

Nonpayroll

DENTAL INSURANCE POLICY (A81000 Series)

- Conversion
New

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

Policy Number:

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 One-Parent Family, 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 Dental Provider (optional):

Name of Employer/Association:

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

Table with 4 columns: Check Coverage Desired, Individual, One-Parent Family, Two-Parent Family, Named Insured and Spouse Only.

- Basic Policy (Series A81100) \$25 Dental Wellness
Standard Policy (Series A81200) \$50 Dental Wellness
Premier Policy (Series A81300) \$50 Dental Wellness

TO BE COMPLETED BY AFLAC AGENT

Billing Method: Direct, Bank Draft (B/D, ACH), Credit Card (C/C)
Modes: 01 Monthly (B/D & C/C Only), 03 Quarterly, 06 Semiannual, 12 Annual

Card Name Card No.

Expiration Date

I authorize American Family Life Assurance Company of Columbus (AFLAC) to charge my VISA/MASTERCARD/AMERICAN EXPRESS account in accordance with the premium rate that I have chosen. Premiums will be advanced by my bank until I cancel authorization in writing to AFLAC. Cancellation will be effective on the first day of the month following AFLAC's receipt of notice to cancel.

Signature _____ Date _____

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

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

1. Have you or has anyone to be covered been diagnosed with or treated for any gum disease such as gingivitis within the last 24 months? Yes No

2. **If Question 1 is answered yes, was it the:**

Named Insured Spouse Child? If "Child," please list the name of the child(ren)

Any person(s) so designated will not be covered under the policy.

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 65 before the effective date of the policy.

