/13)

AFLAC MEDICARE SUPPLEMENT INSURANCE

Policy Series A19MS

MSI

Aflac helps remove some of the guesswork about health care costs during your retirement.

Like most people, you've probably given some serious thought to planning for your retirement. And without a doubt, you have in mind some pretty specific ways of spending your time when you do retire. Whether it's turning a hobby into a business or traveling the world, a wide-open road of possibilities lies ahead of you.

At Aflac, we want to make sure you have the right amount of health care coverage to keep you moving according to plan. That's where the **Aflac Medicare supplement insurance plans** step in.

Aflac policies strengthen your overall coverage because they've been created to help pay for medical expenses not covered by Medicare, such as deductibles, copayments, and noncovered services.

With Aflac Medicare supplement insurance plans, you not only enhance your coverage, but you can also see any doctor who accepts Medicare—wherever and whenever you want.

We know you've spent a lot of time thinking about the future. We're here to help make sure your plans stay on track.

Not connected with or endorsed by the U.S. government or the federal Medicare program.

Aflac herein means American Family Life Assurance Company of Columbus.

This is a solicitation of insurance and an agent may contact you.

UNDERSTANDING THE FACTS CAN HELP YOU UNDERSTAND WHY AFLAC MEDICARE SUPPLEMENT INSURANCE POLICIES MAKE SENSE FOR YOU.

AFLAC IS A FORTUNE 500 COMPANY RATED **A+** (SUPERIOR) BY A.M. BEST.[1]

RECOGNIZED IN 2012 BY *ETHISPHERE* MAGAZINE AS **1** OF THE WORLD'S MOST ETHICAL COMPANIES FOR THE SIXTH YEAR.[2]

AFLAC HAS NEARLY **60** YEARS OF PROVIDING A STRONG AND LASTING SAFETY NET FOR FAMILIES.

MORE THAN **50** MILLION PEOPLE WORLDWIDE ARE INSURED BY AFLAC.[3]

[1] Aflac's A+ (Superior) rating for financial strength was affirmed by A.M. Best on May 27, 2011. The A+ rating is the second highest (of 16 levels) given by A.M. Best with the highest being A++ (Superior).

[2] "World's Most Ethical Companies," *Ethisphere* magazine, Q1 2012 (quarterly).

[3] Aflac annual report: 2011 *Year in Review*.

Choose the Medicare supplement plan that's right for you.[1]

	MEDICARE PAYS	MEDICARE SUPPLEMENT PLANS PAY	PLAN A	PLAN C	PLAN D	PLAN F	PLAN G	PLAN N
PART A: INPATIENT HOSPITAL CARE								
First 60 days	All but $1,184	$1,184 Part A deductible		√	√	√	√	√
Coinsurance 61–90 days	All but $296 a day	$296 a day	√	√	√	√	√	√
Coinsurance 91–150 days	All but $592 a day	$592 a day	√	√	√	√	√	√
After day 150 up to an additional 365 days in your lifetime	Nothing	100% of Medicare-eligible expenses	√	√	√	√	√	√
Blood benefit	All but first 3 pints	First 3 pints	√	√	√	√	√	√
SKILLED NURSING FACILITY CARE								
First 20 days	100%	Nothing						
Coinsurance 21–100 days	All but $148 a day	Up to $148 a day		√	√	√	√	√
PART B: PHYSICIAN SERVICES AND SUPPLIES								
Yearly deductible	Nothing	$147		√		√		
Coinsurance	Generally 80%	Generally 20%	√	√	√	√	√	√[2]
Blood benefit	All but first 3 pints	First 3 pints	√	√	√	√	√	√
Excess benefits	Nothing	100% of Medicare-eligible expenses				√	√	
OTHER BENEFITS								
Emergency care outside the U.S.	Nothing	80% of Medicare-eligible expenses up to a lifetime maximum of $50,000 after a $250 yearly deductible		√	√	√	√	√
Hospice benefits	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	√	√	√	√	√	√

[1]Some plans may not be available in your state.
[2]Plan N pays the balance of the Part B coinsurance except for up to a $20 copayment per office visit and up to a $50 copayment per emergency room visit.

EXCLUSIONS

We will not pay benefits for:

- Expenses incurred while the policy is not in force, except as provided in the Extension of Benefits section;
- Hospital or Skilled Nursing Facility confinement incurred during a Medicare Part A benefit period that begins while the policy is not in force;
- That portion of any expense incurred that is paid for by Medicare;
- Services for non-Medicare-Eligible Expenses, unless specifically covered in the policy, including but not limited to routine exams, take-home drugs, and eye refractions;
- Services for which a charge is not normally made in the absence of insurance;
- Loss or expense that is payable under any other Medicare supplement insurance policy or certificate.

TERMS YOU NEED TO KNOW

Coinsurance Amount means the part of Medicare-Eligible Expenses you have to pay. It does not include Part A or Part B deductible amounts.

Guaranteed-Renewable means that the policy is guaranteed-renewable as long as you live, provided you continue to pay premiums when due or within the grace period. Premiums are based on your issue age. Any change in premium will occur on the policy anniversary date. Aflac reserves the right to change premiums, but only on an entire class of policies.

Hospital means a Hospital that is approved, or eligible to be approved, to receive payments from Medicare and that is accredited by the Joint Commission on Accreditation of Hospitals.

Injury means a bodily Injury that is the direct result of an accident and independent of all other causes.

Medically Necessary means a service or supply that is recognized by Medicare as necessary to diagnose or treat an Injury or Sickness and is: (1) prescribed by a Physician; (2) consistent with the diagnosis and treatment of the Injury or Sickness; (3) in accordance with generally accepted standards or medical practice; and (4) not solely for the convenience of you or the Physician.

Medicare means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendment of 1965, as then constituted or later amended.

Medicare-Eligible Expenses means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and Medically Necessary by Medicare.

Medicare Part A Initial Deductible means the fixed amount Medicare does not pay during the first 60 days of Hospital confinement in a benefit period. This amount is set each year by Medicare. Medicare does not pay this amount.

Medicare Part B Deductible means the fixed amount you must pay each calendar year before Medicare starts paying Part B expenses. This amount is set each year by Medicare. Medicare does not pay this amount. A calendar year begins on January 1 and ends on December 31.

Physician means any practitioner of the healing arts acting within the scope of his/her license. It does not include you or any member of your immediate family.

Policy Effective Date means the effective date of the policy and is shown in the Policy Schedule. The Policy Effective Date is not the date you signed the application for coverage.

Sickness means illness or disease that first manifests itself after the Policy Effective Date and while the policy is in force.

Skilled Nursing Facility means an institution licensed as such by the state in which it is located and operated within the scope and intent of its license. It does not include a facility or any of its sections that is primarily a place for drug addicts, alcoholics, or persons suffering from mental disease.

AMERICAN FAMILY LIFE ASSURANCE COMPANY OF COLUMBUS

Outline of Medicare Supplement Coverage

Benefit Plans A, C, D, F, G and N

Benefit Chart of Medicare Supplement Plans Sold for Effective Dates on or After June 1, 2010

This chart shows the benefits included in each of the standard Medicare supplement plans. Every company must make Plan "A" available. Some plans may not be available in your state.

Basic Benefits:

- **Hospitalization – Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.**
- **Medical Expenses – Part B coinsurance (generally 20% of Medicare-approved expenses) or copayments for hospital outpatient services. Plans K, L, and N require insureds to pay a portion of Part B coinsurance or copayments.**
- **Blood – First three pints of blood each year.**
- **Hospice – Part A coinsurance**

A	B	C	D	F	F*	G	K	L	M	N
Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance*		Basic, including 100% Part B coinsurance	Hospitalization and preventive care paid at 100%; other basic benefits paid at 50%	Hospitalization and preventive care paid at 100%; other basic benefits paid at 75%	Basic, including 100% Part B coinsurance	Basic, including 100 % Part B coinsurance except up to $20 copayment for office visit, and up to $50 copayment for ER
		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance		Skilled Nursing Facility Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible		Part A Deductible	50% Part A Deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible
		Part B Deductible		Part B Deductible						
				Part B Excess (100 %)		Part B Excess (100%)				
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency		Foreign Travel Emergency			Foreign Travel Emergency	Foreign Travel Emergency
							Out- of-pocket limit $4660 paid at 100% after limit reached	Out-of -Pocket limit $2330 paid at 100% after limit reached		

***Plan F also has an option called a high deductible Plan F. This high deductible plan pays the same benefits as Plan F after one has paid a calendar year $2070 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses exceed $2070. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the Policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.**

Rates are effective for applications submitted on or after 09/05/2013

American Family Life Assurance Company of Columbus (Aflac)

Plan A Form A19MSAGAR Revised Premium Rates

State of Georgia

	Non-Tobacco User		Tobacco User	
Issue Age	Female	Male	Female	Male
0-64	14,705.90	16,474.40	16,916.20	18,907.60
65	1,470.59	1,647.44	1,691.62	1,890.76
66	1,492.62	1,680.68	1,713.78	1,934.94
67	1,525.85	1,713.78	1,747.01	1,968.05
68	1,548.01	1,747.01	1,791.19	2,001.28
69	1,581.11	1,791.19	1,824.43	2,056.54
70	1,625.29	1,824.43	1,868.61	2,100.85
71	1,658.52	1,857.53	1,912.79	2,145.03
72	1,691.62	1,901.71	1,946.02	2,189.21
73	1,735.94	1,946.02	1,990.20	2,233.52
74	1,769.04	1,979.12	2,034.38	2,277.70
75	1,791.19	2,012.36	2,056.54	2,310.80
76	1,802.27	2,023.43	2,067.61	2,321.88
77	1,813.35	2,045.46	2,089.77	2,344.04
78	1,824.43	2,067.61	2,100.85	2,377.14
79	1,835.37	2,067.61	2,111.79	2,377.14
80	1,835.37	2,067.61	2,111.79	2,377.14
81	1,835.37	2,067.61	2,111.79	2,377.14
82	1,835.37	2,067.61	2,111.79	2,377.14
83	1,835.37	2,067.61	2,111.79	2,377.14
84	1,835.37	2,067.61	2,111.79	2,377.14
85	1,835.37	2,067.61	2,111.79	2,377.14
86	1,835.37	2,067.61	2,111.79	2,377.14
87	1,835.37	2,067.61	2,111.79	2,377.14
88	1,835.37	2,067.61	2,111.79	2,377.14
89	1,835.37	2,067.61	2,111.79	2,377.14
90	1,835.37	2,067.61	2,111.79	2,377.14
91	1,835.37	2,067.61	2,111.79	2,377.14
92	1,835.37	2,067.61	2,111.79	2,377.14
93	1,835.37	2,067.61	2,111.79	2,377.14
94	1,835.37	2,067.61	2,111.79	2,377.14
95	1,835.37	2,067.61	2,111.79	2,377.14
96	1,835.37	2,067.61	2,111.79	2,377.14
97	1,835.37	2,067.61	2,111.79	2,377.14
98	1,835.37	2,067.61	2,111.79	2,377.14
99	1,835.37	2,067.61	2,111.79	2,377.14

1. The above rates do not include a one-time $20 policy fee at time of issue.
2. If the insured qualifies for household discount, the 7% discount will be applied.
3. For payment made on monthly EBT, there is an additional $2 discount per month.

Area Factors

3-Digit Zip Code	Factor
300-303, 311, 399	0.95
304-310, 312-319	0.85
Rest of State	0.95

Modal Factors

Mode	Factor
Annual	1.00000
Semi-Annual	0.50000
Quarterly	0.25000
Monthly	0.08333

Rates are effective for applications submitted on or after 09/05/2013

American Family Life Assurance Company of Columbus (Aflac)

Plan C Form A19MSCGAR Revised Premium Rates

State of Georgia

	Non-Tobacco User		Tobacco User	
Issue Age	Female	Male	Female	Male
0-64	18,686.10	21,008.50	21,450.30	24,214.50
65	1,868.61	2,100.85	2,145.03	2,421.45
66	1,923.87	2,145.03	2,211.36	2,465.63
67	1,957.10	2,200.29	2,255.54	2,531.96
68	2,012.36	2,266.62	2,310.80	2,598.30
69	2,067.61	2,321.88	2,377.14	2,675.71
70	2,122.87	2,388.21	2,443.60	2,742.05
71	2,178.13	2,443.60	2,509.94	2,819.46
72	2,244.47	2,520.89	2,576.28	2,896.88
73	2,299.86	2,598.30	2,653.56	2,985.37
74	2,366.19	2,664.64	2,720.03	3,062.78
75	2,432.53	2,730.97	2,797.31	3,140.06
76	2,476.71	2,775.28	2,852.70	3,195.45
77	2,531.96	2,841.62	2,907.95	3,272.73
78	2,587.22	2,896.88	2,974.29	3,328.12
79	2,620.46	2,952.13	3,018.47	3,405.54
80	2,653.56	2,985.37	3,051.70	3,438.64
81	2,686.79	3,018.47	3,084.81	3,471.87
82	2,708.95	3,040.63	3,118.04	3,493.90
83	2,742.05	3,084.81	3,151.14	3,538.21
84	2,775.28	3,118.04	3,184.37	3,582.39
85	2,786.36	3,140.06	3,206.40	3,615.62
86	2,852.70	3,217.48	3,283.81	3,703.98
87	2,919.03	3,283.81	3,350.15	3,781.40
88	2,952.13	3,328.12	3,405.54	3,836.65
89	2,996.45	3,372.30	3,449.72	3,880.96
90	3,040.63	3,416.48	3,493.90	3,925.14
91	3,073.73	3,449.72	3,538.21	3,969.32
92	3,106.96	3,493.90	3,582.39	4,013.64
93	3,151.14	3,527.13	3,615.62	4,057.82
94	3,184.37	3,560.23	3,659.80	4,091.05
95	3,206.40	3,593.47	3,692.90	4,135.23
96	3,239.63	3,615.62	3,726.14	4,168.33
97	3,261.79	3,648.72	3,759.24	4,190.49
98	3,283.81	3,670.88	3,781.40	4,223.72
99	3,305.97	3,692.90	3,803.55	4,245.74

1. The above rates do not include a one-time $20 policy fee at time of issue.
2. If the insured qualifies for household discount, the 7% discount will be applied.
3. For payment made on monthly EBT, there is an additional $2 discount per month.

Area Factors

3-Digit Zip Code	Factor
300-303, 311, 399	0.95
304-310, 312-319	0.85
Rest of State	0.95

Modal Factors

Mode	Factor
Annual	1.00000
Semi-Annual	0.50000
Quarterly	0.25000
Monthly	0.08333

Rates are effective for applications submitted on or after 09/05/2013

American Family Life Assurance Company of Columbus (Aflac)

Plan D Form A19MSDGAR Revised Premium Rates

State of Georgia

	Non-Tobacco User		Tobacco User	
Issue Age	Female	Male	Female	Male
0-64	16,806.80	18,907.60	19,349.40	21,781.30
65	1,680.68	1,890.76	1,934.94	2,178.13
66	1,724.86	1,946.02	1,979.12	2,233.52
67	1,769.04	1,990.20	2,034.38	2,288.78
68	1,824.43	2,045.46	2,089.77	2,355.11
69	1,868.61	2,100.85	2,156.11	2,421.45
70	1,923.87	2,156.11	2,211.36	2,476.71
71	1,979.12	2,222.44	2,277.70	2,554.12
72	2,034.38	2,288.78	2,344.04	2,631.53
73	2,089.77	2,355.11	2,410.37	2,708.95
74	2,156.11	2,421.45	2,476.71	2,775.28
75	2,211.36	2,476.71	2,543.04	2,852.70
76	2,255.54	2,531.96	2,598.30	2,907.95
77	2,310.80	2,598.30	2,653.56	2,985.37
78	2,355.11	2,642.61	2,708.95	3,040.63
79	2,410.37	2,697.87	2,764.20	3,106.96
80	2,432.53	2,742.05	2,797.31	3,151.14
81	2,465.63	2,775.28	2,841.62	3,184.37
82	2,487.78	2,808.38	2,863.64	3,228.55
83	2,531.96	2,841.62	2,907.95	3,272.73
84	2,565.20	2,885.80	2,952.13	3,317.05
85	2,598.30	2,919.03	2,985.37	3,350.15
86	2,664.64	2,996.45	3,062.78	3,438.64
87	2,720.03	3,062.78	3,129.12	3,527.13
88	2,764.20	3,106.96	3,184.37	3,582.39
89	2,808.38	3,151.14	3,228.55	3,626.57
90	2,852.70	3,195.45	3,272.73	3,670.88
91	2,885.80	3,239.63	3,317.05	3,715.06
92	2,919.03	3,272.73	3,361.23	3,759.24
93	2,952.13	3,305.97	3,405.54	3,803.55
94	2,985.37	3,339.20	3,438.64	3,836.65
95	3,018.47	3,372.30	3,471.87	3,880.96
96	3,051.70	3,405.54	3,504.97	3,914.07
97	3,073.73	3,427.56	3,538.21	3,947.30
98	3,095.88	3,449.72	3,560.23	3,969.32
99	3,118.04	3,471.87	3,593.47	3,991.48

1. The above rates do not include a one-time $20 policy fee at time of issue.
2. If the insured qualifies for household discount, the 7% discount will be applied.
3. For payment made on monthly EBT, there is an additional $2 discount per month.

Area Factors

3-Digit Zip Code	Factor
300-303, 311, 399	0.95
304-310, 312-319	0.85
Rest of State	0.95

Modal Factors

Mode	Factor
Annual	1.00000
Semi-Annual	0.50000
Quarterly	0.25000
Monthly	0.08333

Rates are effective for applications submitted on or after 09/05/2013

American Family Life Assurance Company of Columbus (Aflac)

Plan F Form A19MSFGAR Revised Premium Rates

State of Georgia

	Non-Tobacco User		Tobacco User	
Issue Age	Female	Male	Female	Male
0-64	19,127.90	21,450.30	22,002.90	24,656.30
65	1,912.79	2,145.03	2,200.29	2,465.63
66	1,957.10	2,200.29	2,255.54	2,531.96
67	2,001.28	2,255.54	2,299.86	2,587.22
68	2,056.54	2,310.80	2,366.19	2,664.64
69	2,122.87	2,377.14	2,432.53	2,730.97
70	2,167.18	2,443.60	2,498.86	2,808.38
71	2,233.52	2,498.86	2,565.20	2,874.72
72	2,288.78	2,576.28	2,642.61	2,963.21
73	2,355.11	2,642.61	2,708.95	3,040.63
74	2,432.53	2,720.03	2,797.31	3,129.12
75	2,476.71	2,797.31	2,852.70	3,206.40
76	2,531.96	2,841.62	2,907.95	3,272.73
77	2,587.22	2,907.95	2,974.29	3,339.20
78	2,631.53	2,963.21	3,029.55	3,416.48
79	2,686.79	3,018.47	3,095.88	3,471.87
80	2,720.03	3,051.70	3,129.12	3,504.97
81	2,742.05	3,084.81	3,151.14	3,549.15
82	2,775.28	3,118.04	3,184.37	3,582.39
83	2,797.31	3,140.06	3,217.48	3,615.62
84	2,830.54	3,184.37	3,261.79	3,659.80
85	2,852.70	3,206.40	3,283.81	3,692.90
86	2,919.03	3,283.81	3,350.15	3,770.32
87	2,985.37	3,350.15	3,427.56	3,858.81
88	3,018.47	3,394.46	3,471.87	3,914.07
89	3,062.78	3,438.64	3,527.13	3,958.38
90	3,106.96	3,482.82	3,571.31	4,002.56
91	3,140.06	3,527.13	3,615.62	4,057.82
92	3,184.37	3,560.23	3,659.80	4,102.00
93	3,217.48	3,593.47	3,703.98	4,135.23
94	3,250.71	3,637.65	3,737.22	4,179.41
95	3,283.81	3,659.80	3,770.32	4,212.64
96	3,305.97	3,692.90	3,803.55	4,245.74
97	3,339.20	3,715.06	3,836.65	4,278.98
98	3,361.23	3,748.29	3,869.89	4,312.08
99	3,383.38	3,770.32	3,892.04	4,334.24

1. The above rates do not include a one-time $20 policy fee at time of issue.
2. If the insured qualifies for household discount, the 7% discount will be applied.
3. For payment made on monthly EBT, there is an additional $2 discount per month.

Area Factors

3-Digit Zip Code	Factor
300-303, 311, 399	0.95
304-310, 312-319	0.85
Rest of State	0.95

Modal Factors

Mode	Factor
Annual	1.00000
Semi-Annual	0.50000
Quarterly	0.25000
Monthly	0.08333

Rates are effective for applications submitted on or after 09/05/2013

American Family Life Assurance Company of Columbus (Aflac)

Plan G Form A19MSGGAR Revised Premium Rates

State of Georgia

	Non-Tobacco User		Tobacco User	
Issue Age	Female	Male	Female	Male
0-64	16,363.70	18,464.50	18,907.60	21,228.70
65	1,636.37	1,846.45	1,890.76	2,122.87
66	1,680.68	1,890.76	1,934.94	2,167.18
67	1,724.86	1,934.94	1,979.12	2,233.52
68	1,769.04	1,990.20	2,034.38	2,288.78
69	1,824.43	2,034.38	2,089.77	2,344.04
70	1,868.61	2,100.85	2,145.03	2,410.37
71	1,923.87	2,156.11	2,211.36	2,476.71
72	1,979.12	2,211.36	2,277.70	2,554.12
73	2,034.38	2,288.78	2,344.04	2,631.53
74	2,089.77	2,355.11	2,399.29	2,708.95
75	2,145.03	2,410.37	2,465.63	2,764.20
76	2,189.21	2,465.63	2,509.94	2,830.54
77	2,233.52	2,509.94	2,576.28	2,896.88
78	2,288.78	2,576.28	2,631.53	2,963.21
79	2,332.96	2,620.46	2,686.79	3,018.47
80	2,366.19	2,653.56	2,720.03	3,051.70
81	2,399.29	2,697.87	2,753.13	3,095.88
82	2,421.45	2,720.03	2,786.36	3,129.12
83	2,454.55	2,764.20	2,819.46	3,173.30
84	2,498.86	2,808.38	2,874.72	3,228.55
85	2,509.94	2,830.54	2,896.88	3,261.79
86	2,576.28	2,907.95	2,963.21	3,339.20
87	2,642.61	2,974.29	3,040.63	3,427.56
88	2,686.79	3,018.47	3,084.81	3,471.87
89	2,720.03	3,062.78	3,129.12	3,516.05
90	2,764.20	3,095.88	3,173.30	3,571.31
91	2,797.31	3,140.06	3,217.48	3,615.62
92	2,830.54	3,173.30	3,261.79	3,648.72
93	2,863.64	3,206.40	3,294.89	3,692.90
94	2,896.88	3,239.63	3,328.12	3,726.14
95	2,929.98	3,272.73	3,361.23	3,759.24
96	2,952.13	3,305.97	3,394.46	3,792.47
97	2,985.37	3,328.12	3,427.56	3,825.58
98	3,007.39	3,350.15	3,449.72	3,858.81
99	3,029.55	3,372.30	3,482.82	3,880.96

1. The above rates do not include a one-time $20 policy fee at time of issue.
2. If the insured qualifies for household discount, the 7% discount will be applied.
3. For payment made on monthly EBT, there is an additional $2 discount per month.

Area Factors

3-Digit Zip Code	Factor
300-303, 311, 399	0.95
304-310, 312-319	0.85
Rest of State	0.95

Modal Factors

Mode	Factor
Annual	1.00000
Semi-Annual	0.50000
Quarterly	0.25000
Monthly	0.08333

Rates are effective for applications submitted on or after 09/05/2013

American Family Life Assurance Company of Columbus (Aflac)

Plan N Form A19MSNGAR Revised Premium Rates

State of Georgia

	Non-Tobacco User		Tobacco User	
Issue Age	Female	Male	Female	Male
0-64	13,268.40	14,926.20	15,258.50	17,137.80
65	1,326.84	1,492.62	1,525.85	1,713.78
66	1,359.95	1,536.93	1,558.95	1,769.04
67	1,404.26	1,570.03	1,614.34	1,802.27
68	1,426.28	1,614.34	1,647.44	1,857.53
69	1,470.59	1,658.52	1,691.62	1,912.79
70	1,514.77	1,702.70	1,747.01	1,957.10
71	1,558.95	1,757.96	1,791.19	2,012.36
72	1,603.27	1,802.27	1,846.45	2,078.69
73	1,658.52	1,857.53	1,912.79	2,133.95
74	1,702.70	1,923.87	1,957.10	2,211.36
75	1,747.01	1,957.10	2,001.28	2,255.54
76	1,780.12	2,012.36	2,056.54	2,310.80
77	1,824.43	2,056.54	2,100.85	2,366.19
78	1,868.61	2,100.85	2,145.03	2,421.45
79	1,912.79	2,145.03	2,200.29	2,465.63
80	1,934.94	2,178.13	2,233.52	2,509.94
81	1,968.05	2,211.36	2,266.62	2,543.04
82	1,990.20	2,244.47	2,288.78	2,576.28
83	2,023.43	2,277.70	2,321.88	2,620.46
84	2,056.54	2,310.80	2,366.19	2,664.64
85	2,089.77	2,344.04	2,399.29	2,697.87
86	2,145.03	2,410.37	2,465.63	2,775.28
87	2,200.29	2,476.71	2,531.96	2,841.62
88	2,233.52	2,509.94	2,576.28	2,885.80
89	2,277.70	2,543.04	2,609.38	2,929.98
90	2,310.80	2,587.22	2,653.56	2,974.29
91	2,344.04	2,620.46	2,686.79	3,007.39
92	2,366.19	2,653.56	2,730.97	3,040.63
93	2,399.29	2,675.71	2,764.20	3,084.81
94	2,432.53	2,708.95	2,797.31	3,118.04
95	2,454.55	2,730.97	2,819.46	3,140.06
96	2,476.71	2,753.13	2,852.70	3,173.30
97	2,498.86	2,775.28	2,874.72	3,195.45
98	2,520.89	2,797.31	2,896.88	3,217.48
99	2,543.04	2,819.46	2,919.03	3,239.63

1. The above rates do not include a one-time $20 policy fee at time of issue.
2. If the insured qualifies for household discount, the 7% discount will be applied.
3. For payment made on monthly EBT, there is an additional $2 discount per month.

Area Factors

3-Digit Zip Code	Factor
300-303, 311, 399	0.95
304-310, 312-319	0.85
Rest of State	0.95

Modal Factors

Mode	Factor
Annual	1.00000
Semi-Annual	0.50000
Quarterly	0.25000
Monthly	0.08333

PREMIUM INFORMATION

American Family Life Assurance Company of Columbus may change your premium on any premium due date if a new table of rates is applicable to the policy. The change in the table of rates will apply to all covered persons in the same class. *Class* is defined as issue age, sex, underwriting class, state of issue, and your most recent ZIP code of residence.

Premiums are based on your issue age.

DISCLOSURES

Use this outline to compare benefits and premiums among policies.

READ YOUR POLICY VERY CAREFULLY

This is only an outline describing your Policy's most important features. The Policy is your insurance contract. You must read the Policy itself to understand all of the rights and duties of both you and American Family Life Assurance Company of Columbus.

RIGHT TO RETURN POLICY

If you find that you are not satisfied with your Policy, you may return it to: American Family Life Assurance Company of Columbus, Medicare Supplement Administration, P.O. Box 1553, Pensacola, Florida 32591. If you send the Policy back to us within 30 days after you receive it, we will treat the Policy as if it had never been issued and return all of your payments.

POLICY REPLACEMENT

If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

NOTICE

This Policy may not fully cover all of your medical costs. Neither American Family Life Assurance Company of Columbus nor its agents are connected with Medicare. This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult *Medicare and You* for more details.

COMPLETE ANSWERS ARE VERY IMPORTANT

When you fill out the application for the new Policy, be sure to answer truthfully and completely all questions about your medical and health history. American Family Life Assurance Company of Columbus may cancel your Policy and refuse to pay any claims if you leave out or falsify important medical information.

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

Please refer to your Policy for details.

PLAN A

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,184	$0	$1,184 (Part A deductible)
61st thru 90th day	All but $296 a day	$296 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $592 a day	$592 a day	$0
— Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare-eligible expenses	$0**
—Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $148 a day	$0	Up to $148 a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited co-payment/ coinsurance for out-patient drugs and inpatient respite care	Medicare copayment/coinsurance	$0

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN A

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed $147 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $147 of Medicare Approved Amounts*	$0	$0	$147 (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $147 of Medicare Approved Amounts*	$0	$0	$147 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE			
MEDICARE APPROVED SERVICES			
— Medically necessary skilled care services and medical supplies	100%	$0	$0
— Durable medical equipment			
First $147 of Medicare Approved Amounts*	$0	$0	$147 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

PLAN C

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,184	$1,184 (Part A deductible)	$0
61st thru 90th day	All but $296 a day	$296 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $592 a day	$592 a day	$0
— Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare-eligible expenses	$0**
—Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $148 a day	Up to $148 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited co-payment/ coinsurance for out-patient drugs and inpatient respite care	Medicare co-payment/coinsurance	$0

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN C
MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed $147 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $147 of Medicare Approved Amounts*	$0	$147 (Part B deductible)	$0
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $147 of Medicare Approved Amounts*	$0	$147 (Part B deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES			
— Medically necessary skilled care services and medical supplies	100%	$0	$0
— Durable medical equipment			
First $147 of Medicare Approved Amounts*	$0	$147 (Part B deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000.	20% and amounts over the $50,000 lifetime maximum.

PLAN D

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,184	$1,184 (Part A deductible)	$0
61st thru 90th day	All but $296 a day	$296 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $592 a day	$592 a day	$0
— Once lifetime reserve days are used:			
Additional 365 days	$0	100% of Medicare-eligible expenses	$0**
— Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $148 a day	Up to $148 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited co-payment/ coinsurance for out-patient drugs and inpatient respite care	Medicare co-payment/coinsurance	$0

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN D

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed $147 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $147 of Medicare Approved Amounts*	$0	$0	$147 (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $147 of Medicare Approved Amounts*	$0	$0	$147 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

(continued)

PLAN D

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES — Medically necessary skilled care services and medical supplies — Durable medical equipment First $147 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 100% $0 80%	 $0 $0 20%	 $0 $147 (Part B deductible) $0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First $250 each calendar year Remainder of charges	 $0 $0	 $0 80% to a lifetime maximum benefit of $50,000.	 $250 20% and amounts over the $50,000 lifetime maximum.

PLAN F

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,184	$1,184 (Part A deductible)	$0
61st thru 90th day	All but $296 a day	$296 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $592 a day	$592 a day	$0
— Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare-eligible expenses	$0**
— Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $148 a day	Up to $148 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited co-payment/ coinsurance for outpatient drugs and inpatient respite care	Medicare co-payment/coinsurance	$0

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN F

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed $147 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $147 of Medicare Approved Amounts*	$0	$147 (Part B deductible)	$0
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $147 of Medicare Approved amounts*	$0	$147 (Part B deductible)	$0
Remainder of Medicare Approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

(continued)

PLAN F

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES — Medically necessary skilled care services and medical supplies — Durable medical equipment First $147 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 100% $0 80%	 $0 $147 (Part B deductible) 20%	 $0 $0 $0

OTHER SERVICES – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First $250 each calendar year Remainder of charges	 $0 $0	 $0 80% to a lifetime maximum benefit of $50,000	 $250 20% and amounts over the $50,000 lifetime maximum

PLAN G

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,184	$1,184 (Part A deductible)	$0
61st thru 90th day	All but $296 a day	$296 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $592 a day	$592 a day	$0
— Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare-eligible expenses	$0**
— Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $148 a day	Up to $148 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited co-payment/ coinsurance for out-patient drugs and inpatient respite care	Medicare co-payment/coinsurance	$0

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN G

MEDICARE (PART B) – MEDICAL SERVICES-PER – CALENDAR YEAR

*Once you have been billed $147 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $147 of Medicare Approved Amounts*	$0	$0	$147 (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $147 of Medicare Approved Amounts*	$0	$0	$147 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

(continued)

PLAN G

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES — Medically necessary skilled care services and medical supplies	100%	$0	$0
— Durable medical equipment First $147 of Medicare Approved Amounts*	$0	$0	$147 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000.	20% and amounts over the $50,000 lifetime maximum

PLAN N

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,184	$1,184 (Part A deductible)	$0
61st thru 90th day	All but $296 a day	$296 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $592 a day	$592 a day	$0
— Once lifetime reserve days are used:			
— Additional 365 days	$0	100% of Medicare-eligible expenses	$0**
— Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $148 a day	Up to $148 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited co-payment/ coinsurance for outpatient drugs and inpatient respite care	Medicare co-payment/coinsurance	$0

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN N

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed $147 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $147 of Medicare Approved Amounts*	$0	$0	$147 (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Balance, other than up to $20 per office visit and up to $50 per emergency room visit. The co-payment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	Up to $20 per office visit and up to $50 per emergency room visit. The co-payment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $147 of Medicare Approved Amounts*	$0	$0	$147 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

(continued)

PLAN N

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES — Medically necessary skilled care services and medical supplies — Durable medical equipment First $147 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 100% $0 80%	 $0 $0 20%	 $0 $147 (Part B deductible) $0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First $250 each calendar year Remainder of charges	 $0 $0	 $0 80% to a lifetime maximum benefit of $50,000.	 $250 20% and amounts over the $50,000 lifetime maximum.

Agent Tip Sheet:

Completing and Submitting Medicare Supplement Applications

1. For all underwritten applications, please include signed copies of the following forms found in this packet:

    a. Application for Medicare Supplement Insurance
    b. Authorization to Obtain Information Form
    c. Authorization to Disclose Information Form
    d. Notice of Information Practices (if applicable)

2. When faxing in applications, please include the information listed below on your fax cover sheet (sample cover sheet provided on the reverse side of this page). This information is critical to allow the underwriting team to contact you if there is a problem with your fax transmission or the application.

    a. Your name & writing number
    b. Your contact phone number
    c. The number you are faxing from
    d. Your email address
    e. The number of pages that you are faxing
    f. The name(s) of the proposed insured(s)

3. In some states, the tobacco question is found in “Section D. Health Questions” on the application. Please complete that question regardless of whether the application is underwritten or not. A “yes” answer will only be used to determine the rate.

4. On page 7 (in most states) of the application, please note you must do one of the following in the “Protection Against Unintended Lapse (Optional)” section:

    a. If the applicant wants the optional notice of cancellation, complete the requested information for the person to receive the notice, but DO NOT have the applicant sign at the bottom.
    b. If the applicant does not want to designate someone to receive the optional notice, then have the applicant sign where requested.

    NOTE: Applications that have name and contact information listed AND a signature or have neither will pend for clarification of the applicant’s intent.

FAX TO: 1.888.312.1974

Direct Fax System
Application Transmission Sheet

NOTE: USE ONLY FOR BANK DRAFT MODE POLICIES.

DO NOT SUBMIT A CHECK FOR PAYMENT WITH THIS APPLICATION.

☐ **Check here if this is an addendum to your original fax. Total addendum pages faxed:**

Fax to: New Business **Total pages:**

Agent Name: **Agent Writing #:**
(Please Print)

Agent Phone #: **Agent Fax:** **Agent Email:**

Name(s) of Proposed Insured(s):

POLICY TYPE: ☐ Medicare Supplement

SIGNED FORMS INCLUDED WITH THIS FAX:

☐ Application for Medicare Supplement Insurance
☐ Authorization to Obtain Information *(required for all underwritten business)*
☐ Authorization to Disclose Information *(required for all underwritten business)*
☐ Notice to Applicant Regarding Replacement *(if applicable)*
☐ Pre-Authorization Form *(include copy of a voided check)*

SPECIAL FORMS:

☐ State-required specified form:
☐ State-required specified form:
☐ Notice of Information Practices
☐ Other:

PLEASE FAX IN THE FOLLOWING ORDER:

1. Application Transmission Sheet
2. Pre-Authorization Form and copy of the voided check
3. Application for Medicare Supplement Insurance
4. Notice to Applicant Regarding Replacement *(if applicable)*
5. All other documents, as required

I have notified the client that the initial premium will draft immediately upon approval of the policy.

X _____ _____

Agent Signature Date

USE CHART BELOW TO INDICATE ANY COMMISSION SPLITS ON THIS BUSINESS	
Producer Name	**Percent (in increments of 10%)**

Please keep all faxed paperwork until the policy has been received, at which time it can be destroyed. Do not forward or mail paperwork to home office. We will contact you if there is a problem with your transmission. Product availability varies by state.

Application for Medicare Supplement Insurance (A19MS Series)
Application to: American Family Life Assurance Company of Columbus
(herein referred to as Aflac)
Worldwide Headquarters • Columbus, Georgia 31999
Administration: P.O. Box 13547
Pensacola, Fl 32591

SECTION A. PROPOSED INSURED INFORMATION

Applicant Name *(exactly as it appears on your Medicare card)*	Male ☐ Female ☐
Street Address	City, State, ZIP Code
Mailing Address *(if different from street address)*	City, State, ZIP Code
Phone *(with area code)*	Email Address *(optional)*
Date of Birth *(mm/dd/yyyy)*	Current Age
Medicare Card No.	Social Security No.
Height (*feet and inches)*	Weight *(pounds)*

SECTION B. PLAN AND PREMIUM INFORMATION

You may be eligible for a policy with a lower premium rate based on your answer to the following questions:

Household does not include any type of licensed facility that provides care.

Does a member of your household with whom you have continuously resided for the last 12 months have an existing Medicare supplement policy with Aflac? Yes ☐ No ☐

Or

Is a member of your household with whom you have continuously resided for the last 12 months applying for a Medicare supplement policy with Aflac? Yes ☐ No ☐

If you answered "yes" to either question above, please provide the following information for that household member:

Name *(exactly as it appears on Medicare card)*

Medicare Card No.

Aflac Policy Number, if applicable

Plan – *(You Are Currently Applying For)*	Requested Policy Effective Date
Premium $	Policy Fee $
Premium Collected $	Payment Method: Bank Draft ☐ Direct Bill ☐

Payment Mode: Monthly ☐ *(Bank Draft ONLY)* Annual ☐ Semiannual ☐ Quarterly ☐

SECTION C. PLEASE ANSWER ALL ELIGIBILITY QUESTIONS

1. Have you used tobacco in any form in the past 12 months? Yes ☐ No ☐
2. Are you covered under Medicare Part A? Yes ☐ No ☐
   If yes, what is your Part A effective date? / /
   If no, what is your eligibility date? / /
3. Are you covered under Medicare Part B? Yes ☐ No ☐
   If yes, what is your Part B effective date? / /
   If no, what is your eligibility date? / /
4. Are you applying during a guaranteed-issue period? (If yes, please attach proof of eligibility.) Yes ☐ No ☐
5. If you are currently on Medicare Disability, are you eligible for Medicare due to disability or end-stage renal disease (ESRD)? Yes ☐ No ☐

   IF yes, please check the box that applies. ☐ Disability ☐ End-Stage Renal Disease (ESRD)

SECTION D. HEALTH QUESTIONS

If applying during open enrollment or a guaranteed-issue period, go to **SECTION F**.

If not, **PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS**. If you answer yes to any of the following Questions 1–7, you are not eligible for coverage.

1. Are you currently hospitalized, confined to a nursing facility, receiving the services of a home health agency, bedridden, or do you require the use of a wheel chair or motorized mobility aid? Yes ☐ No ☐
2. Are you now receiving, or in the last ten years have you received medical advice or treatment for, been advised to have treatment or surgery for, or taken medication for any of the following conditions:
   A. Emphysema, chronic obstructive pulmonary disease (COPD), sarcoidosis, scleroderma, chronic pulmonary disorders, or any chronic pulmonary disease requiring the use of oxygen? Yes ☐ No ☐
   B. Parkinson's disease, systemic lupus, myasthenia gravis, multiple or lateral sclerosis, osteoporosis with fractures, cirrhosis, hepatitis C, or kidney disease? Yes ☐ No ☐
   C. Alzheimer’s disease, senile dementia, or any other cognitive disorder? Yes ☐ No ☐
   D. Acquired immune deficiency syndrome (AIDS) or AIDS-related complex (ARC)? Yes ☐ No ☐
   E. Diabetes with peripheral vascular disease, neuropathy, any type heart condition, kidney disease, retinopathy, or high blood pressure? Yes ☐ No ☐
3. Are you now receiving, or in the last three years have you received medical advice or treatment for, been advised to have treatment or surgery for, or taken medication for any of the following conditions:
   A. Cancer, leukemia, malignant melanoma, Hodgkin's disease, or lymphoma? Yes ☐ No ☐
   B. Ulcerative colitis or Crohn’s disease? Yes ☐ No ☐
   C. Alcoholism or drug abuse? Yes ☐ No ☐

D. Joint replacement? Yes ☐ No ☐

E. Heart attack, heart disease, coronary artery disease, cardiomyopathy, enlarged heart, stroke, transient ischemic attacks (TIA)? Yes ☐ No ☐

F. Congestive heart failure, peripheral vascular disease, heart valve disease, carotid artery disease (not including high blood pressure), heart rhythm disorders? Yes ☐ No ☐

G. Any amputation caused by disease? Yes ☐ No ☐

H. Degenerative bone disease, or rheumatoid or disabling arthritis? Yes ☐ No ☐

I. Major depression, bi-polar disorder, schizophrenia, a paranoid disorder, or any other mental or nervous disorder requiring psychiatric care? Yes ☐ No ☐

J. Diabetes treated with insulin or other injectables? Yes ☐ No ☐

4. Have you been advised by a physician that surgery may be required within 12 months for cataracts? Yes ☐ No ☐

5. In the last three years, have you been advised by a physician to have surgery, medical tests, treatment, or therapy that has not been performed? Yes ☐ No ☐

6. In the last two years, have you been hospitalized three or more times, received home health care three or more times, or been confined to a nursing facility for more than 30 days? Yes ☐ No ☐

7. Within the last ten years, have you had an organ transplant or been advised by a physician to have an organ transplant? Yes ☐ No ☐

SECTION E. MEDICATION HISTORY

Are you taking or have you taken any prescription or over-the-counter medications within the past 12 months? Yes ☐ No ☐
If YES, please list the drug(s) and the condition(s) below. Attach a separate sheet if needed.

Medication Name (copy from pharmacy label)	
Date **Originally** Prescribed	
Dosage and Frequency	
Diagnosis/Condition	
Medication Name (copy from pharmacy label)	
Date **Originally** Prescribed	
Dosage and Frequency	
Diagnosis/Condition	
Medication Name (copy from pharmacy label)	
Date **Originally** Prescribed	
Dosage and Frequency	
Diagnosis/Condition	

Medication Name (copy from pharmacy label)	
Date **Originally** Prescribed	
Dosage and Frequency	
Diagnosis/Condition	

SECTION F. FOR YOUR PROTECTION, the National Association of Insurance Commissioners requires that we ask the following questions about insurance policies or certificates you may have.

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you are eligible for guaranteed issue of a Medicare supplement insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare supplement plans. Please include a copy of the notice from your previous insurer with your application.
PLEASE ANSWER ALL QUESTIONS.

To the Best of Your Knowledge:

1. (a) Did you turn age 65 in the last six months? Yes ☐ No ☐

   (b) Did you enroll in Medicare Part B in the last six months? Yes ☐ No ☐

   (c) If yes, indicate your effective date. / /

2. Are you covered for medical assistance through the state Medicaid program? Yes ☐ No ☐

   (NOTE TO APPLICANT: If you are participating in a spend-down program and have not met your share of cost, please answer no to the above question.)
   If yes, answer (a) and (b) below.

   (a) Will Medicaid pay your premiums for this Medicare supplement policy? Yes ☐ No ☐

   (b) Do you receive any benefits from Medicaid OTHER THAN payment toward your Medicare Part B premium? Yes ☐ No ☐

3. Have you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO)? Yes ☐ No ☐

   If yes, answer (a)–(g) below.

   (a) Name of Company _____

   Plan Type & Policy/Certificate No. _____

   Company Telephone No. _____

   Coverage Dates: START DATE / /

   (If you are still covered under this plan, leave end date blank.) END DATE / /

   (b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy? Yes ☐ No ☐

   If yes, have you received a copy of the replacement notice? Yes ☐ No ☐

   (c) Reason for termination/disenrollment: _____

   (d) Planned date of termination/disenrollment: / /

   (e) Was this your first time participating in this type of Medicare plan? Yes ☐ No ☐

   (f) Did you drop a Medicare supplement or Medicare select policy/certificate to enroll in this Medicare plan? Yes ☐ No ☐

   (g) Is your former Medicare supplement or Medicare select policy/certificate still available? Yes ☐ No ☐

4. Do you have another Medicare supplement or Medicare select insurance policy in force? Yes ☐ No ☐

   If yes, answer (a)–(d) below.

(a) Name of Company

Plan Type & Policy/Certificate No.

Company Telephone No.

Issue Date / /

(b) Do you intend to replace your current Medicare supplement or Medicare select policy/certificate with this policy? Yes ☐ No ☐

(c) Indicate termination date. / /

(d) Have you received a copy of the replacement notice? Yes ☐ No ☐

5. Have you had coverage under any other health insurance within the past 63 days? (for example, an employer, union, or individual non-Medicare supplement plan) Yes ☐ No ☐

If yes, answer (a)–(c) below.

(a) Name of Company

Plan Type & Policy/Certificate No.

Company Telephone No.

Coverage Dates: START DATE / /

(If you are still covered under this plan, leave end date blank.) END DATE / /

(b) Reason for termination or disenrollment:

(c) Planned date of termination/disenrollment: / /

Do you or your spouse have other coverage with Aflac? Yes ☐ No ☐

This section to be completed only by an agent, if applicable.

Agents will list any other health insurance policies they have sold to the applicant.

1. List policies sold that are still in force.

Name of Company

Policy/Certificate Number

Description of Benefits

Effective Date of Coverage

Name of Company

Policy/Certificate Number

Description of Benefits

Effective Date of Coverage

Name of Company

Policy/Certificate Number

Description of Benefits

Effective Date of Coverage

2. List policies sold in the past five years that are no longer in force.
Name of Company
Policy/Certificate Number
Description of Benefits
Effective Date of Coverage
Name of Company
Policy/Certificate Number
Description of Benefits
Effective Date of Coverage
Name of Company
Policy/Certificate Number
Description of Benefits
Effective Date of Coverage

IMPORTANT STATEMENTS TO BE READ BY APPLICANT

- You do not need more than one Medicare supplement policy.
- If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
- You may be eligible for benefits under Medicaid and may not need a Medicare supplement insurance policy.
- If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement insurance policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstated, if requested, within 90 days of losing Medicaid eligibility. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of suspension.
- If you are eligible for, and have enrolled in, a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstated, if requested, within 90 days of losing your employer or union-based group health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of suspension.
- Counseling services may be available in your state to provide advice concerning your purchase of a Medicare supplement insurance policy and concerning medical assistance through the state Medicaid program, including benefits as a qualified Medicare beneficiary (QMB) and a specified low-income Medicare beneficiary (SLMB).

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.

I request that a copy of my application, outline of coverage and premium rate be provided to my advisor (lawyer, financial consultant or my closest relative, etc.). (If you do not wish to name an advisor, so state on the lines below):

Last Name	First Name	MI	( ) Phone

Street/P.O. Box	City	State	ZIP Code

Protection Against Unintended Lapse (Optional)

I request that a notice of cancellation for nonpayment of premium be provided to the person designated below.

Last Name	First Name	MI

Street/P.O. Box

City	State	ZIP Code

I understand that I have the right to designate at least one (1) person other than myself to receive notice of lapse or termination of this Medicare supplement insurance policy for nonpayment of premium. I understand that notice will not be given until 30 days after a premium is due and unpaid. I elect NOT to designate any person to receive this notice.

Proposed Insured's Signature: X _____ Date _____

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit, or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

I wish to apply for a Medicare supplement insurance policy. I acknowledge that I have received or been given access to review or print: (a) an outline of coverage for the policy applied for, and (b) a *Guide to Health Insurance for People with Medicare*.

Signed at: _____ _____ _____

State Applicant's Signature Date

Signed at: _____ _____ _____

State Agent's Signature and Writing Number Date

MAKE CHECK OR MONEY ORDER PAYABLE TO AFLAC.
FOR INFORMATION, CALL TOLL-FREE 1.855.207.2078.
VISIT OUR WEB SITE AT AFLAC.COM.

AUTHORIZATION TO OBTAIN INFORMATION

MAIL TO: **American Family Life Assurance Company of Columbus**
P.O. Box 13547
Pensacola, FL 32591-3547

I authorize the following to give information (as defined below) to American Family Life Assurance Company of Columbus, American Family Life Assurance Company of New York, and Continental American Insurance Company (collectively, "Aflac"): 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" includes 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 are required as part of the underwriting process in order to determine eligibility for insurance or to evaluate a claim for benefits during the time this authorization is valid.

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, 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 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 the policy itself. My revocation must be submitted in writing to Aflac, Policyholder Services, P.O. Box 1553, Pensacola, FL 32591-1553.

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 date this authorization is signed.

I agree that a copy of this authorization is as valid as the original and that I or an authorized representative may request a copy of this authorization.

Form A90063R13

AUTHORIZATION TO DISCLOSE INFORMATION

MAIL TO: **American Family Life Assurance Company of Columbus**
P.O. Box 13547
Pensacola, FL 32591-3547

I authorize American Family Life Assurance Company of Columbus, American Family Life Assurance Company of New York, and Continental American Insurance Company (collectively, "Aflac") to make a brief report of my personal health information to MIB, Inc. (formerly known as the Medical Information Bureau).

I understand that this information will be used by MIB, Inc. for the purpose of assisting the insurance industry in the accurate underwriting of insurance products as well as assisting the insurance industry in facilitating the fair pricing of insurance products through more accurate risk assessment.

"Information" includes information in Aflac's possession relating to my physical or mental health or condition (excluding psychotherapy notes, but including, for example, medical diagnosis/treatment information related to underwriting), and nonmedical financial information (including, for example, policy status).

I understand that any disclosure of health information to MIB, Inc. 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 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 Aflac has taken action in reliance on this authorization. My revocation must be submitted in writing to Aflac, Policyholder Services, P.O. Box 1553, Pensacola, FL 32591-1553.

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 date this authorization is signed.

I agree that a copy of this authorization is as valid as the original and that I or an authorized representative may request a copy of this authorization.

Printed Name of Individual Subject to Disclosure	Date of Birth of Individual Subject to Disclosure
Signature	Date

If this authorization has been signed by a personal representative on behalf of an individual, his/her authority to act on behalf of the individual must be set forth here:

Printed Name of Legal/Personal Representative	Legal Relationship *(e.g. Power of Attorney)*

Form A90078R13

NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE OR MEDICARE ADVANTAGE

AMERICAN FAMILY LIFE ASSURANCE COMPANY OF COLUMBUS
(herein referred to as Aflac)
WORLDWIDE HEADQUARTERS
Columbus, GA 31999

Aflac Medicare Supplement Administrative Office:
PO Box 13547 Pensacola, Fl 32591

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE

According to your application, you intend to terminate existing Medicare supplement or Medicare Advantage insurance and replace it with a policy to be issued by Aflac. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of this Medicare supplement coverage is a wise decision, you should terminate your present Medicare supplement or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

STATEMENT TO APPLICANT BY AGENT:

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare supplement policy will not duplicate your existing Medicare supplement or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare supplement coverage or leave your Medicare Advantage plan. The replacement policy is being purchased for the following reason (check one):

_____ Additional benefits.

_____ No change in benefits, but lower premiums.

_____ Fewer benefits and lower premiums.

_____ Change in benefits. **(Gaining additional benefit(s) but losing some existing benefit(s)).**

_____ My plan has outpatient drug coverage and I am enrolling in Part D.

_____ Disenrollment from a Medicare Advantage plan. Please explain reason for disenrollment.

_____

_____ Other (please specify) _____

If, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

_____
Signature of Agent, Broker or Other Representative

_____
Name and Address of Agent

The above “Notice to Applicant” was delivered to me on:

_____ _____
Applicant’s Signature Date

NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE OR MEDICARE ADVANTAGE

AMERICAN FAMILY LIFE ASSURANCE COMPANY OF COLUMBUS
(herein referred to as Aflac)
WORLDWIDE HEADQUARTERS
Columbus, GA 31999

Aflac Medicare Supplement Administrative Office:
PO Box 13547 Pensacola, Fl 32591

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE

According to your application, you intend to terminate existing Medicare supplement or Medicare Advantage insurance and replace it with a policy to be issued by Aflac. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of this Medicare supplement coverage is a wise decision, you should terminate your present Medicare supplement or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

STATEMENT TO APPLICANT BY AGENT:

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare supplement policy will not duplicate your existing Medicare supplement or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare supplement coverage or leave your Medicare Advantage plan. The replacement policy is being purchased for the following reason (check one):

_____ Additional benefits.

_____ No change in benefits, but lower premiums.

_____ Fewer benefits and lower premiums.

_____ Change in benefits. **(Gaining additional benefit(s) but losing some existing benefit(s)).**

_____ My plan has outpatient drug coverage and I am enrolling in Part D.

_____ Disenrollment from a Medicare Advantage plan. Please explain reason for disenrollment.

_____

_____ Other (please specify) _____

If, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

_____
Signature of Agent, Broker or Other Representative

_____
Name and Address of Agent

The above “Notice to Applicant” was delivered to me on:

_____ _____
Applicant’s Signature Date

American Family Life Assurance Company of Columbus (Aflac)
Worldwide Headquarters

NOTICE OF INFORMATION PRACTICES

Thank you for your application. As part of our normal underwriting procedure, we need to obtain information to determine a proposed insured's eligibility for insurance. Much of that information will come from you; however, we often obtain additional information or verify information through other sources.

COLLECTION

Your application, including the medical questionnaire and any exams, is our main source of information. However, we may need to obtain additional information from other sources about your age, physical condition, occupation, other insurance coverage, health history, financial history, avocations, general reputation and lifestyle.

We may obtain this information from:

- physicians, hospitals, clinics, or other medical professionals or medical care facilities
- the MIB, Inc. as described in this notice or other insurance support organizations
- consumer reporting agencies as described below
- other insurance companies and our reinsurance companies
- employers

We may collect information:

- in person
- by telephone
- by exchanges of correspondence

DISCLOSURES

We will not disclose to others the information that we obtain about you without your prior authorization except as necessary to conduct our business (and then only if disclosure is permitted by law). Most disclosures made by us are to identify you for collection of information, for reinsurance or other services, or to help detect or prevent fraud and misrepresentation.

ACCESS TO INFORMATION

You have the right to access recorded personal information about you that is in our files and we can locate within reason. To ensure the security of information in our files, we will require positive identification before we allow access to that information. To obtain a copy of our information concerning you, send a signed, written request to the address at the end of this notice. Give your full name, address, telephone number, and policy number if a policy has been issued, or if the policy has not been issued, give the application date. Within 30 business days after we receive your request, we will inform you of the recorded personal information that we can locate and retrieve in our files. We will also tell you to whom we have disclosed this information within the last two years. If you wish, we can show you the information at our headquarters, or we will mail copies to you. However, we reserve the right to disclose medical information only through a medical professional of your choice. You may have to pay a reasonable charge to cover the cost of the copies.

ADVERSE UNDERWRITING DECISIONS

If you are refused insurance or if your application for insurance is postponed, you have the right to contact us about this decision within 90 business days from the date of the mailing of the notice or other communication of an adverse underwriting decision. Within 21 business days after we receive your request, we will notify you about the information that we can locate and retrieve in our files. We will also tell you to whom we have disclosed this information within the last two years. If you wish, we can show you the information at our headquarters, or we will mail copies to you. However, we reserve the right to disclose medical information only through a medical professional of your choice.

I hereby certify I have provided the applicant with the Notice of Information Practices.

_____ _____

Associate's signature Date

I, the undersigned, hereby acknowledge I have received and read the above Notice of Information Practices.

_____ _____

Applicant's signature Date

If, after receiving this information, you believe that it is not completely accurate, you also have the right to request that we correct, amend or delete any portion of this information. Within 30 business days from the date we receive your written request, we will either correct, amend or delete the portion of the recorded personal information in dispute, or we will notify you in writing of the reasons for refusal and your right to file a statement if you disagree. If you disagree, you will be permitted to file a concise statement showing what you think is correct, relevant, or fair information and the reasons why you disagree with the refusal to correct, amend, or delete recorded personal information. Your statement will be filed with the disputed recorded personal information. We will give your statement of disagreement to anyone we have given the information to within the preceding two years and to anyone we give it to in the future. If we correct, amend, or delete any recorded personal information, we will notify you in writing and furnish the correction, amendment, or deletion to any person designated by you who, within the preceding two years, may have received the recorded personal information.

MEDICAL INFORMATION BUREAU

We may make a brief report to the MIB, Inc., formerly known as Medical Information Bureau, an organization of similar insurance companies that operates an information exchange. Upon request by another insurance company to which you have applied for life or health insurance or submitted a claim, the MIB will supply the information in their files.

We, or our reinsurers, may also release information to other insurance companies to which you may submit a claim or apply to for life or health insurance. Upon a request from you, the MIB will disclose any information in your file (medical information will be given only to your attending physician). If the information is inaccurate, you may contact the MIB for a correction as set forth in the Federal Fair Credit Reporting Act. The address of the MIB's Information Office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734; Telephone Number, 866-692-6901 (TTY 866-346-3642). Information for consumers about MIB may be obtained on its website at www.mib.com.

INVESTIGATIVE CONSUMER REPORT

In processing your application, we may make an investigative consumer report as to your insurability, including information as to character, general reputation, personal characteristics and mode of living. This information will be obtained through personal interviews with your friends, neighbors or others with whom you are acquainted. We will furnish you additional information about the report upon your written request. Write to the designated address within a reasonable time after you receive this notice. Within five business days of your request, we will give you the name, address and telephone number of the consumer reporting agency from which we requested the report.

You can ask that the consumer reporting agency interview you by so stating on the authorization form.

A consumer reporting agency may collect information and submit a report to us. That agency may keep the report on file and disclose its contents to others who request its services.

You may receive a copy of the report from the consumer reporting agency if you request it and give proper identification.

ADDITIONAL INFORMATION

We hope this information helps you understand how and why we obtain information about you and how we use the information. However, if you have any other questions about our information practices, send them to:

American Family Life Assurance Company of Columbus (Aflac)

Worldwide Headquarters

Columbus, Georgia 31999

1.800.99.AFLAC (1.800.992.3522)

American Family Life Assurance Company of Columbus (Aflac)
Worldwide Headquarters

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Worldwide Headquarters

Columbus, Georgia 31999

1.800.99.AFLAC (1.800.992.3522)

NAME OF INSURED (Please Print)

_____

☐ Check here when reporting a change and provide Policy Number:

PRE-AUTHORIZATION FORM

To Honor Drafts or Electronic Debits

As a convenience to me, I hereby request and authorize you to pay and charge my bank checking or savings account drafts or electronic debits drawn by and payable to the order of the Insurance Company provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights in respect to each draft or debit shall be the same as if it were a draft on you and signed personally by me. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice I agree that you shall be fully protected in honoring any such draft or debit. I further agree that if any such draft or debit be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

_____ Date

_____ Bank Account Number ☐ Checking ☐ Savings

_____ Bank Name (Please Print)

_____ Bank Routing Number

_____ Street Address or P.O. Box

_____ Depositor's Name as it appears on Bank Records

☐ Withdraw on the premium due date of my policy

☐ Withdraw on the following date*: _____

_____ Policyholder's/Applicant's Signature

_____ Date

SUBMIT THIS FORM AND A VOIDED CHECK TO THE HOME OFFICE

*You may select any draft date from the 1st through the 28th of the month, even though the policy due date might be the first of the month. However, if the requested draft date is more than 15 days after the due date, we will draft the month prior. (Note: This does not apply to the initial premium in the case where an application is submitted without premium. In that case, the initial premium is drafted on the approval date, and subsequent premiums are drafted on the requested date.)

RETURN TO COMPANY

Aflac®

RECEIPT

Received of

_____

this _____ day of _____ the sum of

$_____ being the payment of

_____ Premium.

The insurance applied for shall not take effect until the effective date of the policy and the payment of the first premium. In the event the application is declined, any payments made by the Applicant will be returned.

_____

AGENT'S SIGNATURE

Make checks payable to Aflac.
Do not make payable to agent or leave payee blank.

Underwritten by:

Aflac®

American Family Life Assurance Company of Columbus

aflac.com

We've got you under our wing.®

aflac.com | 1.855.207.2078

This brochure is for illustrative purposes only and is not a contract. Consult the policy for a complete description of benefits, definitions, limitations, and exclusions.

Underwritten by:
American Family Life Assurance Company of Columbus
Worldwide Headquarters | 1932 Wynnton Road | Columbus, Georgia 31999