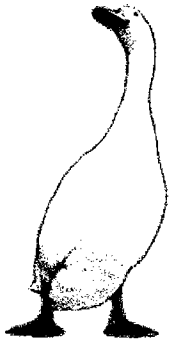
Trust a Proven Leader for Your Voluntary Benefits Program

Proposal for the City of Coral Gables, FL
RFQ#2009.04.14 Administrative Services/Cafeteria Plans



A proposal prepared especially for you by:
American Family Life Assurance Company of Columbus (Aflac)

Authorized By: Deborah B. Griffin

Deborah B. Griffin
Second Vice President
Sales Administration
Phone Number: 706.596.3982
E-Mail Address: CorporateBids@aflac.com

Local Contact: **Ronald Infantino**
Phone Number: 305.445.9958
E-Mail Address: ronald_infantino@us.aflac.com

The plans and services outlined in this proposal will be valid for a period of 90 days, subject to the availability of insurance policies currently being marketed.

CORAL GABLES, FL

City of Coral Gables, 2800 SW 72nd Avenue, Miami, FL 33155

FINANCE DEPARTMENT / PROCUREMENT DIVISION
Tel: 305-460-5121, Fax: 305-460-5116

Request for Quote (RFQ) No 2009.04.14

RFQ RESPONSE FORMS

SUBMITTED TO:

City of Coral Gables
Office of the Chief Procurement Officer
2800 SW 72 Avenue
Miami, Florida 33155

1. Acknowledgement is hereby made of the following Addenda, if any (identified by number) received since issuance of the Request for Quote:

Addendum No. 1 Date 5/14/09 Initials dbg

Addendum No. 2 Date 5/14/09 Initials dbg

Addendum No. 3 Date 5/14/09 Initials dbg

Addendum No. 4 Date 5/14/09 Initials dbg

No addendum was received _____ Date _____ Initials _____

2. Bidders name: Aflac

Address: 1932 Wynnton Road

City/State/Zip: Columbus, GA 31999

Telephone No./Fax No.: 706.596.3982/706.320.4659

Print and Sign Deborah B. Griffin Title: Second Vice President

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Executive Introduction

What We Are Offering the City of Coral Gables:

In addition to our Section 125 Flexible Spending Account and Aflac Now Card, offered at no direct cost to the City of Coral Gables, we are offering our short-term disability, cancer indemnity, Specified Health Event, hospital confinement indemnity, and accident indemnity plans and riders. Brochures* are available in Section Four of this proposal.

*NOTE: A policy has been provided in place of a brochure for our accident plan due to updated and improved benefits that only recently became available for Florida residents. Brochures with this updated information can be requested when available.

Value-Added Services:

We know you can use any of several insurance companies to provide benefits to your employees. But how many of the other companies will provide you with the benefits you need to make the administration painless? In addition to a local agent and toll-free access to our headquarters staff, we are providing, at no direct cost to the City of Coral Gables, the following value-added services: Core Benefits + Aflac, Online Services, Express Services and Employee Benefits Statements. See Section Three for information on these value-added services.

Major Medical May Not Be Enough

The cost of health care continues to rise and with it so does the cost of deductibles and copayments, which aren't covered under most major medical plans. Unfortunately, most employees look to their employers to understand and provide the types of benefits that they need.

Increase Your Benefits. Not Your Overhead.

Money. It, more than anything, determines what we're able to do in business. Finding a way to not only save money but also to simultaneously gain benefits may seem impossible.

But it can be done. Our plans are 100 percent employee paid, so there is no direct cost to your company. Aflac's tax-advantaged plan allows employees to use pre-tax dollars to pay for certain benefit costs through a Section 125 Cafeteria Plan.

And when you lower the taxable incomes of all participating employees, you may also reduce your overall share of FICA and FUTA taxes.

Rate Stability

With our rates, what you see is what you get. Our premiums aren't based on your employees' claims experience nor are the rates changed based on that experience. Our plans are only increased for an entire class of policies when the plan's experience warrants it. And when your employees leave or retire, they can continue their policies at the same payroll rate. So you can feel confident that what you agree to provide your employees today will be there for the long haul.

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Rate Guarantees

We guarantee the rates on our proposed plans for three years and agree to review for additional rate guarantees that we may be able to offer you in subsequent plan years.

Section 125 Cafeteria Plan Fees Waived

All fees traditionally associated with our Section 125 Cafeteria Plan have been waived for your account.

One Size Does Not Fit All

Selecting voluntary insurance is an important decision, but the one-size-fits-all approach is dead. Today's market provides customization in almost any arena. Customers expect plans that are specifically designed with them in mind, as an individual.

Factors like age, gender, marital status, and their medical history can dramatically affect how a person chooses their insurance. Group plans don't offer choice. They offer an average plan based on numbers.

We offer solutions for your employees. So, let them individually choose not only what type of coverage they need but also what level they can afford. And we'll take on the responsibility of helping them select coverage. That keeps it off of your shoulders and your employees happy.

Local Service

A resident of Coral Gables for the past 15 years, District Sales Coordinator, Ronald Infantino, will be the City's main contact locally. During his 26 years with Aflac, he has received the FAME Award for Management Excellence and also received the Top District Coordinator Distinction Company Wide award in 1980, 1991, 1993, 1994, 1997, and 2002. His degree in business administration and marketing, received from Florida International University, and his years of experience in the voluntary insurance industry, combine to provide the City with an advocate who is not only capable, but who will go the extra mile to provide excellent service.

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National Recognition

Throughout our history Aflac has been recognized by numerous outside sources including but not limited to the following:

- In February 2008, Aflac was named to *Fortune* magazine's list of the 100 Best Companies to Work For in America for the tenth consecutive year.
- In July 2008, *Black Enterprise* magazine named Aflac to its list of the 40 Best Companies for Diversity for the fourth consecutive year.
- In July 2008, Aflac was named one of the World's Most Ethical Companies by *Ethisphere* magazine.
- In March 2009, *Fortune* magazine named Aflac to its list of America's Most Admired Companies for the eighth consecutive year. Aflac was ranked as the No. 1 company in the life and health insurance category.
- In February 2007, Aflac was named to *Hispanic* magazine's list of the 100 companies providing the most opportunities to Hispanics. Aflac has appeared on the annual list since 1993.
- In September 2008, Aflac is on *Information Week's* twentieth annual list of the 500 most innovative users of corporate technology.
- Aflac was named to *Latina Style* magazine's list of the 50 best companies for Latinas to work for in the United States (August/September 2008). Aflac has been featured on this annual list for nine of its eleven years.

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Questionnaire

1. How long has your company been providing voluntary benefits?
   Aflac has been providing voluntary benefits for more than 50 years.

2. Do you provide your service to other public sector employers? Please specify.
   Yes. According to 2009 data, we currently service 15,856 active government payroll accounts, have more than one million government policies in force, and have 659,953 policyholders in government payroll accounts.

   Some of the public sector accounts near Coral Gables, currently serviced by District Sales Coordinator Ronald Infantino, include:
   - City of Ft. Lauderdale
   - City of Hialeah
   - City of Sweetwater
   - City of Hialeah Gardens

3. Please describe the security measures in place to ensure that confidential information collected is secure?
   As part of Aflac's HIPAA compliance project, our Information Technology Security Department has developed a survey tool that maps how protected health information flows in, around, and outside Aflac, and determines the employees who need access to protected health information to perform their jobs.

   We do not sell, rent, lease or otherwise disclose personal information of our customers for purposes unrelated to our plans and services. The personal information of our customers is of paramount importance to us. Therefore, we provide this information only to our employees, agents, and third parties as required to allow them to help us develop and provide our insurance and employee benefit plans and services.

   We expect our insurance agents and employees to respect the personal information of our customers. Aflac has business policies and practices in place to help ensure that our employees and agents carry out these practices and otherwise protect personal information about our customers. Both employees and agents are subject to censure, dismissal, or termination for violation of these policies.

   These Privacy Practices apply to our United States customers. Due to legal and cultural differences, our practices may vary outside the United States.

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4. Are rates/costs quoted guaranteed for a specific length of time? If so, please indicate.
   The City of Coral Gables has been approved for a three-year rate guarantee for the following plans:
   - Short-Term Disability
   - Cancer Indemnity (Levels 1 and 3)
   - Specified Health Event (Level 2)
   - Hospital Confinement Indemnity (Levels 1 and 3)
   - Accident Indemnity (Level 2)

   *Note: Although Aflac has approved a rate guarantee, we cannot guarantee the availability of the plans.

5. What rate guarantee do you provide after the initial period?
   After the initial rate-guarantee period of three years, we will review for additional rate guarantees annually.

6. Will you agree to negotiate changes in proposed benefits and/or premiums if the City should desire to do so?
   Yes.

7. Can the contract be cancelled midyear, by either the insurer or the insured, for any reason other than non-payment? If yes, please provide how much notice is required and if a penalty is charged.
   Due to possible tax ramifications, if the premium for an employee's policy is deducted on a pre-tax basis, he or she may not cancel his/her policy until the City of Coral Gables next open enrollment period unless he/she is a new hire. The employee must obtain written authorization from the City on your company letterhead to cancel the policy mid-plan year and then submit the cancellation request to Aflac for processing.

   If the premium for an employee's policy is deducted on an after-tax basis, he/she may cancel his/her policy at any time by submitting a written request to Aflac.

   Once a cancellation is complete in our system, the employee's policy(ies) will be removed from the City's payroll invoice so that you may cease payroll deductions.

   The City can cancel your Aflac program at any time by submitting a written request to Aflac.

8. Is a 90-day notice of termination by the City acceptable?
   Yes.

9. Are there minimum enrollment requirements for the plans being offered?
   There is no minimum participation requirement for our plan(s). We only ask that you establish an account with us by completing and signing a Payroll Account Acknowledgement form and allowing three separate W-2 employees to enroll in at least one of our plan(s).

10. Do you agree to insure all presently employed full-time employees whether at work, disabled, or otherwise?
    For coverage, all employees must meet Aflac's definition of actively-at-work as follows: "Employees at work on the date of insurance eligibility. Dates occurring on a vacation, holiday or weekend require they be at work on the last scheduled workday. Employees absent due to sickness or injury are ineligible until they return to work".

11. Please provide samples of the literature you will present to employees as part of the initial enrollment.
    See brochures in Section Four of this proposal.

12. Do you have the capabilities to provide enrollment materials in Spanish?
    Yes.

13. How many staff members will be assigned to assist the City of Coral Gables in Enrollment and Orientation meetings? Do they speak Spanish? Have public sector experience?
    Local District Sales Coordinator, Ronald Infantino, will be the key contact person and, within his staff, he has eight agents who will assist with the City of Coral Gables enrollment. All eight staff members are fluent in Spanish and have public sector experience. Additionally, a dedicated Account Relations Executive from Aflac Worldwide Headquarters will assist the City with three distinct phases of your Aflac experience as outlined below:

    - Prospective Phase - Includes consultative calls and account visits
    - Implementation Phase - Includes welcome communications, enrollment facilitation, and billing automation and payment reviews
    - Service Phase - Includes account audits and ongoing enrollment facilitation and billing automation

14. Will employees be able to access enrollment materials via the internet?
    Yes. We can create a Web specific enrollment site especially for your employees.

15. Where do employees with questions call? Is it a toll-free number?
    Voluntary Plans
    Employees with questions regarding their Aflac plans or to check on claims can call 1-800-992-3522 Monday through Friday from 8 a.m. to 8 p.m. Eastern Time. Employees may also contact our Interactive Voice Response (IVR) System, which is available 24 hours a day, 7 days a week at 1-800-992-3522.

Aflac provides a separate toll-free customer service line for our Spanish-speaking customers. Aflac's Spanish-speaking customers speak with a Spanish-speaking customer service representative at Aflac Worldwide Headquarters toll-free at 1-800-SI-AFLAC (1-800-742-3522) Monday through Friday from 8 a.m. to 6 p.m. Eastern Time. In addition, customers may obtain policy and claims information from our Spanish-speaking IVR (1-800-742-3522) 24 hours a day, 7 days a week.

Section 125 Flexible Spending Account and Aflac Now Card

Employees wanting to inquire about their Section 125 Flexible Spending Account or Aflac Now Card can call the Aflac Benefit Services Department at 1-800-323-5391 Monday through Friday from 8 a.m. to 7 p.m. Eastern Time. Employees can also call the IVR at 1-877-353-9487. This system is available 24 hours a day, 7 days a week. The IVR allows Flexible Spending Account participants to obtain reimbursement information, balance/election information, reimbursement request forms, or to talk to a customer service representative. An employer can use the IVR to request a nondiscrimination testing packet, plan year information (latest plan year), or talk to a customer service representative.

16. Please provide contact information for the company's regional office that would oversee our account. Preference will be given to proposers with local support staff and offices.
    Your local contact will be:
    Ronald Infantino
    P.O. Box 140127
    Coral Gables, FL 33114
    305.445.9958
    ronald_infantino@us.aflac.com

17. Describe how the enrollment will be organized and managed. Describe the resources necessary to accomplish the purpose of the benefits enrollment, including but not limited to local insurer support staff.
    We provide awareness and education materials to the City's employees before we come onsite. And we do this at no direct cost to the City. This further reduces the time it takes to apply because just like a movie-the preview helps people to decide what to spend their money on before they're even in the theater. We'll also talk directly with your employees at the office, answer their questions, and introduce them to the policies that best suit them. That shortens the experience and allows them to focus on only what they want.

    Along with your Aflac agent, your account will also have a dedicated Aflac Account Relations Executive who will work hand-in-hand with you throughout the implementation process to make sure that it is as seamless and efficient as possible for you and your employees.

18. Proposer shall submit as part of their Proposal a preliminary implementation plan. The plan should consist of sequential listing of all steps necessary to provide the requested services and who is responsible.

Section 125 Implementation Procedures

The following steps are recommended when establishing an Aflac Flex One program:

Step 1	The City of Coral Gables completes the Payroll Account Acknowledgement form with Aflac insurance agent, Ronald Infantino, and sends it to Aflac. The City reviews the sample plan documents and adopts them by signing the Employer's Acknowledgment. Sign the Reimbursement Services Agreement and send it to Aflac Benefit Services.
Step 2	**Two or three weeks before enrollment:** Provide payroll census for salary illustrations to your Aflac insurance agent and discuss any special billing or employee identification procedures as needed.
Step 3	**Two weeks before the enrollment:** Meet with your Aflac insurance agent to schedule Aflac's employee presentation.
Step 4	**Last payroll before the enrollment start date:** Provide payroll stuffers or an employer communication to all eligible employees (upon receipt from your Aflac insurance agent).
Step 5	Begin employee group presentations with your Aflac insurance agent.
Step 6	**One or two days following the group presentation:** Begin the Aflac consultations with individual employees who are enrolled if they desire coverage.
Step 7	Reconcile paperwork (deduction cards, election forms, etc.).
Step 8	**Three weeks before effective date:** Complete a final review of all documentation by the payroll or personnel departments.
Step 9	Complete and send any remaining plan documentation to Aflac Benefit Services.
Step 10	Complete the enrollment in **two or three weeks before the plan effective date**.

19. Does your program allow for on-line enrollment, changes and cancellation? Initial and future enrollees.
Our Web enrollment system is expanding the current plans available for online enrollment to include new plans that will be available soon in Florida.

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Aflac Benefit Services/Flex One Cafeteria Plan Program

A Section 125 Cafeteria Plan allows employees to choose from qualified benefits, providing tax savings to both the participating employees and to you, the sponsoring employer. The tax advantages of a cafeteria plan come from Internal Revenue Code Section 125, which was added to the Code by the Revenue Act of 1978.

Subject to the regulations under Section 125 of the Internal Revenue Code, an employee can choose to reduce his/her salary to purchase qualified benefits on a pre-tax basis. This purchase is also referred to as a *salary redirection.* Redirecting part of an employee's salary to a qualified benefit means that taxable income is calculated after the elected amounts are deducted from that employee's salary. No federal income tax, Social Security tax, or state tax (except New Jersey) is paid on the elected amounts. In Pennsylvania, participants pay state income tax on the dependent-care portion of a Flexible Spending Account, but not on other Section 125-qualified benefits.

Full Plans
The Flexible Spending Account services offered by Aflac are available through the Flex One program. Plans where employers include Flexible Spending Accounts as part of their cafeteria plans are known at Aflac as Full Plans.

Flexible Spending Accounts are individual employee accounts that allow employees to be reimbursed for certain eligible health care expenses and dependent day care expenses. Employees choose to contribute money on a pre-tax basis through payroll redirection—to a health care or dependent day care account (or both). When an eligible expense is incurred, the employee submits a written Request for Reimbursement form to Flex One and is then issued a payment from the Flexible Spending Account. For **qualified reimbursements**, the money is never taxable.

Dependent Day Care Reimbursement Flexible Spending Accounts allow the participant to pay for Dependent Day Care expenses for eligible children and/or other dependents (if the individuals receiving care are claimed as dependents for income tax purposes). These expenses must be incurred to allow the participant and spouse, if applicable, to work, unless the spouse is a full-time student or incapable of self-care.

Unreimbursed Medical Flexible Spending Accounts allow the participant to redirect a predetermined amount of money into an account to be used for unreimbursed medical expenses, such as:

- Deductibles and copayments
- Out-of-pocket expenses not covered by any insurance policy, such as birth control pills, braces, chiropractors, crutches, noncosmetic dental fees, eligible over-the-counter items and

prescription drugs, eyeglasses (including examination fees), insulin, routine physicals, wheelchairs, and X-rays, to name a few

IRS Code Section 125 contains very specific requirements for documentation and maintenance of the program. Failure to comply with all requirements could result in disqualification of the plan and revocation of favorable tax savings realized under the plan. While you are responsible for maintaining plan compliance with federal and state regulations, Aflac has made and continues to make every effort to develop and provide documentation and services necessary to satisfy the IRS requirements. Flex One provides the following services:

- **Sample Plan Documents** including the cafeteria plan document, the Summary Plan Description, and a template privacy notice. These materials were designed to meet the IRS Code Section 125 Cafeteria Plan requirements.

- **Salary Redirection Agreement** forms for employees to indicate or waive participation in the cafeteria plan.
- Individual and group enrollment sessions to help ensure **complete employee awareness.** Each employee must be notified of the benefits available before the effective date of the cafeteria plan.
- Upon employer request, Aflac provides **Nondiscrimination Testing Assistance** in performing cafeteria plan nondiscrimination testing initially and for each consecutive plan year. To provide assistance, Aflac requires the employer to sign a release statement in favor of Aflac because the service is provided as assistance and not as advice. Nondiscrimination testing assistance provides the employer with testing percentages to take to the employer's tax and/or legal advisor for interpretation. These percentages are intended to assist the employer in determining whether the plan is in compliance with three of the relevant cafeteria plan nondiscrimination tests required by the IRS. These tests are:

    - The cafeteria plan (25%) concentration test for key employees.
    - The dependent-care assistance plan average benefits (55%) test.
    - The dependent-care assistance plan concentration test for 5% owners.

    The employer, as plan sponsor, must also perform other applicable nondiscrimination tests (i.e., the eligibility, the contributions, and benefits tests for the cafeteria plan, and any other nondiscrimination tests applicable to the qualified benefits offered) and interpret the significance of the testing percentages provided, as required by the IRS.

- **Change in Status Forms** outline the election changes allowed by the IRS during the plan year and provide participants a way to submit qualified changes. The employer must stipulate in its plan documents if any allowable election changes will not be permitted during the plan year.

Some of the qualifying changes in status include the following: marriage, divorce, birth or adoption of a child, death of a spouse or dependent, a change in employment status or unpaid leave of absence for the employee or spouse that affects eligibility or coverage, and a significant change in the cost of coverage by a third-party provider. The election change(s) made by the employee must be consistent with and on account of the qualified change in status. Qualified changes are further clarified in the Summary Plan Description and in IRS Code Section 125.

- As long as an employer remains an active Aflac payroll account, the employer receives **Notification of Change in Laws** when changes affect the administration or design of the cafeteria plan program on a federal level. Notification generally includes sample revisions to plan documents, if necessary.

- The **Reimbursement Services Agreement** outlines Aflac Benefit Services' processing services. The Reimbursement Services Agreement is the agreement signed by the employer and by Aflac to allow Aflac to be the claims processing service provider for the employer's Flexible Spending Accounts.

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Overview of Aflac Benefit Services and Employer Responsibilities

The effective date of coverage will be July 1, 2009, unless another date is requested. Aflac provides general information about flexible compensation and cafeteria plans to help you decide whether to adopt such a program for your employees. In addition, Aflac supplies sample plan documents, provides informational and enrollment services for employees, and provides reimbursement processing services for Unreimbursed Medical and Dependent Day Care Flexible Spending Accounts. Aflac does not act as a plan administrator or a plan sponsor. Aflac is a plan service provider. You are the plan administrator and plan sponsor of the cafeteria plan.

Event	**Responsibility**
Prepare Sample Plan Document	Aflac Benefit Services
Provide awareness brochures, payroll stuffers, posters, and enrollment form	Aflac Benefit Services
Conduct Initial Enrollment	Aflac Benefit Services*
Update Payroll System	Employer
Maintain Funds (employee election amounts)	Employer
Deduct and Verify Elections	Employer
Provide Request for Reimbursement forms, and process and pay reimbursements (except for self-administered plans, employer groups that choose the self-pay claim funding option, and premium only plans)	Aflac Benefit Services
Provide Change in Status forms to Employer	Aflac Benefit Services
Conduct New Employee Enrollment	Aflac Benefit Services*
Conduct Annual Re-enrollment	Aflac Benefit Services*
Update Annual Payroll System	Employer

**Flex-Certified Aflac insurance agents provide these services, which are ultimately the employer's responsibility.*

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Communication and Enrollment Procedures

- **Certified Insurance Agents**

  All Aflac insurance agents must be certified before offering cafeteria plan services and/or Flexible Spending Accounts. Certification is awarded only after extensive classroom and field training. The basic level of certification teaches insurance agents how to establish premium only plans. After meeting certain qualifications and activity levels, Aflac agents participate in training for advanced certification, which authorizes them to establish full plans. In addition, Aflac agents receive ongoing training via written communication if changes are made to IRS regulations.

  Your Flex-Certified Aflac insurance agent meets with you and your benefits team to evaluate your current benefits package. He or she also discusses all key operations with your payroll department before implementing your Section 125 program. Your Flex-Certified Aflac insurance agent provides the following services:

- **Program Announcements**

  Payroll stuffers: These cards promote interest in the upcoming benefit enrollment and may be included with the employees' paychecks in the pay period immediately before the enrollment.

  Posters: These posters notify and/or remind your employees of the upcoming group enrollment meetings.

- **Management Meetings**

  Program summary: Management receives an overview of a Section 125 program; the positives of the program are discussed.

  Enrollment explanation: Managers and supervisors receive an explanation of the enrollment procedures and scheduling requirements for employees.

  Question-and-answer session: Aflac agents spend this time discussing and answering questions about the program.

- **Group Meetings**

- **Individual Enrollment**
  - Review current benefits

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- Discuss the Section 125 Cafeteria Plan
- Provide personalized salary illustration
- Discuss Aflac Policies
- Present Salary Redirection Agreement election form

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Flexible Spending Account Processing and Funding Options

To facilitate claim reimbursements to Flexible Spending Account participants, Aflac offers several processing and funding options from which employers can choose. These options have been created to ensure prompt and efficient employee reimbursements, while allowing the employer an opportunity to tailor the program to meet specific financial and employee relations objectives.

The following are the current funding/banking arrangements offered by Aflac Benefit Services:

Option One: Daily Local Account
If you choose a Daily Local Account as your payment option, you open a bank account used only for holding and distributing employee and employer Flexible Spending Account contributions at a local bank of their choice. This account cannot be an interest-bearing account per IRS regulations. You give Aflac Benefit Services One check-writing authority over the account for the sole purpose of paying claims, and Aflac Benefit Services prepares and issues all reimbursement payments to employees. With this option, reimbursements can be issued within two to three business days.

Note: To utilize the Aflac Now Card, this is the only funding option that is currently available.

Forms: If the Daily Local Account option is chosen, we require signature cards, but these forms come from your bank.

Option Two: ACH Credit
At the time of processing, you will be provided a Checks Awaiting Printing Report that reflects the total amount due for all requests for reimbursement received. Your bank will send an ACH Credit for the requested funds to Aflac Benefit Services account at Columbus Bank &Trust. Once our bank has confirmed the transfer, Aflac Benefit Services will release the reimbursements. This normally takes 72 hours from the time the bank initiates the credit.

Forms: The ACH Debit Information Sheet must be completed and returned to Aflac Benefit Services.

Option Three: ACH Debit
You must provide in writing to Aflac Benefit Services the routing (ABA or transit) number and account number for the account they wish to use for payment of reimbursements. Aflac Benefit Services will debit the account for the lump sum total at each processing. Accounts are established as ACH Debit Zero Balance Account. In this case, the account signs a Hold Harmless Agreement allowing funds to transfer automatically.

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Upon notification by Aflac Benefit Services, you wire funds for the amount of reimbursement payments to Aflac Benefit Services for distribution to participants. Aflac Benefit Services is authorized to write checks and to initiate direct deposits to participants for the sole purpose of paying claims. With this option, reimbursements can be issued within eight to ten business days.

Forms: The ACH Debit Information Sheet must be completed and returned to Aflac Benefit Services.

Option Four: Self-Pay

Upon notification from Aflac Benefit Services, you issue reimbursement checks to participants. Reimbursements are issued according to your time frame because you are responsible for disbursement. Direct deposit is not available through Aflac Benefit Services with this payment option.

The time frame for issuing participant reimbursements is subject to the claims processing schedule chosen by you and your response time for funding payment amounts.

Forms: There are no forms for the self-pay option.

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Reimbursement Filing and Processing

- **Reimbursement Filing**
  Aflac Benefit Services provides Request for Reimbursement forms and detailed filing instructions for your employees. Request for Reimbursement forms are submitted directly to Aflac Benefit Services with any supporting documentation and proof of the incurred expense(s).

- **Minimum Reimbursement Amount**
  The minimum reimbursement amount is $15, except for reimbursements (no minimum) issued at the end of the cafeteria plan year (at which time there is no minimum).

- **Employee Reimbursements**
  If an employee's reimbursement request exceeds the current account balance on a Dependent Day Care Flexible Spending Account, Aflac Benefit Services reimburses the employee each payroll cycle in installments that correspond to the amounts the employee has redirected from his/her salary and credited to the Flexible Spending Account.

  If an employee's reimbursement request exceeds the current account balance on an Unreimbursed Medical Flexible Spending Account, Aflac Benefit Services reimburses the total amount of the reimbursement up to the annual amount elected by the employee. The funds must be provided by the employer, who is reimbursed as funds are redirected from the employee's salary.

- **Payment**
  The time frame for issuing participant reimbursements is subject to the claims processing schedule and payment option chosen by the employer and the employer's response time in funding payment amounts. However, turnaround time can be as fast as within 24 to 48 hours of claim receipt.

- **Distribution**
  If Aflac Benefit Services issues the reimbursement payments, the payments are mailed directly to the employee's home address or issued via direct deposit to employees' respective financial institutions. However, all reimbursement checks can be mailed to the employer for distribution to employees if the employer selects this option when the cafeteria plan is established.

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- **Account Activity Information**
  Each reimbursement check includes a corresponding Explanation of Benefits, or Flexible Spending Account Activity Statement, that includes current claims information, as well as account information such as account balance, total deposits, and total claims paid.

- **Data Storage and Reporting**
  During the plan year, Aflac Benefit Services systematically images and retains all reimbursement requests as they are submitted. We provide monthly and annual reports of account activity for the employer. The employee receives account information on Flexible Spending Account Activity Statement, which generates with each claim processed. If employees file no claims, quarterly reports with account information are provided.

- **Eligibility of Reimbursements**
  Eligibility for reimbursements is determined by the plan documents. Aflac Benefit Services adheres to the guidelines in the plan documents; however, only expenses eligible under Section 213(d) of the Internal Revenue Code are considered. An employer may place further limitations in the plan documents.

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Service Fees
Without Aflac Now Card

All fees have been waived for the City of Coral Gables.

Full Cafeteria Plan – Flexible Spending Accounts

Includes Dependent Day Care and Unreimbursed Medical Flexible Spending Accounts

Monthly Service Fee (per participant per month):

ACCOUNTS WITH 301+ EMPLOYEES

Initial Set-Up Fee	$450
One or Both Flexible Spending Accounts	$3

*The minimum fee is **$25** per month. Invoices for service fees are issued monthly. All fees are subject to review upon plan anniversary date. This service is available as long as one or more of Aflac's insurance policies are offered and purchased through payroll deduction.*

Service Fees
With Aflac Now Card

All fees have been waived for the City of Coral Gables.

Full Cafeteria Plan – Flexible Spending Accounts – With Aflac Now Card

- Fee includes Dependent Day Care and Unreimbursed Medical Flexible Spending Accounts.
- Cards support Unreimbursed Medical Flexible Spending Accounts only.

Monthly Service Fee (per participant per month):

ACCOUNTS WITH 301+ EMPLOYEES

Initial Set-up Fee	$450.00
One or Both Flexible Spending Accounts	$4.00

*The minimum fee is **$25** per month. Invoices for service fees are issued monthly. All fees are subject to review upon plan anniversary date. This service is available as long as one or more of Aflac's insurance policies are offered and purchased through payroll deduction.*

We've Got You Under Our Wing.℠

Aflac Now Card

Overview

The Aflac Now Card is our solution to a payment card that will store Flexible Spending Account funds. The participant's annual election is stored on the card for Unreimbursed Medical expenses and can be conveniently used to pay for doctor's office, pharmacy, dental, vision care and hospital expenses. Unlike a debit card, no pin number is needed and the participant will select "credit" when using the card at a terminal.

Note: The card may not work at some discount and grocery stores.

The benefit of using the Aflac Now Card is there are no out-of-pocket costs for eligible expenses and reimbursement is immediate. **Receipt substantiation is required after the card is used, as receipts are needed to validate eligibility of expenses.**

How Does It Work?*

The participant uses the card for payment at his or her doctor's office, pharmacy, dentist or vision provider visits, or at a hospital. The transaction goes through a normal credit card-type exchange, and the systems are updated with a current daily balance.

The participant keeps the receipt(s) and submits them to Aflac.

When the participant renews his or her election each year, the card's account is also renewed. The card is re-useable for three years and a new card is not reissued each plan year. If the participant does not re-enroll, his or her card will be deactivated. If he or she still has funds remaining at the end of his or her plan year, manual paper claims must be sent in with receipts attached during the account's runoff or grace period.

**All card swipe transactions will be processed by MediBank, Incorporated (MBI).*

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Aflac Now Card Funding

The **only** funding option available with the Aflac Now Card is the daily local zero balance account.

For Payment Card Transactions:

- MBI will initiate an e-mail to the employer notifying them of the amount that will be drafted from their account to fund the payment card transactions.

For Manual Claims submitted by an Aflac Now Card account:

- A Checks Awaiting Approval report is faxed to the employer on the next business day. This notifies the employer of the amount required to fund the manual claims.
- Checks and/or electronic funds transfers are initiated the night before the fax to the employer.

If an Aflac Now Card account is not funded:

- MBI will notify Aflac, who will contact the employer to verify deposit. Verification will be returned to MBI, and the account will be redrafted.
- If the account is not funded, the account will be inactivated for manual claims processing, and Aflac Now Cards will be deactivated.
- Cards will be reactivated upon funding, but habitual lack of funding will cause permanent deactivation of cards.

Payment Card Claims Processing

Claim transaction priority:

- Payment card claims receive first priority. These claims have already been paid by MBI to the provider of the services.
- Manual claims submitted are paid after any payment card claims are deducted from the participant's election balance.

We've Got You Under Our Wing.℠

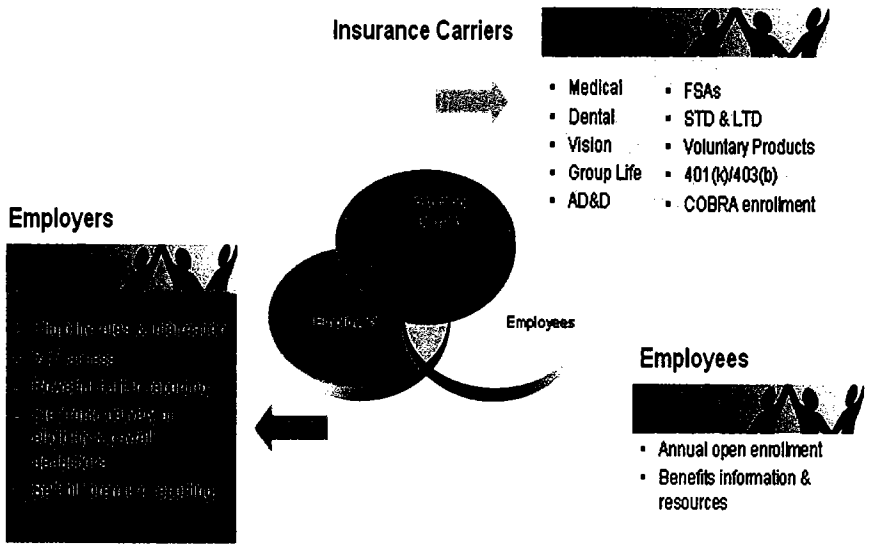
Core Benefits + Aflac

Core Benefits + Aflac allows your employees to enroll for their core, voluntary, and ancillary benefits on a single software platform.

Here's What You Receive with a Core Benefits + Aflac Enrollment

- *An employer-branded site*
- *Easy, step-by-step enrollment process for employees*
- *Comprehensive benefit statements for each employee*
- *Detailed enrollment reports*
- *Customizable benefit educational material for employees*
- *Systematic delivery of enrollment data to various carriers*

Here's How It Works



We've Got You Under Our Wing.℠

Express Services

Express Services is the use of available technical resources to facilitate and support the functional areas of enrollment, premium changes, reconciliation, and billing. It includes the use of several different media options for the delivery of electronic files between Aflac and the payroll accounts capable of supporting the necessary technology. The objective is to fundamentally enhance the effectiveness and operational efficiency of Aflac's Express Services through the innovative use of new technology. New technology provides advanced business capabilities such as process management, workflow, and straight-through processing. This translates to improved productivity, quality, and customer satisfaction.

The primary processes of Express Services are Express Enrollment, Express Changes, and Express Reconciliation.

Express Enrollment

Express Enrollment is the way Aflac provides you with an electronic file containing the deduction amounts of each policy or policyholder. The file provides an electronic file that you can then translate into billable payroll deductions without the use of manual data entry. The delivery of the enrollment file is normally managed through a File Transfer Protocol (FTP) and requires advanced agreements between you and Aflac.

Express Change

Express Change is the process of reporting changes in premium to the account using the same format and media as the enrollment file. The change file relays premium changes as they relate to additions, deletions, conversions, policy transfers, and terminations. Terminations are typically communicated as a zero in the deduction amount column. Change file delivery will normally match your payroll deduction frequency.

Express Reconciliation

Express Reconciliation is the use of an electronic payroll deduction file provided by you to reconcile or balance against a given invoice. Payment associated with each reconciliation file is managed in one of two formats: paper check or electronic (Wire/Automated Clearing House) transfer. Wire transfer is the preferred method.

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Employee Benefits Statements

Employee Benefits Statements are communication tools designed to give your employees a better understanding of the value of their benefits and contributions provided by you. Most employees have no idea of the amount you contribute to the cost of their benefits. Using Info One statements will help employees understand and value the hidden portion of their total compensation package. The average employer spends approximately 30 percent to 40 percent above and beyond payroll on benefits.

You may add your logo, benefit descriptions, and employee information to the statements, and they will be generated within 30 working days from receipt of usable data from you. Most importantly, this a **free** service provided by Aflac.

Frequently Illustrated Employer-Provided Benefits

Listed below are benefits that are commonly illustrated on employee benefit statements and can be used to assist in revealing what benefits you can provide to your employees.

- Group Medical
- Group Dental
- Vision Care Plan
- Credit Union
- United Way
- Dependent-Care Account
- Medical Reimbursement Plan
- Life Insurance
    - Term Life
    - Dependent Life
- Vacation
- Holidays
- Sick Days
- Personal Days
- 401 (k) Plan
- Profit-Sharing
- Disability Insurance
    - Long-Term Disability
    - Short-Term Disability
    - Accidental-Death and -Dismemberment
- Bonus
    - Christmas Bonus
    - Service Bonus
- **Voluntary Insurance**
    - **Aflac Policies**
- Company-Related Benefits

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Online Services

Administer your account with ease, at your convenience

Online Services provides you with a faster, easier way to manage your billing information. It allows quick access to invoice and policyholder information while providing an avenue to submit policyholder service requests via the Web.

Online Services is also the standard billing method for new accounts. Online Billing makes administration of Aflac policies easier by automating the billing and reconciliation processes. Online Services is Online Billing with enhanced security features, expanded online capabilities, and improved navigation.

What Are the Benefits of Online Billing?

- Saves time and money because payments and changes process faster.
- Provides invoice access 24 hours a day, 7 days a week.
- Sends an e-mail response to inquiries within 48 hours.

Online Billing Requirements

- 1,000 employees or less
- Internet access
- A one-time registration process in order to access the system

Online All the Time!

Personal Disability Income Protector

Short-Term Disability Insurance

Plan Highlights

- Selection of:
  - monthly benefit amount
  - elimination period
  - benefit period
- Benefits paid regardless of any other insurance
- Guaranteed-renewable to age 70

Aflac®

Form A57475B2FL IC(6/08)

Personal Disability Income Protector

Policy Series A-57400

Why Income Protection?

If you are suddenly unable to work because of a disability, how will you continue to meet your financial obligations without a paycheck?

Counting on Social Security to provide disability benefits?
Social Security's definition of disability requires that the impairment must be expected to result in death or to last at least 12 months, or must have lasted at least 12 months. Also, Social Security disability benefits usually have a five-month waiting period.

Covered by workers' compensation?
Workers' compensation provides benefits for only occupational-related injuries or illnesses. About two-thirds of the disabling injuries suffered by American workers in 2004 occurred off the job.*

Think your savings will get you through a disability?
Experts recommend a minimum savings of three months' salary to prepare for a sudden loss of income. However, most people simply aren't saving enough money to last more than a few weeks without a regular income. For some, the financial impact of even one missed paycheck can be devastating.

Will you have to turn to family or friends to help support you?
Chances are, if you are not saving enough, your loved ones are not either.

*Injury Facts, 2005–2006 Edition, National Safety Council.

Choose the Coverage You Need

Aflac's Personal Disability Income Protector allows you to choose a level of coverage that best meets your individual financial needs.

- Monthly Benefits: From $600 to $6,000, subject to income requirements and benefit period restrictions
- Benefit Periods: 3, 6, 12, or 24 months
- Elimination Periods (Accident/Sickness): 0/7, 0/14, 7/14, 0/30, 30/30, 60/60, 90/90, 180/180

Benefits

If you are working at a full-time job while coverage is in force and a covered sickness or covered off-the-job injury causes you to become totally disabled, we will pay you one-thirtieth of the benefit shown in the Policy Schedule for each day you remain totally disabled. A full-time job is defined as a job at which you work 30 or more hours per week for pay or benefits.

If you are not working at a full-time job while coverage is in force and you are unable to perform two or more ADLs (activities of daily living) resulting from a covered sickness or covered off-the-job injury, as certified by a physician, and you require direct personal assistance to perform such ADLs, we will pay you one-thirtieth of the benefit shown in the Policy Schedule for each day you cannot perform such ADLs.

The disability benefit is payable up to the benefit period selected and is subject to the elimination period shown in the Policy Schedule. Disability must begin within 90 days of your last treatment for the covered sickness or covered off-the-job injury.

Disability due to pregnancy and childbirth is payable to the same extent as a covered sickness. After the policy has been in force ten months, the maximum benefit period allowed for childbirth is six weeks for noncesarean delivery and eight weeks for cesarean delivery, less the elimination period, unless you furnish proof that you remain disabled beyond these time frames.

Provisions of Coverage

Benefits will be paid for only one disability at a time even if the disability is caused by more than one sickness, more than one injury, or a sickness and an injury.

Aflac reserves the right to meet with you during the pendency of a claim or to use an independent consultant and a physician's statement to determine whether you are totally disabled, or whether you are unable to perform two or more ADLs and require direct personal assistance.

You must be under the care and attendance of a physician for benefits to be payable. Benefits will cease on the date of your death.

If you have any other disability benefit in force with Aflac, only one disability benefit is payable under the policy.

Totally disabled is defined as your continuing inability to perform the material and substantial duties of your full-time job. You must also be under the care and attendance of a physician for your condition. If you are unable to perform the material and substantial duties of your full-time job but are able to work at any job, you will continue to be considered totally disabled as long as your earnings are less than 80 percent of your base pay earnings at the time you became totally disabled. If you return to work at any job and are earning 80 percent or more of your predisability base pay earnings, you will no longer be considered totally disabled.

Base pay earnings is your gross salary or wages for your full-time job, not including variable pay such as overtime (unless contractual), bonuses, or other incentives. If you are self-employed, base pay earnings means your business's gross income minus the allowable business deductions from that business. (For tax purposes, base pay earnings is referred to as net earnings.)

Successive periods of disability resulting from the same or a related condition, and not separated by 180 days or more, are considered a continuation of the prior disability. Separate periods of disability resulting from unrelated causes are considered a continuation of the prior disability unless they are separated by your returning to work at a full-time job for 14 working days, during which you are performing the material and substantial duties of this job and are no longer qualified to receive disability benefits.

Activities of Daily Living

- Continence: maintaining control of urination and bowel movements, including your ability to use ostomy supplies or other devices such as catheters
- Transferring: moving between a bed and a chair, or a bed and a wheelchair
- Dressing: putting on and taking off all necessary items of clothing, and/or medically necessary braces and artificial limbs usually worn
- Toileting: getting to and from a toilet, getting on and off a toilet, and performing associated personal hygiene
- Eating: performing all major tasks of getting food into the body

Guaranteed-Renewable to Age 70

You are guaranteed the right to renew the policy until the policy anniversary date following your 70th birthday by the payment of premiums at the rate in effect at the beginning of each term. You can never be singled out for a rate increase. Rates can be changed only if the rate is changed for all policies of this class. While the policy is in force, no change will be made in your class because of age, sex, or physical condition.

Fully Portable

When you own Aflac's Personal Disability Income Protector, you may choose to keep your policy regardless of job changes by continuing to pay premiums.

The payroll rate may be retained after one month's premium payment on payroll deduction.

Effective Date

The effective date of the policy is the date shown in the Policy Schedule, not the date the application is signed.

This brochure is for illustration purposes only.

Refer to the policy for complete details, limitations, and exclusions.

Pre-Existing Conditions

Disability caused by a pre-existing condition or reinjuries to a pre-existing condition will not be covered unless it begins more than 12 months after the effective date of coverage. A pre-existing condition is a sickness or an injury for which, within the 12-month period before the effective date of coverage, medical advice, consultation, or treatment was recommended or received, or symptoms existed that would ordinarily cause a prudent person to seek diagnosis, care, or treatment.

A sickness is a disease, disorder, infection, or any other abnormal physical condition that is not caused by an injury and that is first manifested or treated more than 30 days after your effective date of coverage and while coverage is in force. Sickness includes diseases or conditions resulting from insect bites or infestations by micro-organisms. If the disease or disorder is first manifested or treated within the first 30 days after your effective date of coverage, any resulting disability will not be covered unless it begins more than 12 months after the effective date of coverage.

What Is Not Covered

We will not pay benefits for a disability that is being treated outside the territorial limits of the United States or, if outside the United States, the territorial limits of the place where your policy was issued.

We will not pay benefits for a disability that is caused by or occurs as a result of your:

- Giving birth within the first ten months of the effective date of the policy as a result of a normal pregnancy, including cesarean (complications of pregnancy will be covered to the same extent as a sickness).
- Being addicted to alcohol or drugs, unless administered by a physician and taken according to the physician's instructions.
- Being under the influence of a controlled substance or illegal drugs (unless administered by a physician and taken according to the physician's instructions) or while intoxicated (intoxicated means that condition as defined by the law of the jurisdiction in which the accident occurred).
- Mountaineering using ropes and/or other equipment, parachuting, or hang gliding.
- Participating in, or attempting to participate in, an illegal activity that is defined as a felony, if convicted (felony is as defined by the law of the jurisdiction in which the activity takes place), or being incarcerated in any type penal institution.
- Intentionally self-inflicting a bodily injury or attempting suicide, while sane or insane.
- Having cosmetic surgery or other elective procedures that are not medically necessary, or having dental treatment except as a result of injury.
- Being exposed to war or any act of war, declared or undeclared.
- Actively serving in any of the armed forces, or units auxiliary thereto, including the National Guard or Army Reserve.
- Participating in any form of flight aviation other than as a fare-paying passenger in a fully licensed, passenger-carrying aircraft.
- Participating in any sport or sporting activity for wage, compensation, or profit, including officiating or coaching, or racing any type vehicle in an organized event.
- Becoming totally disabled due to any of the following: bipolar affective disorder (manic depressive syndrome), delusional (paranoid) disorders, psychotic disorders, somatoform disorders (psychosomatic illness), eating disorders, schizophrenia, anxiety disorders, depression, stress, or post-partum depression. (The policy will pay, however, for covered disabilities resulting from Alzheimer's disease, or similar forms of senility or senile dementia, first manifested while coverage is in force.)
- Donating an organ within the first 12 months of the effective date of the policy.

A physician does not include a member of your immediate family.

Benefits will be paid for only one disability at a time even if the disability is caused by more than one sickness, more than one injury, or a sickness and an injury.

You have life insurance, home insurance, and automobile insurance. But is your *income* insured?

Statistics show you are much more likely to be injured in an accident than to die from one.

A fatal injury occurs every 5 minutes, and a disabling injury occurs every second.[1]

There is a death caused by a motor vehicle crash every 11 minutes; there is a disabling injury every 13 seconds.[1]

In the home, there is a fatal injury every 14 minutes and a disabling injury every 4 seconds.[1]

While many people survive accidental injuries, many others live with serious illnesses.

In the United States, men have slightly less than a 1-in-2 lifetime risk of developing cancer; for women, the risk is a little more than 1-in-3.[2]

One in three adult men and women has some form of cardiovascular disease. High blood pressure is the most common form of cardiovascular disease.[3]

More than 38 million Americans are now living with chronic lung diseases, such as asthma, emphysema, and chronic bronchitis.[4]

Advances in medicine are allowing us to live longer. However, recovery from a serious illness or injury often requires time away from work.

The five-year relative survival rate for all cancers diagnosed between 1996 and 2003 is 66 percent.[2]

More than a quarter of stroke victims are under age 65.[5]

Aflac's Personal Disability Income Protector benefits provide a source of income while you concentrate on getting better.

[1] National Safety Council, Injury Facts, 2005–2006 Edition.
[2] American Cancer Society, Cancer Facts & Figures 2008.
[3] American Heart Association, Heart Disease and Stroke Statistics – 2008 Update.
[4] American Lung Association, Estimated Prevalence and Incidence of Lung Disease by Lung Association Territory, May 2008.
[5] USA Weekend, "All in the Family." January 29, 2006.

Aflac is ...

- A Fortune 500 company with nearly $66 billion in assets, insuring more than 40 million people worldwide.
- Rated AA in insurer financial strength by Standard & Poor's (June 2006), Aa2 (Excellent) in insurer financial strength by Moody's Investors Service (January 2006), A+ (Superior) by A.M. Best (June 2007), and AA in insurer financial strength by Fitch, Inc. (March 2008).*
- Named by Fortune magazine to its list of America's Most Admired Companies for the seventh consecutive year in March 2007.
- A premier provider of insurance policies with premiums payroll deducted for more than 402,300 payroll accounts nationally.
- Outstanding in claims service, with most claims processed within four days.
- Included by Forbes magazine in its annual list of America's 400 Best Big Companies for the eighth time in January 2008.
- Named by Fortune magazine to its list of the 100 Best Companies to Work For in America for the tenth consecutive year in February 2008.

**Ratings refer only to the overall financial status of Aflac and are not recommendations of specific policy provisions, rates, or practices.*

Your local Aflac insurance agent/producer

1.800.99.AFLAC (1.800.992.3522)

En español:
1.800.SI.AFLAC (1.800.742.3522)

Visit our Web site at aflac.com.

American Family Life Assurance Company of Columbus (Aflac) · Worldwide Headquarters · 1932 Wynnton Road · Columbus, Georgia 31999 · aflac.com

Personal Cancer Indemnity Plan

A Cancer Indemnity Insurance Policy

Plan Benefits

- First-Occurrence
- Hospital Confinement
- Medical Imaging
- Radiation and Chemotherapy
- Immunotherapy
- Cancer Screening Wellness
- Plus ... much more

Form A75175BFL IC(6/05)

Aflac™

Personal Cancer Indemnity Plan

Cancer Insurance Only; Policy Series A-75100

First-Occurrence Benefit

Aflac will pay $1,500 for the insured, $1,500 for the spouse, or $2,250 for children when a covered person is diagnosed with internal cancer. This benefit is payable only once for each covered person and will be paid in addition to any other benefit in this policy. Internal cancer includes melanomas classified as Clark's Level III and higher, or a Breslow level greater than 1.5 mm. In addition to the pathological or clinical diagnosis required by the policy, we may require additional information from the attending physician and hospital. Any covered person who has had a previous diagnosis of cancer will not be eligible for a First-Occurrence Benefit under this policy for a recurrence, extension, or metastatic spread of that same cancer.

Hospital Confinement Benefit

Aflac will pay $200 per day when a covered person is confined to a hospital for treatment of cancer and is charged for a room as an inpatient. *Benefits increase to $400 per day* beginning with the 31st day of continuous confinement.

A person confined to a U.S. government hospital does not need to be charged for the Hospital Confinement Benefit to be payable.

When cancer treatment is received in a U.S. government hospital, the remaining benefits (except the Cancer Screening Wellness Benefit) are not payable unless the covered person is actually charged and is legally required to pay for such services.

Medical Imaging Benefit

Aflac will pay $100 per calendar year when a charge is incurred for each covered person who receives an initial diagnosis or follow-up evaluation of internal cancer using one of the following medical imaging exams: CT scans, MRIs, bone scans, multiple gated acquisition (MUGA) scans, positron emission tomography (PET) scans, or transrectal ultrasounds. These exams must be performed in a hospital, an ambulatory surgical center, or a physician's office. This benefit is payable once per calendar year, per covered person.

Radiation and Chemotherapy Benefit

Aflac will pay $200 per day as follows when a charge is incurred for a covered person who receives one or more of the following cancer treatments for the purpose of modification or destruction of abnormal tissue:

1. Cytotoxic chemical substances and their administration in the treatment of cancer:
   a. Injection by medical personnel in a physician's office, clinic, or hospital.
   b. Self-injected medications (limited to $200 per daily treatment, subject to a monthly maximum of $1,600 for all medications).
   c. Medications dispensed by a pump or implant (limited to $200 for the initial prescription and $200 for each pump refill, subject to a monthly maximum of $800 for all medications).
   d. Oral chemotherapy, regardless of where administered (limited to $200 per prescription, subject to a monthly maximum of $800 for all prescriptions).
2. Radiation therapy.
3. The insertion of interstitial or intracavitary application of radium or radioisotopes.

If delivery of radiation or chemotherapy is other than listed above, benefits will be subject to a monthly maximum of $800. Treatments must be FDA- or NCI-approved for the treatment of cancer. This benefit does not pay for laboratory tests, diagnostic X-rays, immunoglobulins, immunotherapy, colony-stimulating factors, therapeutic devices, simulations, dosimetries, treatment plannings, or other procedures related to these therapy treatments. This benefit is not payable on the same day that the Experimental Treatment Benefit is paid.

Experimental Treatment Benefit

Aflac will pay $200 per day when a charge is incurred for a covered person who receives one or more of the following experimental cancer treatments, prescribed by a physician, for the purpose of modification or destruction of abnormal tissue:

- Treatment administered by medical personnel in a physician's office, clinic, or hospital.
- Self-injected medications (limited to $200 per daily treatment, subject to a monthly maximum of $1,600).
- Medications dispensed by a pump (limited to $200 for the initial prescription and $200 for each refill, subject to a monthly maximum of $800).
- Oral medications, regardless of where administered (limited to $200 per prescription, subject to a monthly maximum of $800 for all prescriptions).

Treatments must be approved by the National Cancer Institute (NCI) as viable experimental treatments for cancer. This benefit does not pay for laboratory tests, diagnostic X-rays, immunoglobulins, immunotherapy, colony-stimulating factors, therapeutic devices, or other procedures related to these therapy treatments. This benefit is not payable on the same day that the Radiation and Chemotherapy Benefit is paid.

Immunotherapy Benefit

Aflac will pay $300 per calendar month during which a charge is incurred for a covered person who receives immunoglobulins or colony-stimulating factors as prescribed by a physician as part of a treatment regimen for internal cancer. Any medications paid under the Radiation and Chemotherapy Benefit or the Experimental Treatment Benefit will not be paid under the Immunotherapy Benefit. Lifetime maximum of $1,500 per covered person.

Nursing Services Benefit

Aflac will pay $100 per 24-hour day if, while confined in a hospital, a covered person requires and is charged for private nursing services other than those regularly furnished by the hospital. Services must be required and authorized by the attending physician. This benefit is not payable for private nurses who are members of your immediate family. This benefit is payable for only the number of days the Hospital Confinement Benefit is payable.

Antinausea Benefit

Aflac will pay $100 per calendar month during which a charge is incurred for a covered person who receives antinausea drugs that are prescribed while receiving radiation or chemotherapy treatments.

Skin Cancer Surgery Benefit

Aflac will pay the indemnity ($100 to $600) listed when a surgical operation is performed on a covered person for a diagnosed skin cancer and a charge is incurred for the specific procedure. The benefit listed in the policy includes anesthesia services.

Surgical/Anesthesia Benefit

Aflac will pay the indemnity ($95 to $3,000) listed in the Schedule of Operations when a surgical operation is performed on a covered person for a diagnosed internal cancer and a charge is incurred. If any operation for the treatment of cancer is performed other than those listed, Aflac will pay an amount comparable to the amount shown for the operation most similar in severity and gravity. (Exceptions: Surgery for skin cancer will be payable under the Skin Cancer Surgery Benefit. Reconstructive surgery will be paid under the Reconstructive Surgery Benefit.) Two or more surgical procedures performed through the same incision will be considered one operation, and the highest eligible benefit will be paid.

Aflac will pay an indemnity benefit equal to 25% of the amount shown in the Schedule of Operations for the administration of anesthesia during a covered surgical operation. The combined benefits payable in the Surgical/Anesthesia Benefit for any one operation will not exceed $3,750.

Outpatient Hospital Surgical Benefit

Aflac will pay $200 when a surgical operation is performed on a covered person for a diagnosed internal cancer and an operating room charge is incurred. Surgeries must be performed on an outpatient basis in a hospital, to include an ambulatory surgical center. This benefit is not payable for surgery performed in a physician's office or for skin cancer surgery. This benefit is payable in addition to the Surgical/Anesthesia Benefit, is payable once per day, and is not payable on the same day as the Hospital Confinement Benefit.

Refer to the policy for complete details, limitations, and exclusions.

Prosthesis Benefit

Aflac will pay $2,500 when a charge is incurred for surgically implanted prosthetic devices that are prescribed as a direct result of surgery for cancer treatment. Lifetime maximum of $5,000 per covered person.

Aflac will pay $200 when a charge is incurred for nonsurgically implanted prosthetic devices that are prescribed as a direct result of cancer treatment. Lifetime maximum of $400 per covered person.

The Prosthesis Benefit does not include coverage for a breast transverse rectus abdominus myocutaneous (TRAM) flap procedure listed under the Reconstructive Surgery Benefit.

Reconstructive Surgery Benefit

Aflac will pay the indemnity ($325 to $2,500) listed when a surgical operation is performed on a covered person for reconstructive surgery for the treatment of cancer and a charge is incurred for the specific procedure. *Aflac will pay an indemnity benefit equal to 25%* of the amount shown in the policy for the administration of anesthesia during a covered reconstructive surgical operation. If any reconstructive surgery is performed other than those listed, Aflac will pay an amount comparable to the amount shown in the policy for the operation most similar in severity and gravity.

In-Hospital Blood and Plasma Benefit

Aflac will pay $50 times the number of days paid under the Hospital Confinement Benefit if a covered person receives blood and/or plasma during a covered hospital confinement and a charge is incurred. This benefit does not pay for immunoglobulins, immunotherapy, or colony-stimulating factors.

Outpatient Blood and Plasma Benefit

Aflac will pay $200 for each day a covered person receives blood and/or plasma transfusions for the treatment of cancer as an outpatient in a physician's office, clinic, hospital, or ambulatory surgical center, and a charge is incurred. This benefit does not pay for immunoglobulins, immunotherapy, or colony-stimulating factors.

Second Surgical Opinion Benefit

Aflac will pay $200 when a charge is incurred for a second surgical opinion concerning cancer surgery for a diagnosed cancer by a licensed physician. This benefit is not payable the same day the NCI Evaluation/Consultation Benefit is payable.

National Cancer Institute (NCI) Evaluation/Consultation Benefit

Aflac will pay $500 when a covered person seeks evaluation or consultation at an NCI-designated cancer center as a result of receiving a prior diagnosis of internal cancer. The purpose of the evaluation/consultation must be to determine the appropriate course of cancer treatment. If the NCI-designated cancer center is more than 50 miles from the covered person's residence, *Aflac will pay $250* for the transportation and lodging of the covered person receiving the evaluation/consultation.

This benefit is also payable at the Aflac Cancer Center & Blood Disorders Service of Children's Healthcare of Atlanta. This benefit is not payable the same day the Second Surgical Opinion Benefit is payable. This benefit is payable only once under this policy per covered person.

Ambulance Benefit

Aflac will pay $200 for ground ambulance transportation or $1,000 for air ambulance transportation when a charge is incurred for ambulance transportation of a covered person to or from a hospital where the covered person is confined overnight for cancer treatment. The ambulance service must be performed by a licensed professional ambulance company. This benefit is limited to two trips per confinement.

Transportation Benefit

Aflac will pay 40 cents per mile for round-trip transportation between the hospital or medical facility and the residence of the covered person when a covered person requires cancer treatment that has been prescribed by the local attending physician. Benefits are limited to $1,200 per round trip. This benefit will be paid only for the covered person for whom the treatment is prescribed. If the treatment is for a dependent child and commercial travel (coach-class plane, train, or bus fare) is necessary, Aflac will pay this benefit for up to two adults to accompany the dependent child. This benefit is not payable for transportation to any hospital/facility located within a 50-mile radius of the residence of the covered person or for transportation by ambulance to or from any hospital.

Lodging Benefit

Aflac will pay $50 per day when a charge is incurred for lodging for you or any one adult family member when a covered person receives cancer treatment at a hospital or medical facility more than 50 miles from the covered person's residence. This benefit is not payable for lodging occurring more than 24 hours prior to treatment or for lodging occurring more than 24 hours following treatment. This benefit is limited to 90 days per calendar year.

Bone Marrow Transplantation Benefit

Aflac will pay $10,000 when a covered person incurs a charge for a bone marrow transplantation for the treatment of cancer. This does not include the harvesting of peripheral blood cells or stem cells and subsequent reinfusion. *Aflac will pay the covered person's bone marrow donor the greater of $1,000 or medical costs*, to the same extent and limitations as costs associated with the covered person for a covered bone marrow transplant. Lifetime maximum of $10,000 per covered person.

Stem Cell Transplantation Benefit

Aflac will pay $2,500 when a charge is incurred if a covered person receives a peripheral stem cell transplantation for the treatment of cancer. This benefit does not include the harvesting, storage, and subsequent reinfusion of bone marrow from the recipient or a matched donor under general anesthesia. This benefit is payable once per covered person. Lifetime maximum of $2,500 per covered person.

Extended-Care Facility Benefit

Aflac will pay $100 per day when a charge is incurred if a covered person receives Hospital Confinement Benefits and, within 30 days of hospital confinement, is confined to an extended-care facility, a skilled nursing facility, a rehabilitation unit or facility, a transitional care unit, or any bed designated as a swing bed, or to a section of the hospital used as such. This benefit is limited to the same number of days that the covered person received Hospital Confinement Benefits. For each day this benefit is payable, Hospital Confinement Benefits are not payable. If more than 30 days separates a stay in an extended-care facility, benefits are not payable for the second confinement unless the covered person was again confined to a hospital prior to the second such confinement. Lifetime maximum of 365 days per covered person.

Hospice Benefit

Aflac will pay a one-time benefit of $500 for the first day and $50 per day thereafter for hospice care when a covered person is diagnosed with cancer, therapeutic intervention directed toward the cure of the disease is medically determined no longer appropriate, and the covered person's prognosis is one in which there is a life expectancy of six months or less as the direct result of cancer. This benefit is not payable the same day the Home Health Care Benefit is payable. Lifetime maximum of $12,000 per covered person.

Home Health Care Benefit

Aflac will pay $50 per day when a charge is incurred for home health care or health supportive services when provided on a covered person's behalf within seven days of release from the hospital for the treatment of cancer. The attending physician must prescribe such services to be performed in the home of the covered person and certify that, if these services were not available, the covered person would have to be hospitalized to receive the necessary care, treatment, and services. These services must be performed by a person who is licensed, certified, or otherwise duly qualified to perform such services on the same basis as if the services had been performed in a health care facility. This benefit is not payable the same day the Hospice Benefit is payable. This benefit is limited to ten visits per hospitalization and 30 visits in any calendar year for each covered person.

Cancer Screening Wellness Benefit

This is a preventive benefit; a diagnosis of cancer is not required for this benefit to be payable.

Aflac will pay $40 per calendar year when a charge is incurred for one of the following: mammogram, breast ultrasound, Pap smear, ThinPrep, biopsy, flexible sigmoidoscopy, hemocult stool specimen, chest X-ray, CEA (blood test for colon cancer), CA 125 (blood test for ovarian cancer), PSA (blood test for prostate cancer), thermography, colonoscopy, or virtual colonoscopy. These tests must be performed to determine whether cancer exists in a covered person. This benefit is limited to one payment per calendar year, per covered person.

The Following Benefits Have No Lifetime Maximum:

Hospital Confinement, Medical Imaging, Radiation and Chemotherapy, Experimental Treatment, Antinausea, Nursing Services, Surgical/Anesthesia, Outpatient Hospital Surgical, Skin Cancer Surgery, Reconstructive Surgery, In-Hospital Blood and Plasma, Outpatient Blood and Plasma, Second Surgical Opinion, Ambulance, Transportation, Lodging, Home Health Care, and Cancer Screening Wellness.

Waiver of Premium Benefit

If you, due to having internal cancer, are completely unable to do all of the usual and customary duties of your occupation [or, if you are not employed: are completely unable to perform two or more of the activities of daily living (ADLs) without the assistance of another person] for a period of 90 continuous days, Aflac will waive, from month to month, any premiums falling due during your continued inability. For premiums to be waived, Aflac will require an employer's statement (if applicable) and a physician's statement of your inability to perform said duties or activities, and may each month thereafter require a physician's statement that total inability continues. Aflac may ask for and use an independent consultant to determine whether you can perform an ADL without assistance.

Aflac will also waive, from month to month, any premiums falling due while you are receiving hospice benefits under the Hospice Benefit.

Guaranteed-Renewable

This policy is guaranteed-renewable for your lifetime, subject to Aflac's right to change premiums by class upon any renewal date.

Effective Date

The effective date of this policy is the date shown in the Policy Schedule, not the date the application is signed. This policy is available through age 70 on payroll deduction and through age 64 on direct billing. The payroll rate may be retained after one month's premium payment on payroll deduction.

Family Coverage

Family coverage includes the insured; spouse; and dependent, unmarried children to age 25. Newborn children are automatically insured from the moment of birth. One-parent family coverage includes the insured and all dependent, unmarried children to age 25.

Limitations and Exclusions

Aflac pays only for treatment of cancer, including direct extension, metastatic spread, or recurrence. Benefits are not provided for premalignant conditions; conditions with malignant potential; complications of cancer; or any other disease, sickness, or incapacity. Pathological proof of diagnosis must be submitted. Clinical diagnosis will be accepted when a pathological diagnosis cannot be made, provided medical evidence sustains the diagnosis and the covered person receives treatment for cancer.

This policy contains a 30-day waiting period. If a covered person has cancer diagnosed before coverage has been in force 30 days from the effective date of coverage shown in the Policy Schedule, benefits for treatment of that cancer will apply only to treatment occurring after two years from the effective date of the policy. Or, at your option, you may elect to void the policy from its beginning and receive a full refund of premium.

The First-Occurrence Benefit is not payable for: (1) any internal cancer diagnosed or treated before the effective date of this policy and the subsequent recurrence, extension, or metastatic spread of such internal cancer that is diagnosed prior to the effective date of this policy; (2) cancer diagnosed during this policy's 30-day waiting period; (3) the diagnosis of skin cancer or melanomas classified as Clark's Levels I and II, or a Breslow level less than or equal to 1.5 mm. Any covered person who has had a previous diagnosis of cancer will not be eligible for a First-Occurrence Benefit under this policy for a recurrence, extension, or metastatic spread of that same cancer.

Benefits for the Radiation and Chemotherapy Benefit and the Experimental Treatment Benefit will not be paid for each day the radium or radioisotope remains in the body or for each day of continuous infusion of medications dispensed by a pump or implant. (The Surgical/Anesthesia Benefit provides additional amounts payable for insertion and removal.)

Hospital does not include any institution, or part thereof, used as a hospice unit, including any bed designated as a hospice bed; a swing bed; a convalescent home; a rest or nursing facility; a psychiatric unit; a rehabilitation unit or facility; an extended-care facility; a skilled nursing facility; or a facility primarily affording custodial or educational care, care or treatment for persons suffering from mental diseases or disorders, care for the aged, or care for persons addicted to drugs or alcohol.

The policy to which this sales material pertains is written only in English; the policy prevails if interpretation of this material varies.

*Understanding the Risk**

According to the American Cancer Society:

- In the United States, men have a little less than a 1-in-2 lifetime risk of developing cancer; for women the risk is a little more than 1-in-3.
- About 1,368,030 new cancer cases are expected to be diagnosed in 2004.
- Since 1990, over 18 million new cancer cases have been diagnosed.

As advances in cancer treatment continue, more and more people will survive:

- Approximately 9.6 million Americans with a history of cancer were alive in January 2000.
- The five-year relative survival rate for all cancers combined is 63%.

The National Institutes of Health estimated the overall costs for cancer in the year 2003 at $189.5 billion.

Although health insurance can help offset the costs of cancer treatment, you still may have to cover deductibles and copayments on your own.

Additionally, cancer treatment can cause out-of-pocket expenses that aren't covered by traditional health insurance:

- Travel
- Food
- Lodging
- Long-distance calls
- Child care
- Household help

Meanwhile, living expenses such as car payments, mortgages or rent, and utility bills continue, whether or not you are able to work. If a family member has to stop working to take care of you, the loss of income may be doubled. Aflac helps provide an important safety net in fighting the financial consequences of cancer that result beyond traditional health insurance.

Aflac's** Personal Cancer Indemnity Plan **pays benefits directly to you, unless assigned. You use the cash however <u>you</u> decide.

Aflac™

*American Cancer Society, Cancer Facts & Figures 2004

Aflac is ...

- A Fortune 500 company with assets exceeding $59 billion, insuring more than 40 million people worldwide.
- Rated AA in insurer financial strength by Standard & Poor's (April 2004), Aa2 (Excellent) in insurer financial strength by Moody's Investors Service (March 2003), A+ (Superior) by A.M. Best (June 2004), and AA in insurer financial strength by Fitch, Inc. (December 2003).*
- Named by Fortune magazine to its list of America's Most Admired Companies for the fifth consecutive year in March 2005.
- A premier provider of insurance policies with premiums payroll deducted for more than 300,000 payroll accounts nationally.
- Outstanding in claims service, with most claims processed within four days.
- Included by Forbes magazine in its annual Platinum 400 List of America's Best Big Companies since 2000 (January 2004).
- Named by Fortune magazine to its list of the 100 Best Companies to Work For in America for the seventh consecutive year in January 2005.

* *Ratings refer only to the overall financial status of Aflac and are not recommendations of specific policy provisions, rates, or practices.*

Your local Aflac insurance agent/producer

1.800.99.AFLAC (1.800.992.3522)

En español:
1.800.SI.AFLAC (1.800.742.3522)

Visit our Web site at aflac.com.

American Family Life Assurance Company of Columbus (Aflac) · Worldwide Headquarters · 1932 Wynnton Road · Columbus, Georgia 31999 · aflac.com

Personal Cancer Indemnity Plan

A Cancer Indemnity Insurance Policy

Plan Benefits

- First-Occurrence
- Hospital Confinement
- Medical Imaging
- Radiation and Chemotherapy
- Immunotherapy
- Cancer Screening Wellness
- Plus ... much more

Aflac™

Form A75375BFL

First-Occurrence Benefit

Aflac will pay $5,000 for the insured, $5,000 for the spouse, or $7,500 for children when a covered person is diagnosed with internal cancer. This benefit is payable only once for each covered person and will be paid in addition to any other benefit in this policy. Internal cancer includes melanomas classified as Clark's Level III and higher, or a Breslow level greater than 1.5 mm. In addition to the pathological or clinical diagnosis required by the policy, we may require additional information from the attending physician and hospital. Any covered person who has had a previous diagnosis of cancer will not be eligible for a First-Occurrence Benefit under this policy for a recurrence, extension, or metastatic spread of that same cancer.

Hospital Confinement Benefit

Aflac will pay $300 per day when a covered person is confined to a hospital for treatment of cancer and is charged for a room as an inpatient. *Benefits increase to $600 per day* beginning with the 31st day of continuous confinement.

A person confined to a U.S. government hospital does not need to be charged for the Hospital Confinement Benefit to be payable.

When cancer treatment is received in a U.S. government hospital, the remaining benefits (except the Cancer Screening Wellness Benefit) are not payable unless the covered person is actually charged and is legally required to pay for such services.

Medical Imaging Benefit

Aflac will pay $200 per calendar year when a charge is incurred for each covered person who receives an initial diagnosis or follow-up evaluation of internal cancer using one of the following medical imaging exams: CT scans, MRIs, bone scans, multiple gated acquisition (MUGA) scans, positron emission tomography (PET) scans, or transrectal ultrasounds. These exams must be performed in a hospital, an ambulatory surgical center, or a physician's office. This benefit is payable once per calendar year, per covered person.

Radiation and Chemotherapy Benefit

Aflac will pay $300 per day as follows when a charge is incurred for a covered person who receives one or more of the following cancer treatments for the purpose of modification or destruction of abnormal tissue:

1. Cytotoxic chemical substances and their administration in the treatment of cancer:
    a. Injection by medical personnel in a physician's office, clinic, or hospital.
    b. Self-injected medications (limited to $300 per daily treatment, subject to a monthly maximum of $2,400 for all medications).
    c. Medications dispensed by a pump or implant (limited to $300 for the initial prescription and $300 for each pump refill, subject to a monthly maximum of $1,200 for all medications).
    d. Oral chemotherapy, regardless of where administered (limited to $300 per prescription, subject to a monthly maximum of $1,200 for all prescriptions).
2. Radiation therapy.
3. The insertion of interstitial or intracavitary application of radium or radioisotopes.

If delivery of radiation or chemotherapy is other than listed above, benefits will be subject to a monthly maximum of $1,200. Treatments must be FDA- or NCI-approved for the treatment of cancer. This benefit does not pay for laboratory tests, diagnostic X-rays, immunoglobulins, immunotherapy, colony-stimulating factors, therapeutic devices, simulations, dosimetries, treatment plannings, or other procedures related to these therapy treatments. This benefit is not payable on the same day that the Experimental Treatment Benefit is paid.

Experimental Treatment Benefit

Aflac will pay $300 per day when a charge is incurred for a covered person who receives one or more of the following experimental cancer treatments, prescribed by a physician, for the purpose of modification or destruction of abnormal tissue:

- Treatment administered by medical personnel in a physician's office, clinic, or hospital.
- Self-injected medications (limited to $300 per daily treatment, subject to a monthly maximum of $2,400).
- Medications dispensed by a pump (limited to $300 for the initial prescription and $300 for each refill, subject to a monthly maximum of $1,200).
- Oral medications, regardless of where administered (limited to $300 per prescription, subject to a monthly maximum of $1,200 for all prescriptions).

Treatments must be approved by the National Cancer Institute (NCI) as viable experimental treatments for cancer. This benefit does not pay for laboratory tests, diagnostic X-rays, immunoglobulins, immunotherapy, colony-stimulating factors, therapeutic devices, or other procedures related to these therapy treatments. This benefit is not payable on the same day that the Radiation and Chemotherapy Benefit is paid.

Immunotherapy Benefit

Aflac will pay $500 per calendar month during which a charge is incurred for a covered person who receives immunoglobulins or colony-stimulating factors as prescribed by a physician as part of a treatment regimen for internal cancer. Any medications paid under the Radiation and Chemotherapy Benefit or the Experimental Treatment Benefit will not be paid under the Immunotherapy Benefit. Lifetime maximum of $2,500 per covered person.

Nursing Services Benefit

Aflac will pay $150 per 24-hour day if, while confined in a hospital, a covered person requires and is charged for private nursing services other than those regularly furnished by the hospital. Services must be required and authorized by the attending physician. This benefit is not payable for private nurses who are members of your immediate family. This benefit is payable for only the number of days the Hospital Confinement Benefit is payable.

Antinausea Benefit

Aflac will pay $150 per calendar month during which a charge is incurred for a covered person who receives antinausea drugs that are prescribed while receiving radiation or chemotherapy treatments.

Skin Cancer Surgery Benefit

Aflac will pay the indemnity ($100 to $600) listed when a surgical operation is performed on a covered person for a diagnosed skin cancer and a charge is incurred for the specific procedure. The benefit listed in the policy includes anesthesia services.

Surgical/Anesthesia Benefit

Aflac will pay the indemnity ($100 to $5,000) listed in the Schedule of Operations when a surgical operation is performed on a covered person for a diagnosed internal cancer and a charge is incurred. If any operation for the treatment of cancer is performed other than those listed, Aflac will pay an amount comparable to the amount shown for the operation most similar in severity and gravity. (Exceptions: Surgery for skin cancer will be payable under the Skin Cancer Surgery Benefit. Reconstructive surgery will be paid under the Reconstructive Surgery Benefit.) Two or more surgical procedures performed through the same incision will be considered one operation, and the highest eligible benefit will be paid.

Aflac will pay an indemnity benefit equal to 25% of the amount shown in the Schedule of Operations for the administration of anesthesia during a covered surgical operation. The combined benefits payable in the Surgical/Anesthesia Benefit for any one operation will not exceed $6,250.

Outpatient Hospital Surgical Benefit

Aflac will pay $300 when a surgical operation is performed on a covered person for a diagnosed internal cancer and an operating room charge is incurred. Surgeries must be performed on an outpatient basis in a hospital, to include an ambulatory surgical center. This benefit is not payable for surgery performed in a physician's office or for skin cancer surgery. This benefit is payable in addition to the Surgical/Anesthesia Benefit, is payable once per day, and is not payable on the same day as the Hospital Confinement Benefit.

Refer to the policy for complete details, limitations, and exclusions.

Prosthesis Benefit

Aflac will pay $3,000 when a charge is incurred for surgically implanted prosthetic devices that are prescribed as a direct result of surgery for cancer treatment. Lifetime maximum of $6,000 per covered person.

Aflac will pay $250 when a charge is incurred for nonsurgically implanted prosthetic devices that are prescribed as a direct result of cancer treatment. Lifetime maximum of $500 per covered person.

The Prosthesis Benefit does not include coverage for a breast transverse rectus abdominus myocutaneous (TRAM) flap procedure listed under the Reconstructive Surgery Benefit.

Reconstructive Surgery Benefit

Aflac will pay the indemnity ($350 to $3,000) listed when a surgical operation is performed on a covered person for reconstructive surgery for the treatment of cancer and a charge is incurred for the specific procedure. *Aflac will pay an indemnity benefit equal to 25%* of the amount shown in the policy for the administration of anesthesia during a covered reconstructive surgical operation. If any reconstructive surgery is performed other than those listed, Aflac will pay an amount comparable to the amount shown in the policy for the operation most similar in severity and gravity.

In-Hospital Blood and Plasma Benefit

Aflac will pay $150 times the number of days paid under the Hospital Confinement Benefit if a covered person receives blood and/or plasma during a covered hospital confinement and a charge is incurred. This benefit does not pay for immunoglobulins, immunotherapy, or colony-stimulating factors.

Outpatient Blood and Plasma Benefit

Aflac will pay $250 for each day a covered person receives blood and/or plasma transfusions for the treatment of cancer as an outpatient in a physician's office, clinic, hospital, or ambulatory surgical center, and a charge is incurred. This benefit does not pay for immunoglobulins, immunotherapy, or colony-stimulating factors.

Second Surgical Opinion Benefit

Aflac will pay $300 when a charge is incurred for a second surgical opinion concerning cancer surgery for a diagnosed cancer by a licensed physician. This benefit is not payable the same day the NCI Evaluation/Consultation Benefit is payable.

National Cancer Institute (NCI) Evaluation/Consultation Benefit

Aflac will pay $500 when a covered person seeks evaluation or consultation at an NCI-designated cancer center as a result of receiving a prior diagnosis of internal cancer. The purpose of the evaluation/consultation must be to determine the appropriate course of cancer treatment. If the NCI-designated cancer center is more than 50 miles from the covered person's residence, *Aflac will pay $250* for the transportation and lodging of the covered person receiving the evaluation/consultation.

This benefit is also payable at the Aflac Cancer Center & Blood Disorders Service of Children's Healthcare of Atlanta. This benefit is not payable the same day the Second Surgical Opinion Benefit is payable. This benefit is payable only once under this policy per covered person.

Ambulance Benefit

Aflac will pay $200 for ground ambulance transportation or $1,000 for air ambulance transportation when a charge is incurred for ambulance transportation of a covered person to or from a hospital where the covered person is confined overnight for cancer treatment. The ambulance service must be performed by a licensed professional ambulance company. This benefit is limited to two trips per confinement.

Transportation Benefit

Aflac will pay 50 cents per mile for round-trip transportation between the hospital or medical facility and the residence of the covered person when a covered person requires cancer treatment that has been prescribed by the local attending physician. Benefits are limited to $1,500 per round trip. This benefit will be paid only for the covered person for whom the treatment is prescribed. If the treatment is for a dependent child and commercial travel (coach-class plane, train, or bus fare) is necessary, Aflac will pay this benefit for up to two adults to accompany the dependent child. This benefit is not payable for transportation to any hospital/facility located within a 50-mile radius of the residence of the covered person or for transportation by ambulance to or from any hospital.

Lodging Benefit

Aflac will pay $60 per day when a charge is incurred for lodging for you or any one adult family member when a covered person receives cancer treatment at a hospital or medical facility more than 50 miles from the covered person's residence. This benefit is not payable for lodging occurring more than 24 hours prior to treatment or for lodging occurring more than 24 hours following treatment. This benefit is limited to 90 days per calendar year.

Bone Marrow Transplantation Benefit

Aflac will pay $10,000 when a covered person incurs a charge for a bone marrow transplantation for the treatment of cancer. This does not include the harvesting of peripheral blood cells or stem cells and subsequent reinfusion. *Aflac will pay the covered person's bone marrow donor the greater of $1,000 or medical costs*, to the same extent and limitations as costs associated with the covered person for a covered bone marrow transplant. Lifetime maximum of $10,000 per covered person.

Stem Cell Transplantation Benefit

Aflac will pay $5,000 when a charge is incurred if a covered person receives a peripheral stem cell transplantation for the treatment of cancer. This benefit does not include the harvesting, storage, and subsequent reinfusion of bone marrow from the recipient or a matched donor under general anesthesia. This benefit is payable once per covered person. Lifetime maximum of $5,000 per covered person.

Extended-Care Facility Benefit

Aflac will pay $100 per day when a charge is incurred if a covered person receives Hospital Confinement Benefits and, within 30 days of hospital confinement, is confined to an extended-care facility, a skilled nursing facility, a rehabilitation unit or facility, a transitional care unit, or any bed designated as a swing bed, or to a section of the hospital used as such. This benefit is limited to the same number of days that the covered person received Hospital Confinement Benefits. For each day this benefit is payable, Hospital Confinement Benefits are not payable. If more than 30 days separates a stay in an extended-care facility, benefits are not payable for the second confinement unless the covered person was again confined to a hospital prior to the second such confinement. Lifetime maximum of 365 days per covered person.

Hospice Benefit

Aflac will pay a one-time benefit of $1,000 for the first day and $50 per day thereafter for hospice care when a covered person is diagnosed with cancer, therapeutic intervention directed toward the cure of the disease is medically determined no longer appropriate, and the covered person's prognosis is one in which there is a life expectancy of six months or less as the direct result of cancer. This benefit is not payable the same day the Home Health Care Benefit is payable. Lifetime maximum of $12,000 per covered person.

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Cancer Screening Wellness Benefit

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Aflac will pay $75 per calendar year when a charge is incurred for one of the following: mammogram, breast ultrasound, Pap smear, ThinPrep, biopsy, flexible sigmoidoscopy, hemocult stool specimen, chest X-ray, CEA (blood test for colon cancer), CA 125 (blood test for ovarian cancer), PSA (blood test for prostate cancer), thermography, colonoscopy, or virtual colonoscopy. These tests must be performed to determine whether cancer exists in a covered person. This benefit is limited to one payment per calendar year, per covered person.

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Riders become a part of the policy and are subject to all policy provisions unless otherwise stated.

First-Occurrence Building Benefit

This benefit can be purchased in units of $100 each, up to a maximum of five units or $500. All amounts cited in this rider are for one unit of coverage. If more than one unit has been purchased, then the amounts listed must be multiplied by the number of units in force.

The First-Occurrence Benefit, as defined in the policy, will be increased by $100 for each unit purchased on each rider anniversary date while this rider remains in force. This building benefit will be paid under the same terms as the First-Occurrence Benefit. This benefit will cease to build for each covered person on the anniversary date of this rider following the covered person's 65th birthday or at the time internal cancer is diagnosed for that covered person, whichever occurs first. However, regardless of the age of the covered person on the effective date of this rider, this benefit will accrue at least five years, unless internal cancer is diagnosed prior to the fifth year of coverage.

Termination

This rider will terminate if the policy to which it is attached terminates, when the benefit has been paid to all covered persons, or if the premium for this rider is not paid.

Effective Date

The effective date of this rider is the effective date of the policy to which it is attached or the effective date of this rider, as stated on the Policy Schedule, if later.

The policy to which this sales material pertains is written only in English; the policy prevails if interpretation of this material varies.

Refer to the policy and rider for complete details, limitations, and exclusions.

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Riders become a part of the policy and are subject to all policy provisions unless otherwise stated.

Specified-Disease Benefits
While coverage is in force, if an insured is first diagnosed with one or more covered specified diseases and is hospitalized for the definitive treatment of any covered specified disease, Aflac will pay the rates designated below.

Initial Hospitalization Benefit
Aflac will pay an Initial Hospitalization Benefit of $1,000 when a covered person is confined to a hospital for 12 or more hours as a result of receiving treatment for a specified disease. This benefit is payable only once per period of confinement and once per calendar year for each covered person.

A period of confinement is a hospital confinement that starts while the policy is in force. If the confinement follows a previously covered confinement, it will be deemed a continuation of the first confinement unless it is the result of an entirely different sickness or injury, or unless the confinements are separated by 30 days or more.

Hospital Confinement Benefit
Aflac will pay $200 per day when a covered person is hospitalized during any continuous period for 30 days or less for a covered specified disease. *Benefits increase to $500 per day* beginning with the 31st day of continuous confinement.

Definition of Covered Diseases
Specified disease means one of the diseases listed below:

1. Adrenal hypofunction (Addison's disease)
2. Amyotrophic lateral sclerosis (ALS or Lou Gehrig's disease)
3. Botulism
4. Bubonic plague
5. Cerebral palsy
6. Cholera
7. Cystic fibrosis
8. Diphtheria
9. Encephalitis (including encephalitis contracted from West Nile virus)
10. Huntington's chorea
11. Legionnaires' disease
12. Malaria
13. Meningitis (bacterial)
14. Multiple sclerosis
15. Muscular dystrophy
16. Myasthenia gravis
17. Necrotizing fasciitis
18. Osteomyelitis
19. Polio
20. Rabies
21. Reye's syndrome
22. Scarlet fever
23. Scleroderma
24. Sickle cell anemia
25. Systemic lupus
26. Tetanus
27. Toxic shock syndrome
28. Tuberculosis
29. Tularemia
30. Typhoid fever
31. Variant Creutzfeldt-Jakob disease (mad cow disease)
32. Yellow fever

For benefits to be paid, these diseases must be first diagnosed by a physician 30 days following the effective date of the rider. The diagnosis must be made by and upon a tissue specimen, culture, and/or titer. If any of these diseases is diagnosed before the rider has been in effect for 30 days, benefits for that disease will be paid only for loss incurred after the rider has been in force two years.

Termination
The rider will terminate if the policy to which it is attached terminates or if the premium for the rider is not paid.

Effective Date
The effective date of the rider is the effective date of the policy or the effective date of the rider, as stated on the Policy Schedule, if later.

The rider to which this sales material pertains is written only in English; the rider prevails if interpretation of this material varies.

Refer to the policy and rider for complete details, limitations, and exclusions.

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Plan 2

Specified Health Event Protection

Specified Health Event Insurance

Plan Highlights

Pays a First-Occurrence Benefit as well as Hospital Confinement and Continuing Care Benefits for:

- Heart Attack & Coronary Artery Bypass Surgery
- Stroke
- End-Stage Renal Failure
- Major Human Organ Transplant
- Major Third-Degree Burns
- Coma
- Plus ... much more

Form A71275RFL IC(6/08)

Aflac™

Specified Health Event Protection

Policy Series A71000

The Specified Health Event Protection policy provides hospital intensive care coverage for sickness and injury, and provides specified health event coverage for critical illness. Some benefits are payable for both hospital intensive care and specified health events, and some benefits apply only to specified health events. Some benefits reduce at age 70. Read each benefit carefully.

Benefits for Hospital Intensive Care Unit Confinements

Hospital Intensive Care Unit Benefit

Aflac will pay the following benefits when a covered person incurs a charge for confinement in a hospital intensive care unit or a step-down intensive care unit for a covered sickness or injury:

Confinement in a Hospital Intensive Care Unit:

	Sickness	Injury
Days 1–7	$ 700 per day	$ 800 per day
Days 8–15	$1,200 per day	$1,300 per day

This benefit is limited to 15 days per period of confinement. No lifetime maximum.

Confinement in a Step-Down Intensive Care Unit:

Aflac will pay benefits for confinement in a step-down intensive care unit after exhaustion of benefits paid for confinement in a hospital intensive care unit or for Days 1–15 of a step-down intensive care unit confinement. This benefit is limited to 15 days per period of confinement. No lifetime maximum.

	Sickness	Injury
Days 1–15 (Step-Down Intensive Care Unit)	$350 per day	$350 per day
or		
Days 16–30 (Hospital Intensive Care Unit)	$350 per day	$350 per day

Benefits payable for confinement in a hospital intensive care unit or for confinement in a step-down intensive care unit are not payable on the same day. If a covered person is charged for both on the same day, only the highest eligible benefit will be paid. Treatment or confinement in a U.S. government hospital does not require a charge for benefits to be payable. Benefits reduce by one-half for losses incurred on or after the policy anniversary date following the 70th birthday of a covered person.

Hospital intensive care units include cardiac intensive care units and infant (neonatal) intensive care units. Hospital intensive care units do not provide benefits for telemetry or surgical recovery rooms, postanesthesia care units, progressive care units, intermediate care units, private monitored rooms, observation units located in emergency rooms or outpatient surgery units, step-down intensive care units, or other facilities that do not meet the standards for a hospital intensive care unit.

Step-down intensive care units do not provide benefits for telemetry or surgical recovery rooms; observation units located in emergency rooms or outpatient surgery units; postanesthesia care units; beds, wards, or private or semiprivate rooms with or without telemetry monitoring equipment; or emergency rooms, labor rooms, or delivery rooms.

Progressive Benefit for Hospital Intensive Care Unit/Step-Down Intensive Care Unit Confinement

A $2 indemnity will accumulate for the named insured and the covered spouse for each calendar month the policy remains in force after the effective date. This accumulated indemnity, if any, will be paid in addition to any benefits paid under the Hospital Intensive Care Unit Benefit. This progressive benefit will cease to build on the policy anniversary date following the 65th birthday of a covered person. Any amount accrued at the time this benefit ceases to build for a covered person will continue to be added to the benefit amount for all hospital intensive care unit/step-down intensive care unit confinements commencing prior to the policy anniversary date following the 70th birthday of a covered person. This accumulated benefit reduces at age 70. This accumulated benefit will be reduced by one-half for hospital intensive care unit/step-down intensive care unit confinements commencing on or after the policy anniversary date following the 70th birthday of a covered person. This benefit is not applicable and will not accrue to any covered person who has attained age 65 prior to the effective date of the policy. The named insured and covered spouse, if any, are the only persons eligible for this benefit. Dependent children do not qualify for this benefit. When a spouse is added to an existing policy, this benefit will begin to accrue from the endorsement date adding such spouse, provided the spouse has not yet attained age 65.

Benefits for Primary Specified Health Events

Primary specified health events covered by the Specified Health Event Protection policy include:

- Coma
- Stroke
- Paralysis
- Heart Attack
- Major Human Organ Transplant
- Major Third-Degree Burns
- Persistent Vegetative State
- Coronary Artery Bypass Surgery
- End-Stage Renal Failure

First-Occurrence Benefit

Aflac will pay $5,000 for the named insured and spouse or $7,500 for each dependent child covered under the policy when he or she is first diagnosed as having had a primary specified health event. This benefit is paid only once for each covered person and will be paid in addition to any other benefit in the policy. Lifetime maximum is $5,000 per named insured and spouse, and $7,500 per dependent child.

Reoccurrence Benefit

Aflac will pay $2,500 if benefits have been paid to a covered person under the First-Occurrence Benefit and if such covered person is later diagnosed as having had a subsequent primary specified health event.

For the Reoccurrence Benefit to be payable, the primary specified health event must occur more than 180 days after the date the First-Occurrence Benefit or the Reoccurrence Benefit becomes payable. No lifetime maximum.

Hospital Confinement Benefit*

Aflac will pay $300 per day for each day a covered person is charged as an inpatient and requires hospital confinement for the treatment of a covered primary specified health event. This benefit is limited to confinements for the treatment of a covered primary specified health event that occurs within 500 days following the occurrence of the most recent covered primary specified health event. This benefit is payable for only one covered primary specified health event at a time per covered person. This benefit includes confinement in a U.S. government hospital, and such treatment or confinement does not require a charge for benefits to be payable. No lifetime maximum.

Continuing Care Benefit*

Aflac will pay $125 each day a covered person is charged for receiving any of the following treatments from a licensed physician as the result of a covered primary specified health event:

- Dialysis
- Hospice Care
- Extended Care
- Physician Visits
- Speech Therapy
- Physical Therapy
- Home Health Care
- Nursing Home Care
- Respiratory Therapy
- Occupational Therapy
- Rehabilitation Therapy
- Dietary Therapy/Consultation

Treatment is limited to 60 days for continuing care received within 180 days following the occurrence of the most recent covered primary specified health event. Daily maximum for this benefit is $125 regardless of the number of treatments received. No lifetime maximum.

Transportation Benefit

Aflac will pay 50 cents per mile for noncommercial travel or the costs incurred for commercial travel (coach class plane, train, or bus fare) for transportation of a covered person for the round-trip distance between the hospital or medical facility and the residence of the covered person, if a covered person requires special medical treatment that has been prescribed by the local attending physician for a covered primary specified health event. This benefit is not payable for transportation by ambulance or air ambulance to the hospital. Reimbursement will be made only for the method of transportation actually taken. This benefit will be paid only for the covered person for whom the special treatment is prescribed. If the special treatment is for a dependent child and commercial travel is necessary, Aflac will pay this benefit for up to two adults to accompany the dependent child. The benefit amount payable is limited to $1,500 per occurrence of a covered primary specified health event. Transportation benefits are not payable beyond the 180th day following the occurrence of a covered primary specified health event. This benefit is not payable for transportation to any hospital located within a 50-mile radius of the residence of the covered person. No lifetime maximum.

Lodging Benefit

Aflac will pay the charges incurred up to $75 per day for lodging for you or any one adult family member when a covered person receives special medical treatment for a covered primary specified health event at a hospital or medical facility. The hospital, medical facility, and lodging must be more than 50 miles from the covered person's residence. This benefit is not payable for lodging occurring more than 24 hours prior to treatment or for lodging occurring more than 24 hours following treatment. This benefit is limited to 15 days per occurrence of a covered primary specified health event. Lodging benefits are not payable beyond the 180th day following the occurrence of a covered primary specified health event. No lifetime maximum.

The Continuing Care Benefit, Transportation Benefit, and Lodging Benefit will be paid for care received within 180 days following the occurrence of a covered primary specified health event. Benefits are payable for only one covered primary specified health event at a time per covered person. If a covered person is eligible to receive benefits for more than one covered primary specified health event, we will pay benefits only for care received within the 180 days following the occurrence of the most recent event.

Benefit for Secondary Specified Health Events

Secondary Specified Health Event Benefit

Aflac will pay $250 for each covered person under the policy when he or she has a coronary angioplasty, with or without stents. This benefit is limited to one coronary angioplasty per 30-day period. No lifetime maximum.

Miscellaneous Benefits

Major Human Organ Transplant Benefit

Aflac will pay $25,000 as a result of a major human organ transplant procedure when a covered person is confined in a hospital and receives one or more of the following human organs:

- Lung
- Liver
- Kidney
- Heart
- Pancreas

Transplant procedures involving more than one major organ will be considered one organ transplant procedure. This benefit is not payable for tissue, cell, or fluid transplants, or transplants involving mechanical or nonhuman organs and is limited to one procedure per 180-day period. Benefits reduce by one-half for losses incurred on or after the policy anniversary date following the 70th birthday of a covered person. No lifetime maximum.

*If the Hospital Confinement Benefit and the Continuing Care Benefit are payable on the same day, only the highest eligible benefit will be paid.

Ambulance Benefit

Aflac will pay $250 if, due to a covered primary specified health event or confinement in a hospital intensive care unit or a step-down intensive care unit for a covered sickness or injury, a covered person requires ground ambulance transportation to or from a hospital. *Aflac will pay $2,000* if air ambulance transportation is required due to a covered primary specified health event for a covered sickness or injury, or for confinement in a hospital intensive care unit or a step-down intensive care unit. A licensed professional or licensed volunteer ambulance company must provide the ambulance service. This benefit will not be paid for more than two times per occurrence of a primary specified health event or confinement in a hospital intensive care unit or step-down intensive care unit for a covered sickness or injury. Ambulance benefits are not payable beyond the 180th day following the occurrence of a covered primary specified health event. No lifetime maximum.

Waiver of Premium Benefit

If you, due to a primary specified health event, are completely unable to do all of the usual and customary duties of your occupation [if you are not employed: are completely unable to perform three or more of the activities of daily living (ADLs) without the assistance of another person] for a period of 90 continuous days, Aflac will waive, from month to month, any premiums falling due during your continued inability. For premiums to be waived, Aflac will require an employer's statement (if applicable) and a physician's statement of your inability to perform said duties, and may each month thereafter require a physician's statement that total inability continues.

Definitions

The following specified health events must occur after the effective date of coverage for benefits to be payable:

Primary Specified Health Event: heart attack, stroke, coronary artery bypass surgery, end-stage renal failure, major human organ transplant, major third-degree burns, persistent vegetative state, coma, or paralysis.

Coma: a continuous state of profound unconsciousness, diagnosed or treated after the effective date of the policy, lasting for a period of seven or more consecutive days and characterized by the absence of (1) spontaneous eye movement, (2) response to painful stimuli, and (3) vocalization. The condition must require intubation for respiratory assistance.

Coronary Artery Bypass Surgery: open-heart surgery to correct narrowing or blockage of one or more coronary arteries with bypass grafts, excluding procedures such as but not limited to coronary angioplasty, laser relief, or other nonsurgical procedures. This does not include valve replacement surgery.

End-Stage Renal Failure: permanent and irreversible kidney failure, not of an acute nature, requiring dialysis or a kidney transplant to maintain life.

Heart Attack: a myocardial infarction, coronary thrombosis, or coronary occlusion that is diagnosed (includes post-mortem diagnosis by autopsy) or treated after the effective date of the policy. The attack must be positively diagnosed by a physician and must be evidenced by electrocardiographic findings or clinical findings together with blood enzyme findings. The definition of heart attack will not be construed to mean congestive heart failure, atherosclerotic heart disease, angina, coronary artery disease, or any other dysfunction of the cardiovascular system.

Major Human Organ Transplant: a surgery in which a covered person receives, as a result of a surgical transplant, one or more of the following human organs: kidney, liver, heart, lung, or pancreas. It does not include tissue, cell, or fluid transplants, or transplants involving mechanical or nonhuman organs.

Major Third-Degree Burns: an area of tissue damage in which there is destruction of the entire epidermis and underlying dermis and that covers more than 10 percent of total body surface. The damage must be caused by heat, electricity, radiation, or chemicals.

Paralysis: spinal cord injuries resulting in complete and total loss of use of two or more limbs (paraplegia, quadriplegia, or hemiplegia) for a continuous period of at least 30 days. The paralysis must be confirmed by your attending physician.

Persistent Vegetative State: a state of severe mental impairment in which only involuntary bodily functions are present and for which there exists no reasonable expectation of regaining significant cognitive function. The procedure for establishing a persistent vegetative state is as follows: two physicians, one of whom must be the attending physician, who, after personally examining the covered person, will certify in writing, based upon conditions found during the course of their examination, that (1) the covered person's cognitive function has been substantially impaired, and (2) there exists no reasonable expectation that the covered person will regain significant cognitive function.

Secondary Specified Health Event: coronary angioplasty, with or without stents, occurring after the effective date of coverage.

Stroke: apoplexy due to rupture or acute occlusion of a cerebral artery that is diagnosed (includes post-mortem diagnosis by autopsy) or treated after the effective date of the policy. The apoplexy must cause complete or partial loss of function involving the motion or sensation of a part of the body and must last more than 24 hours. The stroke must be positively diagnosed by a physician based upon documented neurological deficits and confirmed by neuroimaging studies. Stroke does not mean head injury, transient ischemic attack (TIA), or cerebrovascular insufficiency.

Guaranteed-Renewable

The policy is guaranteed-renewable for your lifetime, with some benefits reduced at age 70, subject to Aflac's right to change premiums by class upon any renewal date.

Family Coverage

Family coverage includes the insured; spouse; and dependent, unmarried children to age 25. Newborn children are automatically insured as any other family member. One-parent family coverage includes the insured and dependent, unmarried children to age 25.

Effective Date

The effective date is the date shown in the Policy Schedule, not the date you signed the application for coverage. The payroll rate may be retained after one month's premium payment on payroll deduction.

Pre-Existing Conditions

A pre-existing condition is an illness, disease, disorder, or injury for which, within the six-month period before the effective date of coverage, medical advice, consultation, or treatment was recommended by or received from a physician. Benefits for a primary or secondary specified health event that is caused by a pre-existing condition will not be covered unless the primary or secondary specified health event occurs more than 30 days after the effective date. Any reoccurrence of a primary or secondary specified health event occurring more than 30 days after the effective date will be covered. The pre-existing condition DOES NOT apply to hospital intensive care benefits.

If this coverage is a replacement of similar coverage, we will give credit for the time the person was covered under previous coverage when determining the pre-existing conditions limitations, exclusive of any applicable waiting periods under the new coverage.

Limitations and Exclusions

Benefits payable under the Hospital Intensive Care Unit Benefit, Progressive Benefit for Hospital Intensive Care Unit/Step-Down Intensive Care Unit Confinement, and the Major Human Organ Transplant Benefit of the policy will be reduced by one-half for losses that begin on or after the policy anniversary date following the 70th birthday of a covered person.

Children born within ten months of the effective date of the policy will not be covered for any losses or confinements payable under the Hospital Intensive Care Unit Benefit, Progressive Benefit for Hospital Intensive Care Unit/Step-Down Intensive Care Unit Confinement, or the Major Human Organ Transplant Benefit that occur or begin during the first 28 days of life.

Benefits are not payable under the Hospital Intensive Care Unit Benefit or the Progressive Benefit for Hospital Intensive Care Unit/Step-Down Intensive Care Unit Confinement for confinement in units such as telemetry or surgical recovery rooms, postanesthesia care units, progressive care units, intermediate care units, private monitored rooms, observation units located in emergency rooms or outpatient surgery units, or other facilities that do not meet the standards for a hospital intensive care unit or step-down intensive care unit.

Benefits are not payable for losses or confinements that begin or occur before the policy effective date or after termination of the policy.

Benefits for a primary or secondary specified health event that is caused by a pre-existing condition will not be covered unless the primary or secondary specified health event occurs more than 30 days after the effective date. Benefits are payable for only one covered primary or secondary specified health event at a time per covered person.

The policy does not cover losses or confinements caused by or resulting from a covered person's:

- Participating in any sport or sporting activity for wage, compensation, or profit;
- Intentionally self-inflicting bodily injury or attempting suicide;
- Being exposed to war or any act of war, declared or undeclared, or actively serving in any of the armed forces or units auxiliary thereto, including the National Guard or Reserve;
- Participating in or attempting to participate in any illegal activity that is classified as a felony, if convicted (the term felony is as defined by the law of the jurisdiction in which the activity takes place);
- Having treatment for a mental or nervous disorder or disease;
- Sustaining or contracting any loss due, directly or indirectly, to being intoxicated or under the influence of alcohol, drugs, or any narcotic unless administered on the advice of a physician and taken according to the physician's instructions (the term intoxicated refers to that condition as defined by the law of the jurisdiction in which the injury or cause of the loss occurred).

Hospital does not include any institution or part thereof used as an emergency room; a hospice unit, including any bed designated as a hospice bed or a swing bed; a transitional care unit; a convalescent home; a rest or nursing facility; a psychiatric unit; an extended-care facility; a skilled nursing facility; or a facility primarily affording custodial or educational care, care or treatment for persons suffering from mental disease or disorders, care for the aged, or care for persons addicted to drugs or alcohol.

A physician does not include a member of your immediate family.

This brochure is for illustration purposes only.

Refer to the policy for complete details, limitations, and exclusions.

Aflac is ...

- A Fortune 500 company with nearly $66 billion in assets, insuring more than 40 million people worldwide.
- Rated AA in insurer financial strength by Standard & Poor's (June 2006), Aa2 (Excellent) in insurer financial strength by Moody's Investors Service (January 2006), A+ (Superior) by A.M. Best (June 2007), and AA in insurer financial strength by Fitch, Inc. (March 2008).*
- Named by Fortune magazine to its list of America's Most Admired Companies for the seventh consecutive year in March 2007.
- A premier provider of insurance policies with premiums payroll deducted for more than 402,300 payroll accounts nationally.
- Outstanding in claims service, with most claims processed within four days.
- Included by Forbes magazine in its annual list of America's 400 Best Big Companies for the eighth time in January 2008.
- Named by Fortune magazine to its list of the 100 Best Companies to Work For in America for the tenth consecutive year in February 2008.

**Ratings refer only to the overall financial status of Aflac and are not recommendations of specific policy provisions, rates, or practices.*

Your local Aflac insurance agent/producer

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Optional First-Occurrence Building Benefit Rider Summary Page

Rider A71050

The First-Occurrence Building Benefit Rider is a part of the policy and is subject to all policy provisions unless modified herein.

First-Occurrence Benefit

The First-Occurrence Benefit will be increased by $500 on each rider anniversary date while the rider remains in force. (The amount of the monthly increase will be determined on a pro rata basis.) This benefit will be paid under the same terms as the First-Occurrence Benefit. This benefit will cease to build for each covered person on the anniversary date of the rider following the covered person's 65th birthday or at the time of a primary specified health event for that covered person, whichever occurs first. However, regardless of the age of the covered person on the effective date of the rider, this benefit will accrue for a period of at least five years unless a primary specified health event is diagnosed prior to the fifth year of coverage.

Effective Date

The effective date of the rider is the effective date of the policy or the effective date of the rider as stated in the Policy Schedule, if later.

Termination

The rider will terminate if the policy to which it is attached terminates, when the benefit has been paid to all covered persons as described in the First-Occurrence Benefit listed in your policy, or if the premium for the rider is not paid.

The rider to which this sales material pertains is written only in English; the rider prevails if interpretation of this material varies.

Refer to the policy and rider for complete details, limitations, and exclusions.

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Optional Primary Specified Health Event Recovery Benefit Rider Summary Page

Rider A71051

The Primary Specified Health Event Recovery Benefit Rider is a part of the policy and is subject to all policy provisions unless modified herein.

Primary Specified Health Event Recovery Benefit

Aflac will pay $500 per month while a covered person remains in primary specified health event recovery upon receipt of written proof of loss from that person's physician. For periods of primary specified health event recovery less than one month, we will pay a pro rata benefit. Lifetime maximum of six months per covered person.

Definitions

Primary Specified Health Event Recovery: A covered person will be considered in specified health event recovery if he or she continues to be under the active care and treatment by a physician for a covered primary specified health event OR if he or she is unable to engage in the duties of his or her regular occupation due to a covered primary specified health event. A primary specified health event includes heart attack, stroke, coronary artery bypass surgery, end-stage renal failure, major human organ transplant, major third-degree burns, persistent vegetative state, coma, or paralysis occurring after the effective date of the rider.

Limitations and Exclusions

Benefits for a primary specified health event that is caused by a pre-existing condition will not be covered unless the primary specified health event occurs more than 30 days after the effective date. Benefits are payable for only one covered primary specified health event at a time per covered person.

The rider does not cover losses or confinements caused by or resulting from a covered person's:

- Sustaining or contracting any loss due, directly or indirectly, to being intoxicated or under the influence of alcohol, drugs, or any narcotic unless administered on the advice of a physician and taken according to the physician's instructions (the term intoxicated refers to that condition as defined by the law of the jurisdiction in which the injury or cause of the loss occurred);
- Participating in any sport or sporting activity for wage, compensation, or profit;
- Intentionally self-inflicting bodily injury or attempting suicide;
- Being exposed to war or any act of war, declared or undeclared, or actively serving in any of the armed forces or units auxiliary thereto, including the National Guard or Reserve.

Effective Date

The effective date of the rider is the effective date of the policy or the effective date of the rider as stated in the Policy Schedule, if later.

Termination

The rider will terminate if the policy to which it is attached terminates or if the premiums for the rider are not paid.

The rider to which this sales material pertains is written only in English; the rider prevails if interpretation of this material varies.

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FOR ILLUSTRATION PURPOSES ONLY

ACCIDENT-ONLY POLICY

This is an accident-only policy;
it does not pay benefits for Sickness.

IMPORTANT: This is a limited policy.
Read it carefully with the Outline of Coverage, if applicable.

In this policy, you, the Insured as shown in the Policy Schedule, are referred to as "you," "your," or "yours." **American Family Life Assurance Company of Columbus (Aflac)**, a stock company, is referred to as "we," "our," "us," or "Aflac."

CONSIDERATION

We promise to insure you for the benefits described in this policy. We make this promise in consideration of the application for this policy and the payment of all premiums when due.

YOUR RIGHT TO EXAMINE THIS POLICY

It is important to us that you are satisfied with this policy and that it meets your insurance needs. If you are not satisfied, you may return it within 30 days after you receive it. Send it to our agent or to Aflac Worldwide Headquarters, 1932 Wynnton Road, Columbus, Georgia 31999. You will receive a full refund of all premiums paid, and your policy will be void from its Effective Date. If you return the policy, please note in writing: "This policy is returned for cancellation and refund of premium."

IMPORTANT NOTICE: Please read your application attached to this policy. This policy is issued on the basis that the information shown on the application is correct and complete to the best of your knowledge and belief. Carefully check the application. Write to us within 30 days of the date you receive this policy if any information shown on it is not correct or complete. Incorrect information can result in the denial of a claim or termination of this policy. No agent may change this policy or waive any of its provisions.

THIS POLICY IS GUARANTEED-RENEWABLE FOR YOUR LIFETIME, SUBJECT TO OUR RIGHT TO CHANGE PREMIUMS BY CLASS UPON ANY RENEWAL DATE.

We agree that this policy will never be restricted by the addition of any rider without your consent, nor will renewal be refused because of any change in a covered person's health or physical condition. You are guaranteed the right to renew this policy for your lifetime by the payment of premiums at the rate in effect at the beginning of each term. We may change the established premium rate, but only if the rate is changed for all policies of this class. While this policy is in force, no change will be made in your class because of the age, sex, or physical condition of any covered person(s). "Class" means all policies of this form number and premium classification in your state that are then in force. If the established premium rate changes, we will notify you in writing at your last known address at least 45 days before the change becomes effective.

American Family Life Assurance Company of Columbus (Aflac)
Worldwide Headquarters: 1932 Wynnton Road, Columbus, Georgia 31999
For assistance or information about this policy, call 1-800-99-AFLAC (1-800-992-3522).

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Policy Schedule

INSURED: John A. Doe

POLICY NUMBER: 111-2222

TYPE OF COVERAGE: Individual

COVERAGE: XXXXXX
AAABBB

MODE OF PAYMENT: Monthly

DISABILITY BENEFIT PERIOD:

Accident:
Sickness:
Rider:

ELIMINATION PERIOD:

Accident:
Sickness:
Rider:

PREMIUMS

Policy: $XX
Rider: $XX

EFFECTIVE DATES

Policy: XX/XX/XX
Riders: XX/XX/XX

In witness whereof, Aflac's president and secretary signed this policy in Columbus, Georgia, as of the policy Effective Date shown in the Policy Schedule.

Paul S. Amos II, President

Joey M. Loudermilk, Secretary

This policy is a contract between you and Aflac.

READ YOUR POLICY CAREFULLY.

Part 1
DEFINITIONS

A. ACCIDENTAL-DEATH OR -DISMEMBERMENT: death or Dismemberment caused by an accident that occurs on or after the Effective Date of coverage and while coverage is in force, independent of disease, bodily infirmity, or any other cause. See the Limitations and Exclusions section for death or Dismemberment not covered by this policy.

B. AMBULATORY SURGICAL CENTER: a facility, licensed as such, that provides surgical services on an outpatient basis. This does not include a Physician's or dentist's office, clinic, or other such location.

C. COMA: a continuous state of profound unconsciousness, diagnosed or treated after the Effective Date of this policy, lasting for a period of seven or more consecutive days, characterized by the absence of: 1) spontaneous eye movements, 2) response to painful stimuli, and 3) vocalization. The condition must require intubation for respiratory assistance.

D. CHIP FRACTURE: a Fracture in which a piece of the bone is broken off near a joint at a place where a ligament is usually attached. It must be diagnosed by a Physician through the use of an X-ray.

E. COMMON-CARRIER ACCIDENTS: accidents that occur on or after the Effective Date of coverage and while coverage is in force directly involving a vehicle in which a covered person is a passenger at the time of the accident and which is duly licensed by a proper authority to transport passengers for a fee. Common-carrier vehicles are limited to airplanes, trains, buses, trolleys, and boats that operate on a regularly scheduled basis between predetermined points or cities. **A taxi is not a common-carrier vehicle.**

F. DISLOCATION: a completely separated joint. It must be diagnosed as a Dislocation by a Physician within 72 hours after the date of the accident. The Dislocation must require correction by a Physician. It can be corrected by open or closed Reduction.

G. DISMEMBERMENT OR LOSS OF (with or without reattachment): (1) Arm - actual severance above the elbow; (2) Leg - actual severance above the knee; (3) Hand - actual severance above the wrist; (4) Foot - actual severance above the ankle; (5) Finger - actual severance at the joint (proximate to the first interphalangeal joint) where it is attached to the hand; (6) Toe - actual severance at the joint (proximate to the first interphalangeal joint) where it is attached to the foot; and (7) Eye - loss of the eye or permanent loss of vision such that central visual acuity cannot be corrected to better than 20/200. **Loss of use does not constitute Dismemberment, except as stated above in (7) Eye.**

H. EFFECTIVE DATE: the date shown in the Policy Schedule. The Effective Date of the policy **is not** the date you signed the application for coverage.

I. FRACTURE: a break in a bone that can be seen by X-ray. It must be diagnosed as a Fracture by a Physician within 14 days after the date of the accident. The Fracture must require correction by a Physician. It can be corrected by open or closed Reduction.

J. HOSPITAL: the term "Hospital" is defined as a legally licensed Hospital which is accredited by the Joint Commission on Accreditation of Hospitals; the American Osteopathic Association or the Commission of Accreditation of Rehabilitative Facilities that maintains and uses on its

premises or in facilities available to it on a prearranged, written, contractual basis: a laboratory, X-ray equipment and an operating room. The institution must also have permanent and full-time facilities for the care of overnight resident bed patients under the supervision of one or more licensed Physicians, provide 24-hour-a-day nursing service by or under the supervision of a registered nurse, and maintain the patients' written histories and medical records on the premises. "Hospital" does not include any institution, or part thereof, used as an Ambulatory Surgical Center; a convalescent home; a rest or nursing facility; an extended-care facility; a skilled nursing facility; or a facility primarily affording custodial care, educational care, or care or treatment for persons suffering from mental disease or disorders, or care for the aged, drug addicts or alcoholics.

K. HOSPITAL CONFINEMENT: a stay of a covered person confined to a bed in a Hospital for which a room charge is made. The Hospital Confinement must be on the advice of a Physician and medically necessary. The confinement must be as a result of Injuries sustained in a covered accident or for rehabilitative care for Injuries sustained in a covered accident. Benefits are also payable for confinement in Hospitals operated by or for the United States government.

L. IMMEDIATE FAMILY: anyone related to you in the following manner: your spouse; brothers or sisters (includes stepbrothers and stepsisters); children (includes stepchildren); parents (includes stepparents); grandchildren; father-in-law or mother-in-law; and spouses, as applicable, of any of these.

M. INJURY: a bodily Injury caused directly by an accident, independent of Sickness, disease, bodily infirmity, or any other cause, occurring on or after the Effective Date of coverage and while coverage is in force. See the Limitations and Exclusions section for Injuries not covered by this policy.

N. INTENSIVE CARE UNIT (ICU): a specifically designated facility of the Hospital that provides the highest level of medical care and that is restricted to those patients who are critically ill or injured. Such facilities must be separate and apart from the surgical recovery room and from rooms, beds, and wards customarily used for patient confinement. The ICU must be permanently equipped with special lifesaving equipment for the care of the critically ill or injured, and the patients must be under constant and continual observation by nursing staffs assigned exclusively to the ICU on a full-time basis. These units must be listed as Intensive Care Units in the current edition of the American Hospital Association Guide or be eligible to be listed therein. This guide lists three types of facilities that meet this definition: (1) Intensive Care Units, (2) Cardiac Intensive Care Units, and (3) Infant (Neonatal) Intensive Care Units.

O. OTHER ACCIDENTS: accidents that occur on or after the Effective Date of coverage and while coverage is in force that are not classified as Common-Carrier Accidents and that are not specifically excluded in the Limitations and Exclusions section.

P. PARALYSIS: spinal cord Injuries received in a covered accident that result in complete and total loss of use of two or more limbs for a period of not less than 30 days. Your Paralysis must be confirmed by your attending Physician.

Q. PERIOD OF HOSPITAL CONFINEMENT: a time period of Hospital Confinement that starts while this policy is in force. If the confinement follows a previously covered confinement, it will be deemed a continuation of the first confinement unless the later confinement is the result of an entirely unrelated Injury or the confinements are separated by 30 days or more.

R. **PHYSICAL THERAPIST (also known as "Physiotherapist"):** a licensed specialist in physical therapy.

S. **PHYSICIAN:** a legally qualified person, other than a member of your Immediate Family, who is licensed as a Physician by the state to treat the type of condition for which a claim is made.

T. **PROSTHETIC DEVICE/PROSTHESIS:** an artificial device designed to replace a missing part of the body.

U. **REDUCTION:** open (surgical) or closed (manipulative) repair of a Fracture or Dislocation.

V. **SICKNESS:** a disease, disorder, infection, or any other abnormal physical condition that is not caused by an Injury that is first manifested or treated more than 30 days after your Effective Date of coverage and while coverage is in force. "Sickness" includes diseases or conditions resulting from insect bites or infestations by microorganisms. If you purchase the Optional Sickness Disability Rider Series A-34052, and the disease or disorder is first manifested or treated within the first 30 days after your Effective Date of coverage, any resulting disability will not be covered unless it begins more than 12 months after the Effective Date of coverage.

W. **TYPE OF COVERAGE:** see your Policy Schedule to determine the Type of Coverage issued: Individual, Named Insured/Spouse Only, One-Parent Family, or Two-Parent Family.

(1) **Individual:** coverage for only you (the Insured listed in the Policy Schedule).

(2) **Named Insured/Spouse Only:** coverage for only you (the Insured) and your spouse.

(3) **One-Parent Family:** coverage for you (the Insured) and all of your dependent children (or those of your spouse) who are unmarried and under age 19. "Dependent children" are your natural children, stepchildren, or legally adopted children who are unmarried, who are under age 19, and who qualify as legal dependents for tax exemption purposes under the United States Internal Revenue Service Tax Code. Coverage of a dependent child will be extended to age 23 if he/she is enrolled as a full-time student in a post secondary institution of higher learning for five calendar months in that calendar year; or, if not enrolled, would have been eligible to enroll and was prevented from enrolling due to Sickness or Injury.

(4) **Two-Parent Family:** coverage for you (the Insured), your spouse, and all of your dependent children (or those of your spouse) who are unmarried and under age 19. Dependent children are your natural children, stepchildren, or legally adopted children who are unmarried, who are under age 19, and who qualify as legal dependents for tax exemption purposes under the United States Internal Revenue Service Tax Code. Coverage of a dependent child will be extended to age 23 if he/she is enrolled as a full-time student in a post secondary institution of higher learning for five calendar months in that calendar year; or, if not enrolled, would have been eligible to enroll and was prevented from enrolling due to Sickness or Injury.

Persons covered under Individual, Named Insured/Spouse, One-Parent Family, or Two-Parent Family coverage are referred to as "covered persons." Newborn children are automatically covered under the terms of the policy from the moment of birth, and adopted children are covered from the date of petition. If Individual or Named Insured/Spouse coverage is issued and you desire uninterrupted coverage for a newborn or adopted child, you must notify Aflac within 31 days of the child's birth or the date of petition for adoption. Upon

notification, Aflac will convert this policy to One-Parent Family or Two-Parent Family coverage and advise you of the additional premium due. If One-Parent Family or Two-Parent Family coverage is in force, it is not necessary for you to notify Aflac of the birth of your child or the date of petition for adoption, and an additional premium payment is not required. If you wish any other person to be covered after the Effective Date of the policy, you must apply for such coverage, and that person must be added by endorsement. Insurance for persons added by endorsement becomes effective on the date specified on the endorsement.

The insurance on any dependent child will terminate on the policy anniversary date following the child's 19th birthday (23rd if a full-time student), the child's marriage, or at the time the child no longer qualifies as a legal dependent for tax exemption purposes under the United States Internal Revenue Service Tax Code, whichever occurs first. Termination will be without prejudice to any prior claim. Aflac's acceptance of premium after such date will be considered as premium for only the remaining persons who qualify as covered persons under the policy. Coverage provided under any One-Parent Family or Two-Parent Family contract will include any other unmarried dependent child, regardless of age, who is incapable of self-sustaining employment by reason of mental retardation or physical handicap and who became so incapacitated before age 19. If a claim is denied under this policy for the stated reason that the child has attained the limiting age for dependent children specified in this policy, the notice of denial must state that the policyholder has the burden of establishing that the child continues to be incapable of self-sustaining employment by reason of mental retardation or physical handicap and is chiefly dependent upon the policyholder for support and maintenance. Proof of such incapacity and dependency must be furnished to Aflac by you within 31 days of the dependent child's 19th birthday. Proof of continued incapacity and dependency must be furnished at Aflac's request, but not more often than annually, after the two-year period following the child's 19th birthday.

Part 2
LIMITATIONS AND EXCLUSIONS

A. We will not pay benefits for services rendered by a member of the Immediate Family of a covered person.

B. We will not pay benefits for an accident or Sickness that is caused by or occurs as a result of a covered person's:

1. Being under the influence of a controlled substance or illegal drugs (unless administered by a Physician and taken according to the Physician's instructions) or while intoxicated ("intoxicated" means that condition as defined by the law of the jurisdiction in which the accident occurred);
2. Driving any taxi for wage, compensation, or profit;
3. Mountaineering using ropes and/or other equipment; parachuting; or hang gliding;
4. Participating in, or attempting to participate in, an illegal activity that is defined as a felony, if convicted ("felony" is as defined by the law of the jurisdiction in which the activity takes place); or being incarcerated in any type penal institution;
5. Intentionally self-inflicting bodily Injury or attempting suicide, while sane or insane;
6. Having cosmetic surgery or other elective procedures that are not medically necessary, or having dental treatment except as a result of Injury;
7. Being exposed to war or any act of war, declared or undeclared;

8. Actively serving in any of the armed forces, or units auxiliary thereto, including the National Guard or Army Reserve;

9. Participating in any form of flight aviation other than as a fare-paying passenger in a fully licensed, passenger-carrying aircraft;

10. Participating in any sport or sporting activity for wage, compensation, or profit, including officiating or coaching; or racing any type vehicle in an organized event.

Part 3
RIGHT OF CONVERSION

A. Dissolution of Marriage:

If you and your spouse dissolve your marriage by a valid decree of dissolution of marriage and your spouse was covered under Named Insured/Spouse Only or Two-Parent Family coverage, coverage for your spouse will terminate. Your ex-spouse can apply for and receive, without evidence of insurability, a policy in his/her occupation class providing coverage not greater than the terminated coverage. To obtain the policy, your ex-spouse must apply to Aflac within 60 days following the entry of the decree of dissolution of marriage and pay the appropriate premium. Conversion rights do not apply to Off-the-Job Accident Disability Rider Series A-34050, On-the-Job Accident Disability Rider Series A-34051 and Sickness Disability Rider Series A-34052. If your ex-spouse is covered under the Spouse Off-the-Job Rider Series A-34053, this rider will terminate. However, the spouse rider will convert to the Off-the-Job Rider Series A-34050 for the same amount of coverage as provided in the Spouse Off-the-Job Rider Series A-34053. If additional coverage is desired, additional underwriting will be required.

If such dissolution of marriage occurs, the Named Insured under this policy at the time of the dissolution will retain that status. Any covered dependents may be insured under either policy, but not both.

B. Death:

In the event of your death, your spouse (if covered hereunder) will become the Named Insured and coverage will continue in the same occupation class. Conversion rights do not apply to Off-the-Job Accident Disability Rider Series A-34050, On-the-Job Accident Disability Rider Series A-34051 and Sickness Disability Rider Series A-34052. If your spouse is covered under the Spouse Off-the-Job Rider Series A-34053, this rider will terminate. However, the spouse rider will convert to the Off-the-Job Rider Series A-34050 for the same amount of coverage as provided in the Spouse Off-the-Job Rider Series A-34053. If additional coverage is desired, additional underwriting will be required.

C. Termination of Dependency:

A dependent child covered under this policy who has reached his or her 19th birthday or who has married and desires to continue coverage as the Insured under a separate policy may do so by notifying Aflac of the request in writing. The child will have the right to continue coverage as an Insured on a separate equivalent policy in his/her occupation class without a requirement for evidence of insurability and without interruption in coverage, provided Aflac receives written notification of the request before 30 days after the policy anniversary date following the dependent's 19th birthday or marriage. Conversion rights do not apply to Off-the-Job Accident Disability Rider Series A-34050, On-the-Job Accident Disability Rider Series A-34051 and Sickness Disability Rider Series A-34052.

Part 4

UNIFORM PROVISIONS

A. **ENTIRE CONTRACT; CHANGES:** This policy, together with the application, endorsements, benefit agreements, riders, and attached papers, if any, constitutes the entire contract of insurance. No change in this policy is valid until approved in writing by the secretary and president of Aflac at our worldwide headquarters. Any such change must be noted on or attached hereto. No agent has the authority to change this policy or to waive any of its provisions.

B. **TIME LIMIT ON CERTAIN DEFENSES:** After two years from the issue date, only fraudulent misstatements may be used to void the coverage or to deny a claim for loss incurred or disability starting after the two-year period.

C. **TERM:** The term of this policy begins at midnight, standard time, at the place where you reside on the Effective Date shown in the Policy Schedule. It ends at midnight, at the same standard time, on the first renewal date. Each renewal term ends at midnight, at the same standard time, on the next following renewal date. Renewal dates are determined by the mode of payment. The mode of payment for the original term of this policy is shown in the Policy Schedule. An annual premium will maintain this policy in force for 12 months, semiannual for six months, quarterly for three months, and monthly for one month. Premium for a term is due on the first day of that term. If you fail to pay your premium by the end of the grace period, coverage under this policy will terminate.

   Termination shall be without prejudice to any claim originating thereto.

D. **MISSTATEMENT OF AGE:** If an age has been misstated on the application, the benefits will be those the premium paid would have purchased at the correct age. We will refund all unearned premiums paid, less any benefits paid, if the misstated age at the time of application was outside the age limits for this policy.

E. **REINSTATEMENT:** If the renewal premium is not paid before the grace period ends, the policy will lapse. Later acceptance of the premium by Aflac or by an agent authorized to accept premium without requiring an application for reinstatement, will reinstate the policy. If Aflac or our agent requires an application, you will be given a conditional receipt for the premium. If the application is approved, the policy will be reinstated as of the approval date. Lacking such approval, the policy will be reinstated on the 45th day after the date of the conditional receipt unless Aflac has previously written you of our disapproval. The reinstated policy shall cover only loss resulting from accidental Injury that takes place after the date of reinstatement and loss resulting from Sickness (if you purchased Rider Form Series A-34052) that begins more than 10 days after the date of reinstatement. In all other respects, you and Aflac shall have the same rights as provided under the policy immediately before the due date of the defaulted premium, subject to any provisions added in connection with the reinstatement. Any premiums Aflac accepts for reinstatement will be applied to a period for which premiums have not been paid. No premiums will be applied to any period more than 60 days before the reinstatement date.

F. **GRACE PERIOD:** This policy has a 31 day grace period. This provision means that if a renewal premium is not paid on or before the date it is due, it may be paid during the following grace period. During the grace period, this policy will continue in force.

G. **MISSTATEMENT OF OCCUPATION OR INCOME:** If your occupation has been misstated, the benefits will be those that the premiums paid would have purchased for your correct

occupation. If your income has been misstated, the benefit payable will be that which would have been allowed for your true income level, and any overpayment of premium will be refunded.

H. **NOTICE OF CLAIM:** Written notice of claim must be given within 60 days after a covered loss starts or as soon as reasonably possible. The notice can be given to Aflac at our worldwide headquarters or to your agent. The notice should include the name of the covered person and the policy number.

I. **CLAIM FORMS:** When we receive a notice of claim, we will send you forms for filing proof of loss. If the forms are not given to you within ten working days, you will meet the proof-of-loss requirements by giving us a written statement of the nature and extent of the loss within the time limit stated in the Proof of Loss provision.

J. **PROOF OF LOSS:** Written proof of loss must be furnished to Aflac at our worldwide headquarters within 90 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate or reduce any claim if it was not reasonably possible to give proof within such time. However, such proof must be furnished as soon as reasonably possible and in no event (except in the absence of legal capacity) later than 15 months from the time proof is otherwise required.

K. **TIME OF PAYMENT OF CLAIMS:** Benefits payable under this policy will be paid immediately upon receipt of written proof of loss.

We will reimburse all claims or any portion of any claim from an Insured or an Insureds assignees, for payment under a health insurance policy, within 45 days after receipt of the claim by us. If a claim or a portion of the claim is contested by us, you or your assignees shall be notified in writing, that the claim is contested or denied within 45 days after receipt of the claim by us. The notice that a claim is contested shall identify the contested portion of the claim and the reasons for contesting the claim.

Upon receipt of the additional information requested from you or your assignees, we will pay or deny the contested portion within 60 days. We will pay or deny any claim no later than 120 days after receiving the claim. Payment shall be treated as being made on the date a draft or other valid instrument which is equivalent to payment, was placed in the United States mail in a properly addressed, postpaid envelope, or, if not so posted, the date of delivery. All overdue payments shall bear simple interest at the rate of 10 per cent per year.

Upon notification by you, we will investigate any claim of improper billing by a Physician, Hospital or other health care provider. We will determine if you were properly billed for those procedures and services you actually received. If we determine that you have been improperly billed, we will notify you and the provider of our findings and shall reduce the amount of payment to the provider by the amount of payment determined to be improperly billed. If a reduction is made due to such notification by you, we will pay you 20 percent of the amount of the reduction up to $500.

L. **PAYMENT OF CLAIMS:** All benefits will be payable to you unless assigned by you or by operation of law. Any accrued benefits unpaid at your death will be paid to your estate.

M. **LEGAL ACTIONS:** No action at law or equity shall be brought to recover on this policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of applicable statute of limitations from the time written proof of loss is required to be furnished.

N. CONFORMITY WITH STATE AND FEDERAL STATUTES: Any provision of this policy that, on its Effective Date, is in conflict with the statutes of the state in which it was issued or with any federal statute is hereby amended to conform to the minimum requirements of such statutes.

O. PHYSICAL EXAMINATIONS AND AUTOPSY: Aflac, at its own expense, shall have the right and opportunity to have you examined by a Physician of our choice as often as it may be reasonably required during the pendency of a claim hereunder. We may also have an autopsy made unless prohibited by law.

P. CHANGE OF BENEFICIARY: Unless you made the beneficiary designation in the attached application irrevocable, you have the right to make a change. The consent of the beneficiary is not required to surrender the policy, assign benefits, or make any other changes to this policy.

Q. ASSIGNMENT: We will not assume responsibility for determining the validity of an assignment of your benefits to a provider of services. No such assignment of benefits will be recognized until we receive notice that you have specifically assigned the benefits of your Aflac policy at our worldwide headquarters.

Part 5
BENEFITS

Benefit A is a preventive benefit; the death, Dismemberment, or Injury of a covered person is not required for this benefit to be payable.

A. WELLNESS BENEFIT: After this policy has been in force for 12 months, we will pay $60 (sixty dollars) if you or any one family member undergoes routine examinations or other preventive testing during the following policy year. Services covered are: annual physical examinations, dental exams, mammograms, Pap smears, eye examinations, immunizations, flexible sigmoidoscopies, prostate-specific antigen tests (PSAs), ultrasounds, and blood screenings. This benefit will become available following each anniversary of the policy's Effective Date for service received during the following policy year and is payable only once per policy each 12-month period following your policy anniversary date. Eligible family members are your spouse and the dependent children of either you or your spouse. Service must be under the supervision of or recommended by a Physician, received while your policy is in force, and a charge must be incurred.

We will pay the following benefits as applicable if a covered person's death, Dismemberment, or Injury is caused by a covered accident that occurs on or off the job. Death, Dismemberment, or Injury must be independent of disease or bodily infirmity, or of any cause other than a covered accident. A covered accident must also occur while coverage is in force and is subject to the limitations and exclusions.

B. ACCIDENT EMERGENCY TREATMENT BENEFIT: If a covered person receives treatment for Injuries sustained in a covered accident, we will pay the following benefit for treatment received. This benefit is payable for treatment by a Physician, X-rays, or treatment received in a Hospital emergency room. Treatment must be received within 72 hours of the accident for benefits to be payable. This benefit is payable once per 24-hour period and only once per covered accident, per covered person.

Insured	Spouse	Child
$135	$135	$80

Form A91310 (Effective March 1, 2009 or the Policy Effective Date, whichever is later.)

C. **ACCIDENT FOLLOW-UP TREATMENT BENEFIT:** If a covered person receives emergency treatment for Injuries sustained in a covered accident and later requires additional treatment over and above emergency treatment administered in the first 72 hours following the accident, we will pay $40 (forty dollars) per treatment for such follow-up treatment. We will pay for one treatment per day for up to a maximum of six treatments per covered accident, per covered person. The treatment must begin within 30 days of the covered accident or discharge from the Hospital. Treatments must be furnished by a Physician in a Physician's office or in a Hospital on an outpatient basis. **This benefit is not payable for the same visit that the Physical Therapy Benefit is paid.**

Form A91310 (Effective March 1, 2009 or the Policy Effective Date, whichever is later.)

D. **INITIAL ACCIDENT HOSPITALIZATION BENEFIT:** When a covered person is confined to a Hospital for at least 24 hours for Injuries sustained in a covered accident, we will pay an Initial Accident Hospitalization Benefit of $1,650 (one thousand six hundred fifty dollars), or we will pay $3,300 (three thousand three hundred dollars) if the covered person is admitted directly to an Intensive Care Unit. This benefit is payable only once per Hospital or Intensive Care Unit Confinement and only once per calendar year, per covered person. Confinements must start within 30 days of the accident.

Form A91310 (Effective March 1, 2009 or the Policy Effective Date, whichever is later.)

E. **ACCIDENT HOSPITAL CONFINEMENT BENEFIT:** When a covered person is confined to a Hospital for at least 18 hours for treatment of Injuries sustained in a covered accident, we will pay $500 (five hundred dollars) for each day of Hospital Confinement for which a covered person is charged for a room. We will pay this benefit up to 365 days per covered accident, per covered person. Confinements must start within 30 days of the accident.

Form A91310 (Effective March 1, 2009 or the Policy Effective Date, whichever is later.)

F. **INTENSIVE CARE UNIT CONFINEMENT BENEFIT:** While a covered person is receiving the Accident Hospital Confinement Benefit, we will pay an additional $725 (seven hundred twenty-five dollars) for each day the covered person is confined and charged for a room in an Intensive Care Unit. This Intensive Care Unit Confinement Benefit is payable for up to 15 days per covered accident, per covered person. Confinements must start within 30 days of the accident.

Form A91310 (Effective March 1, 2009 or the Policy Effective Date, whichever is later.)

G. **ACCIDENT SPECIFIC-SUM INJURIES BENEFITS:** If a covered person receives treatment for Injuries sustained in a covered accident, we will pay the following benefit for the treatment listed.

1. **Dislocation (reduced under general anesthesia):**

We will pay for no more than two Dislocations per covered accident, per covered person.

Benefits are payable for only the first Dislocation of a joint.

	Benefit:	
	Open Reduction	**Closed Reduction**
a. Hip	$2,750	$700

b. Knee or shoulder	$700	$275
c. Collar bone	$1,100	$225
d. Ankle or foot (excluding toes)	$700	$225
e. Lower jaw	$700	$350
f. Wrist or elbow	$550	$275
g. Toe or finger	$140	$70

If a Dislocation is reduced with local anesthesia or no anesthesia by a Physician, we will pay **25%** of the amount shown for the closed Reduction Dislocation.

2. Burns (treated by a Physician within 72 hours after a covered accident):

	Benefit:	
	2nd Degree	**3rd Degree**
Less than 20 square centimeters of the body surface	$140	$275
More than 20 but less than 40 square centimeters of the body surface	$275	$700
More than 40 but less than 65 square centimeters of the body surface	$550	$1,375
More than 65 but less than 160 square centimeters of the body surface	$825	$4,125
More than 160 but less than 225 square centimeters of the body surface	$1,100	$9,625
More than 225 square centimeters of the body surface	$1,375	$13,750

3. Skin Grafts:

If a covered person receives one or more skin grafts for a covered burn, we will pay a total of 50% of the Burn benefit amount we paid for the burn involved.

4. Eye Injury:

	Benefit:
Surgical repair	$325
Removal of foreign body by a Physician	$70

5. Lacerations requiring sutures (must be repaired within 72 hours after the accident and repaired under the attendance of a Physician):

	Benefit:
Laceration(s) not requiring sutures and treated by a Physician	$40
Single laceration less than 5 centimeters	$70
Lacerations at least 5 centimeters but not more than 15 centimeters (total of all lacerations)	$275
Lacerations over 15 centimeters (total of all lacerations)	$550

6. Fractures:

We will pay 25% of the benefit amount shown for the closed Reduction for Chip Fractures and other Fractures not reduced by open or closed Reduction.

We will pay for no more than two Fractures per covered accident, per covered person.

	Benefit:	
	Open Reduction	**Closed Reduction**
a. Hip	$2,750	$1,375
b. Leg	$1,375	$700
c. Hand (excluding fingers)	$700	$350
d. Foot (excluding toes/heel)	$700	$350
e. Wrist, elbow, ankle, or kneecap	$700	$350
f. Shoulder blade or forearm	$700	$350
g. Lower jaw	$700	$350

h.	Vertebrae (body of), pelvis (excluding coccyx), or sternum		$1,375	$700
i.	Upper jaw, upper arm, or face (excluding nose)		$825	$425
j.	Rib		$1,375	$140
k.	Nose, heel, or finger		$700	$140
l.	Coccyx		$275	$140
m.	Toe		$275	$140
n.	Vertebral processes		$1,375	$225
o.	Skull			
	depressed	$2,075		
	simple	$700		

7. Concussion (brain):

	Benefit:
	$55

8. Emergency dental work:

	Benefit:
Broken teeth repaired with crowns	$225
Broken teeth resulting in extractions	$70

We will pay for no more than one dental benefit per covered accident, per covered person.

9. Coma duration of at least 7 days:

	Benefit:
	$13,750

10. Paralysis:

If a covered person suffers Paralysis as a result of a covered accident, we will pay the applicable benefit indicated below. The duration of the Paralysis must be a minimum of 30 days.

	Benefit:
Quadriplegia (Paralysis of four limbs)	$13,750
Paraplegia (Paralysis of lower limbs)	$6,875

This benefit will be payable once per covered person.

11. Surgical Procedures:

Treatment must be performed within one year of a covered accident. Two or more surgical procedures performed through the same incision will be considered one operation and benefits will be paid based upon the most expensive procedure.

	Benefit:
Repair of:	
Tendons and/or ligaments	$700
Torn Rotator Cuffs	$700
Ruptured discs	$700
Torn knee cartilages	$700
Arthroscopy without surgical repair	$325
Open abdominal (including exploratory laparotomy), cranial, hernia, or thoracic surgery	$1,375

Miscellaneous surgery requiring general anesthesia that is not covered by any other specific-sum Injury benefit (Only one miscellaneous surgery benefit is payable per 24-hour period even though more than one surgical procedure may be performed.):

Benefit:
$325

Form A91310 (Effective March 1, 2009 or the Policy Effective Date, whichever is later.)

H. MAJOR DIAGNOSTIC EXAMS: If a covered person requires one of the following exams for Injuries sustained in a covered accident and a charge is incurred, we will pay $225 (two hundred twenty-five dollars): CT (computerized tomography) scan, MRI (magnetic resonance imaging), or EEG (electroencephalogram). These exams must be performed in a Hospital, a Physician's office, or an Ambulatory Surgical Center. This benefit is limited to one payment per calendar year, per covered person. No lifetime maximum.

Form A91310 (Effective March 1, 2009 or the Policy Effective Date, whichever is later.)

I. PHYSICAL THERAPY BENEFIT: If a covered person receives emergency treatment for Injuries sustained in a covered accident and later a Physician advises the covered person to seek treatment from a Physical Therapist, we will pay $40 (forty dollars) per treatment. Physical therapy must be for Injuries sustained in a covered accident and must start within 30 days of the covered accident or discharge from the Hospital. We will pay for one treatment per day for up to a maximum of 10 treatments per covered accident, per covered person. The treatment must take place within six months after the accident. **This benefit is not payable for the same visit that the Accident Follow-Up Treatment Benefit is paid.**

Form A91310 (Effective March 1, 2009 or the Policy Effective Date, whichever is later.)

J. APPLIANCES BENEFIT: If, as a result of Injuries sustained in a covered accident, a covered person requires, as advised by a Physician, the use of a medical appliance as an aid in personal locomotion, we will pay $140 (one hundred forty dollars). Benefits include and are payable for crutches, wheelchairs, leg braces, back braces, and walkers. This benefit is payable once per covered accident, per covered person.

Form A91310 (Effective March 1, 2009 or the Policy Effective Date, whichever is later.)

K. PROSTHESIS BENEFIT: If a covered person requires use of a Prosthetic Device as a result of Injuries sustained in a covered accident, we will pay $825 (eight hundred twenty-five dollars). This benefit is not payable for hearing aids, wigs, or any dental aids to include false teeth. This benefit is payable once per covered accident, per covered person.

Form A91310 (Effective March 1, 2009 or the Policy Effective Date, whichever is later.)

L. BLOOD/PLASMA/PLATELETS BENEFIT: If a covered person requires blood/plasma and/or platelets for the treatment of Injuries sustained in a covered accident, we will pay $225 (two hundred twenty-five dollars). This benefit does not pay for immunoglobulins and is payable only one time per covered accident, per covered person.

Form A91310 (Effective March 1, 2009 or the Policy Effective Date, whichever is later.)

M. AMBULANCE BENEFIT: If a covered person requires ambulance transportation to a Hospital or emergency center for Injuries sustained in a covered accident, we will pay $225 (two hundred twenty-five dollars). Ambulance transportation must be within 72 hours of the

covered accident. We will pay $1,650 (one thousand six hundred fifty dollars) for transportation provided by an air ambulance. A licensed professional ambulance company must provide the ambulance service.

Form A91310 (Effective March 1, 2009 or the Policy Effective Date, whichever is later.)

N. TRANSPORTATION BENEFIT: If a covered person requires special treatment and confinement in a Hospital for Injuries sustained in a covered accident, we will pay $650 (six hundred fifty dollars) per round trip. This benefit is not payable for transportation by ambulance or air ambulance to the Hospital. If the treatment is for a dependent child and commercial travel is necessary, the dependent child's parent or legal guardian who travels with the dependent child will also receive this benefit (only one person will be paid to travel with such dependent child). The local attending Physician must prescribe the treatment, and the treatment must not be available locally. This benefit is not payable for transportation to any Hospital located within a 100-mile radius of the site of the accident or residence of the covered person. This benefit is payable for up to three round trips per calendar year, per covered person.

Form A91310 (Effective March 1, 2009 or the Policy Effective Date, whichever is later.)

O. FAMILY LODGING BENEFIT: If a covered person requires Hospital Confinement for the treatment of Injuries sustained in a covered accident, we will pay $140 (one hundred forty dollars) per night for one motel/hotel room for a member(s) of the Immediate Family to accompany the covered person. This benefit is payable only during the same period of time the injured covered person is confined to the Hospital. The Hospital and motel/hotel must be more than 100 miles from the residence of the covered person. This benefit is payable up to 30 days per covered accident.

Form A91310 (Effective March 1, 2009 or the Policy Effective Date, whichever is later.)

P. ACCIDENTAL-DEATH BENEFIT: We will pay the applicable lump-sum benefit indicated below for Accidental Death. Death must occur as a result of Injuries sustained in a covered accident and must occur within 90 days of such accident.

	Insured	Spouse	Child
Common-Carrier Accidents	$275,000	$275,000	$55,000
Other Accidents	$82,500	$82,500	$27,500

Form A91310 (Effective March 1, 2009 or the Policy Effective Date, whichever is later.)

Q. ACCIDENTAL-DISMEMBERMENT BENEFIT: We will pay the applicable lump-sum benefit indicated below for Dismemberment. Dismemberment must occur as a result of Injuries sustained in a covered accident and must occur within 90 days of the accident.

Dismemberment or complete loss of, with or without reattachment:

	Insured	Spouse	Child
Both arms and both legs	$44,000	$44,000	$13,750
Two eyes, feet, hands, arms, or legs	$44,000	$44,000	$13,750
One eye, foot, hand, arm, or leg	$11,000	$11,000	$4,125
One or more fingers and/or one or more toes	$2,200	$2,200	$700

Only the highest single benefit per covered person will be paid for Accidental Dismemberment. Benefits will be paid only once for any covered accident. If death and Dismemberment result from the same accident, only the Accidental-Death Benefit will be paid.

Form A91310 (Effective March 1, 2009 or the Policy Effective Date, whichever is later.)

Optional Off-the-Job Accident Disability Benefit Rider Summary Page

Rider A-34050-FL

Coverage is provided for off-the-job accidents only. The rider does not apply to the spouse or dependents.*

Choose the Coverage You Need

Aflac's Personal Accident Indemnity Off-the-Job Accident Disability Benefit Rider allows you to choose a level of coverage that best meets your individual financial needs.

- Monthly Benefits: From $100 to $2,000, subject to income requirements
- Benefit Periods: 6 or 12 months
- Elimination Periods: 0 or 7 days

Provisions of Coverage

Disability benefits are available for ages 18 through 69 or for age 70 and above. Benefits are not payable in both categories for the same day.

Ages 18 through 69: If you are working at a full-time job while coverage is in force and a covered off-the-job accident causes you to become totally disabled, we will pay you one-thirtieth of the benefit shown in the Policy Schedule for each day you remain totally disabled.

If you are not working at a full-time job while coverage is in force and a covered off-the-job accident causes you to be unable to perform two or more activities of daily living (ADLs) as certified by your physician, and you require direct personal assistance to perform such ADLs, we will pay you one-thirtieth of the benefit shown in the Policy Schedule for each day you cannot perform such ADLs.

Disability must begin within 90 days of your last treatment for the covered off-the-job accident. This benefit is payable up to the benefit period selected and is subject to the elimination period shown in the Policy Schedule. A full-time job is a job at which you work 30 or more hours per week for pay or benefits.

Age 70 and above: While coverage is in force, if you require hospital confinement resulting from a covered off-the-job accident within 90 days of your last treatment for the accident, we will pay you one-thirtieth of the benefit shown in the Policy Schedule times three for each day you are confined. This benefit is payable regardless of whether you are working at a full-time job. It is payable up to the benefit period selected and is not subject to the elimination period shown in the Policy Schedule.

Benefits will be paid for only one disability at a time, even if that disability is caused by more than one injury. If you have any other disability benefit in force with Aflac, only one disability benefit is payable. Turning age 70 will not stop benefits otherwise payable. Aflac reserves the right to meet with you during the pendency of a claim or to use an independent consultant and physician's statement to determine whether you are totally disabled, or whether you are unable to perform two or more ADLs and require direct personal assistance. You must be under the care and attendance of a physician for these benefits to be payable. Benefits will cease on the date of your death.

Totally disabled is defined as your continuing inability to perform the material and substantial duties of your full-time job. You must also be under the care and attendance of a physician for your condition. If you are unable to perform the material and substantial duties of your full-time job but are able to work at any job, you will continue to be considered totally disabled as long as your earnings are less than 80 percent of your base pay earnings at the time you became totally disabled. If you return to work at any job and are earning 80 percent or more of your predisability base pay earnings, you will no longer be considered totally disabled. Base pay earnings is your gross salary or wages for your full-time job, not including variable pay such as overtime (unless contractual), bonuses, or other incentives. If you are self-employed, base pay earnings means your business's gross income minus the allowable business deductions from that business. (For tax purposes, base pay earnings is referred to as net earnings.)

Successive periods of disability resulting from the same or a related condition, and not separated by 180 days or more, are considered a continuation of the prior disability. Separate periods of disability resulting from unrelated causes are considered a continuation of the prior disability unless they are separated by your returning to work at a full-time job for 14 working days, during which you are performing the material and substantial duties of this job and are no longer qualified to receive disability benefits.

*An off-the-job accident is an injury that occurs while you are not working at any job for pay or benefits.

Pre-Existing Conditions

Disability or hospitalization caused by a pre-existing condition or reinjuries to a pre-existing condition will not be covered unless it begins more than 12 months after the effective date of coverage. A pre-existing condition is an injury for which, within the 12-month period before the effective date of coverage, medical advice, consultation, or treatment was recommended or received from a member of the medical profession.

Activities of Daily Living

- Continence: maintaining control of urination and bowel movements, including your ability to use ostomy supplies or other devices such as catheters
- Transferring: moving between a bed and a chair, or a bed and a wheelchair
- Dressing: putting on and taking off all necessary items of clothing, and/or medically necessary braces and artificial limbs usually worn
- Toileting: getting to and from a toilet, getting on and off a toilet, and performing associated personal hygiene
- Eating: performing all major tasks of getting food into the body

What Is Not Covered

- We will not pay benefits for a disability that is being treated outside the territorial limits of the United States or, if outside the United States, the territorial limits of the place where your policy was issued.
- Refer to your policy for additional limitations and exclusions.

We will not pay benefits for an accident that occurs while you are working at any job for pay or benefits.

We will not pay benefits for any sickness.

Termination

The rider will terminate if the policy to which it is attached terminates, if the premiums for the rider are not paid, or upon your death.

Effective Date

The effective date of the rider is the effective date of the policy or the effective date of the rider as stated in the Policy Schedule, if later.

Refer to the policy and rider for complete details, limitations, and exclusions.

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Optional Sickness Disability Benefit Rider Summary Page

Rider A-34052-FL

Coverage is provided for sickness only. The rider does not apply to the spouse or dependents.

Choose the Coverage You Need

Aflac's Personal Accident Indemnity Sickness Disability Benefit Rider allows you to choose a level of coverage that best meets your individual financial needs.

- Monthly Benefits: From $100 to $2,000, subject to income requirements
- Benefit Periods: 6 or 12 months

The Sickness Disability Benefit Rider includes a 14-day elimination period.

Provisions of Coverage

Disability benefits are available for ages 18 through 69 or for age 70 and above. Benefits are not payable in both categories for the same day.

Ages 18 through 69: If you are working at a full-time job while coverage is in force and a covered sickness causes you to become totally disabled, we will pay you one-thirtieth of the benefit shown in the Policy Schedule for each day you remain totally disabled.

If you are not working at a full-time job while coverage is in force and a covered sickness causes you to be unable to perform two or more activities of daily living (ADLs) as certified by your physician, and you require direct personal assistance to perform such ADLs, we will pay you one-thirtieth of the benefit shown in the Policy Schedule for each day you cannot perform such ADLs.

Disability must begin within 90 days of your last treatment for the covered sickness. This benefit is payable up to the benefit period selected and is subject to the 14-day elimination period shown in the Policy Schedule. A full-time job is a job at which you work 30 or more hours per week for pay or benefits.

Age 70 and above: While coverage is in force, if you require hospital confinement resulting from a covered sickness within 90 days of your last treatment for the sickness, we will pay you one-thirtieth of the benefit shown in the Policy Schedule times three for each day you are confined. This benefit is payable regardless of whether you are working at a full-time job. It is payable up to the benefit period selected and is not subject to the 14-day elimination period shown in the Policy Schedule.

Benefits will be paid for only one disability at a time, even if that disability is caused by more than one sickness. If you have any other disability benefit in force with Aflac, only one disability benefit is payable. Turning age 70 will not stop benefits otherwise payable. Aflac reserves the right to meet with you during the pendency of a claim or to use an independent consultant and a physician's statement to determine whether you are totally disabled, or whether you are unable to perform two or more ADLs and require direct personal assistance. You must be under the care and attendance of a physician for these benefits to be payable. Benefits will cease on the date of your death.

Totally disabled is defined as your continuing inability to perform the material and substantial duties of your full-time job. You must also be under the care and attendance of a physician for your condition. If you are unable to perform the material and substantial duties of your full-time job but are able to work at any job, you will continue to be considered totally disabled as long as your earnings are less than 80% of your base pay earnings at the time you became totally disabled. If you return to work at any job and are earning 80% or more of your predisability base pay earnings, you will no longer be considered totally disabled. Base pay earnings is your gross salary or wages for your full-time job, not including variable pay such as overtime (unless contractual), bonuses, or other incentives. If you are self-employed, base pay earnings means your business's gross income minus the allowable business deductions from that business. (For tax purposes, base pay earnings is referred to as net earnings.)

Successive periods of disability resulting from the same or a related condition, and not separated by 180 days or more, are considered a continuation of the prior disability. Separate periods of disability resulting from unrelated causes are considered a continuation of the prior disability unless they are separated by your returning to work at a full-time job for 14 working days, during which you are performing the material and substantial duties of this job and are no longer qualified to receive disability benefits.

Pre-Existing Conditions

Disability or hospitalization caused by a pre-existing condition will not be covered unless it begins more than 12 months after the effective date of coverage. A pre-existing condition is a sickness for which, within the 12-month period before the effective date of coverage, medical advice, consultation, or treatment was recommended or received from a member of the medical profession.

A sickness is a disease, disorder, infection, or any other abnormal physical condition that is not caused by an injury and that is first manifested or treated more than 30 days after your effective date of coverage and while coverage is in force. If the disease or disorder is first manifested or treated within the first 30 days after your effective date of coverage, any resulting disability will not be covered unless it begins more than 12 months after the effective date of coverage.

Activities of Daily Living

- Continence: maintaining control of urination and bowel movements, including your ability to use ostomy supplies or other devices such as catheters
- Transferring: moving between a bed and a chair, or a bed and a wheelchair
- Dressing: putting on and taking off all necessary items of clothing, and/or medically necessary braces and artificial limbs usually worn
- Toileting: getting to and from a toilet, getting on and off a toilet, and performing associated personal hygiene
- Eating: performing all major tasks of getting food into the body

What Is Not Covered

We will not pay benefits for a disability that is being treated outside the territorial limits of the United States or, if outside the United States, the territorial limits of the place where your policy was issued.

We will not pay benefits for a disability that is caused by or occurs as a result of your:

- Becoming totally disabled due to any of the following: bipolar affective disorder (manic depressive syndrome), delusional (paranoid) disorders, psychotic disorders, somatoform disorders (psychosomatic illness), eating disorders, schizophrenia, anxiety disorders, depression, stress, or post-partum depression. The rider will pay, however, for covered disabilities resulting from Alzheimer's disease, or similar forms of senility or senile dementia, first manifested while coverage is in force;
- Giving birth within the first ten months of the effective date of the rider as a result of a normal pregnancy, including cesarean (complications of pregnancy will be covered to the same extent as a sickness);
- Donating an organ within the first 12 months of the effective date of the rider.

Refer to your policy for additional limitations and exclusions.

Termination

The rider will terminate if the policy to which it is attached terminates, if the premiums for the rider are not paid, or upon your death.

Effective Date

The effective date of the rider is the effective date of the policy or the effective date of the rider as stated in the Policy Schedule, if later.

Refer to the policy and rider for complete details, limitations, and exclusions.

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Optional Spouse Off-the-Job Accident Disability Benefit Rider Summary Page

Rider A-34053-FL

Coverage is provided for off-the-job accidents* for the spouse only. In the rider, you, the spouse, will be referred to as you, your, or yours. The rider does not apply to the insured or dependents.

Coverage Amount

You may choose a monthly benefit ranging from $100 to $700, subject to a minimum income requirement. The benefit period is six months and there is no elimination period.

Provisions of Coverage

Disability benefits are available for ages 18 through 69 or for age 70 and above. Benefits are not payable in both categories for the same day.

Ages 18 through 69: If you are working at a full-time job while coverage is in force and a covered off-the-job accident causes you to become totally disabled, we will pay you one-thirtieth of the benefit shown in the Policy Schedule for each day you remain totally disabled.

If you are not working at a full-time job while coverage is in force and a covered off-the-job accident causes you to be unable to perform two or more activities of daily living (ADLs) as certified by your physician, and you require direct personal assistance to perform such ADLs, we will pay you one-thirtieth of the benefit shown in the Policy Schedule for each day you cannot perform such ADLs.

Disability must begin within 90 days of your last treatment for the covered accident. This benefit is payable up to the six-month benefit period and is subject to the elimination period shown in the Policy Schedule. A full-time job is a job that you, the insured's spouse, work at 30 or more hours per week for pay or benefits.

Age 70 and above: While coverage is in force, if you require hospital confinement resulting from a covered off-the-job accident within 90 days of your last treatment for the accident, we will pay you one-thirtieth of the benefit shown in the Policy Schedule times three for each day you are confined. This benefit is payable regardless of whether you are working at a full-time job. It is payable up to the six-month benefit period selected and is not subject to the elimination period shown in the Policy Schedule.

Benefits will be paid for only one disability at a time, even if that disability is caused by more than one injury. If you have any other disability benefit in force with Aflac, only one disability benefit is payable. Turning age 70 will not stop benefits otherwise payable. Aflac reserves the right to meet with you during the pendency of a claim or to use an independent consultant and a physician's statement to determine whether you are totally disabled, or whether you are unable to perform two or more ADLs and require direct personal assistance. You must be under the care and attendance of a physician for these benefits to be payable. Benefits will cease on the date of your death.

Totally disabled is defined as your continuing inability to perform the material and substantial duties of your full-time job. You must also be under the care and attendance of a physician for your condition. If you are unable to perform the material and substantial duties of your full-time job but are able to work at any job, you will continue to be considered totally disabled as long as your earnings are less than 80 percent of your base pay earnings at the time you became totally disabled. If you return to work at any job and are earning 80 percent or more of your predisability base pay earnings, you will no longer be considered totally disabled. Base pay earnings is your gross salary or wages for your full-time job, not including variable pay such as overtime (unless contractual), bonuses, or other incentives. If you are self-employed, base pay earnings means your business's gross income minus the allowable business deductions from that business. (For tax purposes, base pay earnings is referred to as net earnings.)

Successive periods of disability resulting from the same or a related condition, and not separated by 180 days or more, are considered a continuation of the prior disability. Separate periods of disability resulting from unrelated causes are considered a continuation of the prior disability unless they are separated by your returning to work at a full-time job for 14 working days, during which you are performing the material and substantial duties of this job and are no longer qualified to receive disability benefits.

*An off-the-job accident is an injury that occurs while you are not working at any job for pay or benefits.

Pre-Existing Conditions

Disability or hospitalization caused by a pre-existing condition or reinjuries to a pre-existing condition will not be covered unless it begins more than 12 months after the effective date of coverage. A pre-existing condition is an injury for which, within the 12-month period before the effective date of coverage, medical advice, consultation, or treatment was recommended or received from a member of the medical profession.

Activities of Daily Living

- Continence: maintaining control of urination and bowel movements, including your ability to use ostomy supplies or other devices such as catheters
- Transferring: moving between a bed and a chair, or a bed and a wheelchair
- Dressing: putting on and taking off all necessary items of clothing, and/or medically necessary braces and artificial limbs usually worn
- Toileting: getting to and from a toilet, getting on and off a toilet, and performing associated personal hygiene
- Eating: performing all major tasks of getting food into the body

What Is Not Covered

- We will not pay benefits for a disability that is being treated outside the territorial limits of the United States or, if outside the United States, the territorial limits of the place where your policy was issued.
- Refer to your policy for additional limitations and exclusions.

We will not pay benefits for an accident that occurs while you are working at any job for pay or benefits.

We will not pay benefits for any sickness.

Termination

The rider will terminate if the policy to which it is attached terminates, if the premiums for the rider are not paid, upon the dissolution of your marriage, upon the death of the named insured, or upon your death.

Effective Date

The effective date of the rider is the effective date of the policy or the effective date of the rider as stated in the Policy Schedule, if later.

Refer to the policy and rider for complete details, limitations, and exclusions.

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Plan 1

Hospital Protection

Hospital Confinement Indemnity Insurance ...

what you need, when you need it.

Form A46175FL

Aflac™

Annual Hospitalization Confinement Benefit

Aflac will pay the amount listed below for the first five days of hospitalization when a covered person requires hospital confinement* for a covered sickness or injury and a charge is incurred.

Sickness	*$400 per day*
Injury	*$500 per day*

Benefits for the Annual Hospitalization Confinement Benefit are limited to a total benefit payment of five days per calendar year, per policy. Confinements not separated by 30 days or more, or hospitalization that begins prior to the end of one calendar year and continues into the next calendar year, will be considered one confinement.

Daily Hospital Confinement Benefit

Aflac will pay $100 per day for the period of hospital confinement* when a covered person requires hospital confinement for a covered sickness or injury. This benefit is payable in addition to the Annual Hospitalization Confinement Benefit. The maximum benefit period for any one period of hospital confinement is 365 days. No lifetime maximum.

*Hospital confinement does not include emergency rooms. Treatment or confinement in a U.S. government hospital does not require a charge for benefits to be payable.

Waiver of Premium Benefit

Aflac will waive from month to month, for the named insured only, any premium(s) falling due during the named insured's continued hospital confinement. This benefit will begin after the named insured has received Daily Hospital Confinement Benefits from the policy for 30 consecutive days. When Daily Hospital Confinement Benefits are no longer being paid, premium payments must be resumed. Once premium payments are resumed, any new confinements must again satisfy the 30-day continued confinement for premiums to be waived. If you die and your spouse becomes the new named insured, premiums will start again at the appropriate rate and will be due on the first premium due date after the change. The new named insured will then be eligible for this benefit if the need arises.

Guaranteed-Renewable

The policy is guaranteed-renewable for your lifetime, subject to Aflac's right to change premiums by class upon any renewal date.

Family Coverage

Family coverage includes the insured; spouse; and dependent, unmarried children to age 19 (or 23 if they are full-time students). Newborn children are automatically insured from the moment of birth. One-parent family coverage includes the insured and dependent, unmarried children to age 19 (or 23 if they are full-time students). A dependent child must be under age 19 at the time of application to be eligible for coverage.

Effective Date

The effective date is the date shown in the Policy Schedule, not the date the application is signed. Payroll rates may be retained after one month's premium payment on payroll deduction.

Pre-Existing Conditions

A pre-existing condition is an illness, disease, or disorder for which, within the 12-month period before the effective date of coverage, medical advice, consultation, or treatment was recommended or received, or for which conditions existed that would ordinarily cause a prudent person to seek diagnosis, care, or treatment. Care or treatment caused by a pre-existing condition will not be covered unless it begins more than six months after the effective date of coverage. A sickness is an illness, disease, or disorder, independent of injury, diagnosed or treated more than 30 days after the effective date of coverage and while coverage is in force.

If this coverage is a replacement of similar coverage, we will give credit for the time the person was covered under the previous coverage when determining the pre-existing conditions limitations, exclusive of any applicable waiting periods under the new coverage.

Limitations and Exclusions

Any illness, disease, or disorder diagnosed by a physician or medically treated during the 12 months prior to the effective date of the policy will not be covered, unless the loss begins more than six months after the effective date of the policy. Benefits are not payable for any illness, disease, or disorder that is diagnosed by a physician or medically treated before coverage has been in force 30 days from the effective date shown in the Policy Schedule, unless the loss begins more than six months after the effective date of the policy. Benefits for a covered sickness for all persons added to the policy (including newborns) are subject to a 30-day waiting period. Aflac will waive the waiting period for newborns added after the policy has been in force for ten full months.

The policy does not cover losses caused by or resulting from intentionally self-inflicting bodily injury or attempting suicide; participating in or attempting to participate in any illegal activity that is classified as a felony, if convicted (the term felony is as defined by the law of the jurisdiction in which the activity takes place); being exposed to war or any act of war, declared or undeclared, or actively serving in any of the armed forces or units auxiliary thereto, including the National Guard or Reserve; having treatment for a mental or nervous disorder or disease; alcoholism or drug dependency; any loss sustained or contracted due to a covered person's being intoxicated or under the influence of alcohol, drugs, or any narcotic unless administered on the advice of a physician and taken according to the physician's instructions (the term intoxicated refers to that condition as defined by the law of the jurisdiction in which the injury or cause of the loss occurred); having cosmetic surgery that is not medically necessary; having elective surgery that is not medically necessary within the first 12 months of the effective date of the policy; pregnancy or childbirth within the first ten months of the effective date of the policy (complications of pregnancy will be covered to the same extent as a sickness); routine nursing or well-baby care for a newborn child; being hospitalized before the effective date of coverage; or donating an organ within the first 12 months of the effective date of the policy.

If the period of hospital confinement follows a previously covered confinement, it will be deemed a continuation of the first confinement unless the later confinement is the result of an entirely unrelated sickness or injury, or the confinements are separated by 30 days or more during which the covered person is not confined in any institution or facility.

A physician does not include a member of your immediate family.

Hospital does not include any institution or part thereof used as an emergency room; a hospice unit, including any bed designated as a hospice or a swing bed; a convalescent home; a rest or nursing facility; a psychiatric unit; an extended-care facility; a skilled nursing facility; or a facility primarily affording custodial or educational care, care or treatment for persons suffering from mental disease or disorders, care for the aged, or care for persons addicted to drugs or alcohol.

Complications of pregnancy do not include premature delivery without incidence, false labor, occasional spotting, prescribed rest during pregnancy, morning sickness, and similar conditions associated with the management of a difficult pregnancy not constituting a classifiably distinct complication of pregnancy. Cesarean deliveries are not considered complications of pregnancy.

The policy to which this sales material pertains is written only in English; the policy prevails if interpretation of this material varies.

1.800.99.AFLAC (1.800.992.3522)

En español:
1.800.SI.AFLAC (1.800.742.3522)

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Plan 3

Hospital Protection

Hospital Confinement Indemnity Insurance ...

what you need, when you need it.

Plan Benefits

- Annual Hospitalization Confinement
- Daily Hospital Confinement
- Invasive Diagnostic Exams
- Wellness
- Plus ... more

Form A46375FL

IC(4/07)

Aflac™

Hospital Protection

Policy Series A46000

Annual Hospitalization Confinement Benefit

Aflac will pay the amount listed below for the first five days of hospitalization when a covered person requires hospital confinement* for a covered sickness or injury and a charge is incurred.

Sickness	*$400 per day*
Injury	*$500 per day*

Benefits for the Annual Hospitalization Confinement Benefit are limited to a total benefit payment of five days per calendar year, per policy. Confinements not separated by 30 days or more, or hospitalization that begins prior to the end of one calendar year and continues into the next calendar year, will be considered one confinement.

Daily Hospital Confinement Benefit

Aflac will pay $100 per day for the period of hospital confinement* when a covered person requires hospital confinement for a covered sickness or injury. This benefit is payable in addition to the Annual Hospitalization Confinement Benefit. The maximum benefit period for any one period of hospital confinement is 365 days. No lifetime maximum.

*Hospital confinement does not include emergency rooms. Treatment or confinement in a U.S. government hospital does not require a charge for benefits to be payable.

Invasive Diagnostic Exams Benefit

Aflac will pay $100 when a covered person requires one of the following exams and a charge is incurred: arthroscopy, bronchoscopy, colonoscopy, cystoscopy, gastroscopy, laryngoscopy, sigmoidoscopy, esophagoscopy, or myringoscopy. These exams must be performed in a hospital or an ambulatory surgical center. Only one benefit is payable per 24-hour period, per covered person. When an invasive diagnostic exam and a surgical benefit are performed on the same day, only one benefit is payable per 24-hour period. The highest eligible benefit will be paid. No lifetime maximum.

Surgical Benefit

Aflac will pay $50–$1,000 when a surgical operation is performed, including a vaginal or cesarean delivery, on a covered person for a covered sickness or injury in a hospital or an ambulatory surgical center. If any operation for the treatment of the covered sickness or injury is performed other than those listed, Aflac will pay an amount comparable to the amount shown in the Schedule of Operations for the operation most nearly similar in severity and gravity. Only one benefit is payable per 24-hour period for surgery even though more than one surgical procedure may be performed. The highest eligible benefit will be paid. Exams covered under the Invasive Diagnostic Exams Benefit are not payable under this benefit. No lifetime maximum.

Surgical Benefits are not payable for surgery performed in a doctor's or dentist's office, clinic, or other such location. Surgical Benefits are not payable for losses caused by or resulting from elective surgery that is not medically necessary within the first 12 months of the effective date of the policy unless the loss begins after 12 months from the effective date of the policy.

Outpatient Surgical Room Charge Benefit

Aflac will pay the amount listed below when a covered person has a surgical operation or an invasive diagnostic exam performed on an outpatient basis in a hospital, to include an ambulatory surgical center. This benefit is not payable on the same day as the Hospital Confinement Benefit. No lifetime maximum on the number of operations.

Surgical operation or invasive diagnostic exam with general anesthesia	*$300*
Surgical operation or invasive diagnostic exam without general anesthesia	*$100*

Medical Diagnostic and Imaging Benefit

Aflac will pay $150 per calendar year for each covered person when a covered person requires one of the following exams and a charge is incurred: CT scan, MRI (magnetic resonance imaging), EEG (electroencephalogram), thallium stress test, myelogram, angiogram, or arteriogram. These exams must be performed in a hospital, an ambulatory surgical center, or a doctor's office. This benefit is limited to one payment per calendar year, per covered person. No lifetime maximum.

Ambulance Benefit

Aflac will pay $100 if, due to a covered sickness or injury, a covered person requires ground ambulance transportation to or from a hospital and a charge is incurred. If air ambulance transportation is required due to a covered sickness or injury and a charge is incurred, *Aflac will pay $1,000*. A licensed professional ambulance company must provide the ambulance service. This benefit is limited to two trips per calendar year, per covered person. No lifetime maximum.

Wellness Benefit

After the policy has been in force for 12 months, *Aflac will pay $50* if you or any one family member undergoes routine examinations or other preventive testing during the following policy year. Services covered are annual physical examinations, dental exams, mammograms, Pap smears, eye examinations, immunizations, prostate-specific antigen tests, ultrasounds, and blood screenings. This benefit will become available following each anniversary of the policy's effective date for service received during the following policy year and is payable only once per policy each 12-month period following your policy anniversary date. Eligible family members are your spouse and the dependent children of either you or your spouse. Service must be under the supervision of or recommended by a physician, received while your policy is in force, and a charge must be incurred.

Waiver of Premium Benefit

Aflac will waive from month to month, for the named insured only, any premium(s) falling due during the named insured's continued hospital confinement. This benefit will begin after the named insured has received Daily Hospital Confinement Benefits from the policy for 30 consecutive days. When Daily Hospital Confinement Benefits are no longer being paid, premium payments must be resumed. Once premium payments are resumed, any new confinements must again satisfy the 30-day continued confinement for premiums to be waived. If you die and your spouse becomes the new named insured, premiums will start again at the appropriate rate and will be due on the first premium due date after the change. The new named insured will then be eligible for this benefit if the need arises.

Guaranteed-Renewable

The policy is guaranteed-renewable for your lifetime, subject to Aflac's right to change premiums by class upon any renewal date.

Family Coverage

Family coverage includes the insured; spouse; and dependent, unmarried children to age 19 (or 23 if they are full-time students). Newborn children are automatically insured from the moment of birth. One-parent family coverage includes the insured and dependent, unmarried children to age 19 (or 23 if they are full-time students). A dependent child must be under age 19 at the time of application to be eligible for coverage.

Pre-Existing Conditions

A pre-existing condition is an illness, disease, or disorder for which, within the 12-month period before the effective date of coverage, medical advice, consultation, or treatment was recommended or received, or for which conditions existed that would ordinarily cause a prudent person to seek diagnosis, care, or treatment. Care or treatment caused by a pre-existing condition will not be covered unless it begins more than six months after the effective date of coverage. A sickness is an illness, disease, or disorder, independent of injury, diagnosed or treated more than 30 days after the effective date of coverage and while coverage is in force.

If this coverage is a replacement of similar coverage, we will give credit for the time the person was covered under the previous coverage when determining the pre-existing conditions limitations, exclusive of any applicable waiting periods under the new coverage.

Limitations and Exclusions

Any illness, disease, or disorder diagnosed by a physician or medically treated during the 12 months prior to the effective date of the policy will not be covered, unless the loss begins more than six months after the effective date of the policy. Benefits are not payable for any illness, disease, or disorder that is diagnosed by a physician or medically treated before coverage has been in force 30 days from the effective date shown in the Policy Schedule, unless the loss begins more than six months after the effective date of the policy. Benefits for a covered sickness for all persons added to the policy (including newborns) are subject to a 30-day waiting period. Aflac will waive the waiting period for newborns added after the policy has been in force for ten full months.

The policy does not cover losses caused by or resulting from intentionally self-inflicting bodily injury or attempting suicide; participating in or attempting to participate in any illegal activity that is classified as a felony, if convicted (the term felony is as defined by the law of the jurisdiction in which the activity takes place); being exposed to war or any act of war, declared or undeclared, or actively serving in any of the armed forces or units auxiliary thereto, including the National Guard or Reserve; having treatment for a mental or nervous disorder or disease; alcoholism or drug dependency; any loss sustained or contracted due to a covered person's being intoxicated or under the influence of alcohol, drugs, or any narcotic unless administered on the advice of a physician and taken according to the physician's instructions (the term intoxicated refers to that condition as defined by the law of the jurisdiction in which the injury or cause of the loss occurred); having cosmetic surgery that is not medically necessary; having elective surgery that is not medically necessary within the first 12 months of the effective date of the policy; pregnancy or childbirth within the first ten months of the effective date of the policy (complications of pregnancy will be covered to the same extent as a sickness); routine nursing or well-baby care for a newborn child; being hospitalized before the effective date of coverage; or donating an organ within the first 12 months of the effective date of the policy.

If the period of hospital confinement follows a previously covered confinement, it will be deemed a continuation of the first confinement unless the later confinement is the result of an entirely unrelated sickness or injury, or the confinements are separated by 30 days or more during which the covered person is not confined in any institution or facility.

A physician does not include a member of your immediate family.

Hospital does not include any institution or part thereof used as an emergency room; a hospice unit, including any bed designated as a hospice or a swing bed; a convalescent home; a rest or nursing facility; a psychiatric unit; an extended-care facility; a skilled nursing facility; or a facility primarily affording custodial or educational care, care or treatment for persons suffering from mental disease or disorders, care for the aged, or care for persons addicted to drugs or alcohol.

Complications of pregnancy do not include premature delivery without incidence, false labor, occasional spotting, prescribed rest during pregnancy, morning sickness, and similar conditions associated with the management of a difficult pregnancy not constituting a classifiably distinct complication of pregnancy. Cesarean deliveries are not considered complications of pregnancy.

Effective Date

The effective date is the date shown in the Policy Schedule, not the date the application is signed. Payroll rates may be retained after one month's premium payment on payroll deduction.

The policy to which this sales material pertains is written only in English; the policy prevails if interpretation of this material varies.

This is a brief summary of coverage. Refer to the policy for complete details, limitations, and exclusions.

Aflac is ...

- A Fortune 500 company with nearly $60 billion in assets, insuring more than 40 million people worldwide.
- Rated AA in insurer financial strength by Standard & Poor's (June 2006), Aa2 (Excellent) in insurer financial strength by Moody's Investors Service (January 2006), A+ (Superior) by A.M. Best (June 2006), and AA in insurer financial strength by Fitch, Inc. (June 2006).*
- Named by Fortune magazine to its list of America's Most Admired Companies for the seventh consecutive year in March 2007.
- A premier provider of insurance policies with premiums payroll deducted for more than 370,000 payroll accounts nationally.
- Outstanding in claims service, with most claims processed within four days.
- Included by Forbes magazine in its annual list of America's 400 Best Big Companies for the seventh year in January 2007.
- Named by Fortune magazine to its list of the 100 Best Companies to Work For in America for the ninth consecutive year in January 2007.

**Ratings refer only to the overall financial status of Aflac and are not recommendations of specific policy provisions, rates, or practices.*

1.800.99.AFLAC (1.800.992.3522)

En español:
1.800.SI.AFLAC (1.800.742.3522)

Visit our Web site at aflac.com.

Your local Aflac insurance agent/producer

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Riders become a part of the policy and are subject to all policy provisions unless otherwise stated.

❑ **$250 Initial Hospitalization Benefit**

❑ **$500 Initial Hospitalization Benefit**

❑ **$750 Initial Hospitalization Benefit**

❑ **$1,000 Initial Hospitalization Benefit**

Aflac will pay the Initial Hospitalization Benefit selected above when a covered person requires hospital confinement for a covered sickness or injury, for each period of hospital confinement. This benefit is limited to one payment per calendar year, per covered person.

Termination
The rider will terminate if the policy to which it is attached terminates or if the premiums for the rider are not paid.

Effective Date
The effective date of the rider is the effective date of the policy or the effective date of the rider as stated in the Policy Schedule, if later.

The rider to which this sales material pertains is written only in English; the rider prevails if interpretation of this material varies.

Refer to the policy and rider for complete details, limitations, and exclusions.

American Family Life Assurance Company of Columbus (Aflac)
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Rates

Short-Term Disability

For Illustration Purposes

Industry Class A (Administrative Employees Only)

The monthly premiums quoted are based on Aflac's Personal Disability Income Protector Base Plan with a minimum of $600 (6 units) of monthly benefits, Industry Class A.

ELIMINATION PERIOD	AGES	3-Month Benefit Period	6-Month Benefit Period	12-Month Benefit Period	24-Month Benefit Period
0/7	18-49	$11.40	$15.00	$19.10	$26.40
	50-64	$13.20	$17.70	$24.80	$35.90
ELIMINATION PERIOD	AGES	3-Month Benefit Period	6-Month Benefit Period	12-Month Benefit Period	24-Month Benefit Period
0/14	18-49	$8.60	$10.90	$14.80	$18.70
	50-64	$10.00	$13.70	$19.10	$26.80
ELIMINATION PERIOD	AGES	3-Month Benefit Period	6-Month Benefit Period	12-Month Benefit Period	24-Month Benefit Period
7/14	18-49	$8.20	$10.00	$12.70	$16.80
	50-64	$9.10	$12.70	$16.80	$23.20

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Short-Term Disability Industry Code A (continued)

ELIMINATION PERIOD	AGES	3-Month Benefit Period	6-Month Benefit Period	12-Month Benefit Period	24-Month Benefit Period
0/30	18-49	$ --	$7.70	$9.60	$12.30
	50-64	$ --	$10.00	$13.20	$17.70
ELIMINATION PERIOD	**AGES**	**3-Month Benefit Period**	**6-Month Benefit Period**	**12-Month Benefit Period**	**24-Month Benefit Period**
30/30	18-49	$ --	$6.40	$8.60	$11.40
	50-64	$ --	$8.20	$11.40	$15.90
ELIMINATION PERIOD	**AGES**	**3-Month Benefit Period**	**6-Month Benefit Period**	**12-Month Benefit Period**	**24-Month Benefit Period**
60/60	18-49	$ --	$ --	$7.70	$10.50
	50-64	$ --	$ --	$9.60	$14.80
ELIMINATION PERIOD	**AGES**	**3-Month Benefit Period**	**6-Month Benefit Period**	**12-Month Benefit Period**	**24-Month Benefit Period**
90/90	18-49	$ --	$ --	$5.00	$6.80
	50-64	$ --	$ --	$7.30	$10.80
ELIMINATION PERIOD	**AGES**	**3-Month Benefit Period**	**6-Month Benefit Period**	**12-Month Benefit Period**	**24-Month Benefit Period**
180/180	18-49	$ --	$ --	$4.10	$5.00
	50-64	$ --	$ --	$5.50	$7.70

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Short-Term Disability Industry Class B (Employees Other than Administrative)

The monthly premiums quoted are based on Aflac's Personal Disability Income Protector Base Plan with a minimum of $600 (6 units) of monthly benefits, Industry Class B.

ELIMINATION PERIOD	AGES	3-Month Benefit Period	6-Month Benefit Period	12-Month Benefit Period	24-Month Benefit Period
0/7	18-49	$13.70	$17.70	$23.70	$31.40
	50-64	$16.40	$23.20	$33.20	$45.00
ELIMINATION PERIOD	AGES	3-Month Benefit Period	6-Month Benefit Period	12-Month Benefit Period	24-Month Benefit Period
0/14	18-49	$10.50	$13.20	$17.70	$23.70
	50-64	$12.70	$17.70	$24.10	$35.90
ELIMINATION PERIOD	AGES	3-Month Benefit Period	6-Month Benefit Period	12-Month Benefit Period	24-Month Benefit Period
7/14	18-49	$10.00	$12.30	$15.90	$20.90
	50-64	$11.40	$15.50	$21.80	$31.90
ELIMINATION PERIOD	AGES	3-Month Benefit Period	6-Month Benefit Period	12-Month Benefit Period	24-Month Benefit Period
0/30	18-49	$ --	$10.00	$12.70	$16.80
	50-64	$ --	$13.70	$17.70	$25.90

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Short-Term Disability Industry Class B (Con'd)

ELIMINATION PERIOD	AGES	3-Month Benefit Period	6-Month Benefit Period	12-Month Benefit Period	24-Month Benefit Period
30/30	18-49	$ --	$ 8.60	$11.40	$15.50
	50-64	$ --	$11.80	$16.40	$24.10
ELIMINATION PERIOD	**AGES**	**3-Month Benefit Period**	**6-Month Benefit Period**	**12-Month Benefit Period**	**24-Month Benefit Period**
60/60	18-49	$ --	$ --	$10.50	$15.00
	50-64	$ --	$ --	$14.60	$23.70
ELIMINATION PERIOD	**AGES**	**3-Month Benefit Period**	**6-Month Benefit Period**	**12-Month Benefit Period**	**24-Month Benefit Period**
90/90	18-49	$ --	$ --	$ 6.80	$ 9.10
	50-64	$ --	$ --	$10.90	$16.80
ELIMINATION PERIOD	**AGES**	**3-Month Benefit Period**	**6-Month Benefit Period**	**12-Month Benefit Period**	**24-Month Benefit Period**
180/180	18-49	$ --	$ --	$5.00	$ 6.40
	50-64	$ --	$ --	$8.20	$11.80

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Cancer Indemnity

For Illustration Purposes

Monthly Premiums Ages 18–70

Coverage Type	Level One	Level Three
Individual	$18.70	$33.50
One-Parent Family	$21.70	$40.20
Two-Parent Family	$30.50	$55.90

~Rider premiums are in addition to the plan premium selected. ~

For Illustration Purposes

Monthly Premiums

Coverage Type	Building Benefit Rider Ages 18-70	Specified Disease Benefit Rider Ages 18-70
Individual	$0.60	$1.00
One-Parent Family	$0.90	$1.50
Two-Parent Family	$1.30	$2.00

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Specified Health Event

For Illustration Purposes

Level Two Base Plan

Coverage Type	Monthly Premiums
Individual	
Ages 18-35	$16.38
Ages 36-45	$23.40
Ages 46-55	$31.85
Ages 56-70	$41.08
One-Parent Family	
Ages 18-35	$28.08
Ages 36-45	$33.02
Ages 46-55	$42.51
Ages 56-70	$55.90
Insured/Spouse	
Ages 18-35	$31.59
Ages 36-45	$41.08
Ages 46-55	$55.25
Ages 56-70	$76.96
Two-Parent Family	
Ages 18-35	$35.88
Ages 36-45	$45.50
Ages 46-55	$60.84
Ages 56-70	$83.59

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Specified Health Event (Cont'd)

Specified Health Event Riders

Coverage Type	Monthly Premiums Building Benefit Rider	Monthly Premiums Event Recovery Rider
Individual		
Ages 18-35	**$2.34**	**$1.17**
Ages 36-45	**$4.29**	**$2.86**
Ages 46-55	**$5.07**	**$4.68**
Ages 56-70	**$5.59**	**$6.63**
One-Parent Family		
Ages 18-35	**$2.47**	**$1.30**
Ages 36-45	**$4.55**	**$2.86**
Ages 46-55	**$5.20**	**$4.68**
Ages 56-70	**$5.85**	**$6.76**
Insured/Spouse		
Ages 18-35	**$4.68**	**$2.34**
Ages 36-45	**$8.58**	**$4.81**
Ages 46-55	**$10.14**	**$8.06**
Ages 56-70	**$11.18**	**$12.35**
Two-Parent Family		
Ages 18-35	**$4.81**	**$2.47**
Ages 36-45	**$8.84**	**$5.20**
Ages 46-55	**$10.27**	**$8.71**
Ages 56-70	**$11.44**	**$13.00**

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Hospital Confinement Indemnity

For Illustration Purposes

Level One Base Plan

Coverage Type	Monthly Premiums
Individual	
Ages 18-39	$20.93
Ages 40-49	$26.26
Ages 50-59	$34.97
Ages 60-70	$43.68
One-Parent Family	
Ages 18-39	$30.94
Ages 40-49	$31.72
Ages 50-59	$40.69
Ages 60-70	$59.02
Insured/Spouse	
Ages 18-39	$41.86
Ages 40-49	$49.27
Ages 50-59	$66.69
Ages 60-70	$85.02
Two-Parent Family	
Ages 18-39	$49.27
Ages 40-49	$ 54.34
Ages 50-59	$ 72.67
Ages 60-70	$98.80

Level Three Base Plan

Coverage Type	Monthly Premiums
Individual	
Ages 18-39	$29.64
Ages 40-49	$39.26
Ages 50-59	$50.31
Ages 60-70	$60.84
One-Parent Family	
Ages 18-39	$41.99
Ages 40-49	$45.37
Ages 50-59	$56.03
Ages 60-70	$77.35

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Hospital Confinement Indemnity (Cont'd)

Level Three Base Plan (Con'd)

Coverage Type	Monthly Premiums
Insured/Spouse	
Ages 18-39	$58.89
Ages 40-49	$75.79
Ages 50-59	$96.46
Ages 60-70	$118.30
Two-Parent Family	
Ages 18-39	$71.63
Ages 40-49	$ 81.38
Ages 50-59	$ 102.18
Ages 60-70	$134.29

Initial Hospitalization Rider (per $250 Unit)

Coverage Type	Monthly Premiums
Individual	
Ages 18-39	$3.38
Ages 40-49	$3.51
Ages 50-59	$4.68
Ages 60-70	$6.24
One-Parent Family	
Ages 18-39	$4.29
Ages 40-49	$4.42
Ages 50-59	$5.07
Ages 60-70	$6.50
Insured/Spouse	
Ages 18-39	$6.76
Ages 40-49	$7.02
Ages 50-59	$8.71
Ages 60-70	$12.35
Two-Parent Family	
Ages 18-39	$7.15
Ages 40-49	$ 7.28
Ages 50-59	$ 9.23
Ages 60-70	$12.74

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Accident Indemnity Rates

Industry Code A (Administration Employees Only)

For Illustration Purposes

Monthly Premiums Ages 18–65
(Level Two Base Plan, "A" Industry Rating)

Coverage Type	Monthly Premiums
Individual	$17.10
Insured/Spouse	$24.30
One-Parent Family	$28.40
Two-Parent Family	$36.00

- ***Rider premiums are in addition to the plan premium selected.***
- ***For All Riders: Monthly Premiums Per Unit, One Unit = $100***

Off-The-Job Accident Disability Rider
(Benefits are for Primary Insured Only)
Ages 18-64

Minimum: 1 Unit ***Maximum: 20 Units***

Industry Level	6-Month Benefit Period		12-Month Benefit Period	
	0-Day Elimination PD	7-Day Elimination PD	0-Day Elimination PD	7-Day Elimination PD
"A"	$0.50	$0.40	$0.60	$0.50

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Accident Indemnity Plans (Cont'd)

Sickness Disability Rider
(Benefits are for Primary Insured Only)

Minimum: 1 Unit **Maximum: 20 Units**

Industry Level "A" Ages	14-Day Elimination Period	
	6-Month Benefit Period	12-Month Benefit Period
18-49	$1.70	$1.90
50-64	$2.30	$2.60

Spouse Off-The-Job Accident Disability Rider
Ages 18-64

Minimum: 1 Unit **Maximum: 7 Units**

Industry Level	6-Month Benefit Period 0-Day Elimination PD
"A"	$1.20

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Accident Indemnity Plans (Cont'd)

Industry Code B

For Illustration Purposes
(Level Two Base Plan, "B" Industry Rating)

Coverage Type	Monthly Premiums
Individual	$21.30
Insured/Spouse	$28.50
One-Parent Family	$31.00
Two-Parent Family	$38.30

- ***Rider premiums are in addition to the plan premium selected.***
- ***For All Riders: Monthly Premiums Per Unit, One Unit = $100***

Off-The-Job Accident Disability Rider
(Benefits are for Primary Insured Only)
Ages 18-64

Minimum: 1 Unit ***Maximum: 20 Units***

Industry Level	6-Month Benefit Period		12-Month Benefit Period	
	0-Day Elimination PD	7-Day Elimination PD	0-Day Elimination PD	7-Day Elimination PD
"B"	$0.80	$0.70	$1.00	$0.90

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Accident Indemnity Plans (Cont'd)

Sickness Disability Rider

(Benefits are for Primary Insured Only)

Minimum: 1 Unit ***Maximum: 20 Units***

Industry Level "B"	14-Day Elimination Period	
Ages	6-Month Benefit Period	12-Month Benefit Period
18-49	$1.80	$2.10
50-64	$2.60	$3.30

Spouse Off-The-Job Accident Disability Rider

Ages 18-64

Minimum: 1 Unit ***Maximum: 7 Units***

Industry Level	6-Month Benefit Period
	0-Day Elimination PD
"B"	$1.20

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Summaries of Additional Aflac Plans Available to City of Coral Gables Employees

Life

Life insurance is a key foundation for financial planning. There are numerous reasons to apply for life insurance, including immediate needs and future needs. Most group term life insurance plans do a good job of covering the immediate expenses but significantly fall short of meeting the future needs. That's where Aflac fits in! Our life insurance allows us to offer plans that exceed the immediate needs of the insured.

Life Protector Factors
Aflac's Life Protector series provides coverage during a time when families need it the most. This helps give consumers peace of mind. Policies are Whole, Term (10-, 20-, or 30-year) or a combination of both. In addition to an Accelerated Death Benefit and a Waiver of Premium Benefit, our life plans include a Return of Premium Rider, Spouse Rider, Child Rider, and an Accidental Death Benefit Rider.

Note: Policies may not be available in all states.*

Long-Term Care

Long-term care insurance allows a freedom of choice in preserving one's assets from the cost associated with nursing homes, residential community care, home and community based care services. With two out of five people over the age 65 needing long-term care at some point in their life, it is a very critical issue that Aflac has addressed. Aflac has sold long-term care insurance (qualified and non-qualified) since 1989. We introduced our Personal Long-Term Care in June 2003.

Aflac's Personal Long-Term Care Plan offers four levels of coverage to choose from through payroll deduction. Plans 1-3 are available to applicants' ages 18-65 and Plan 4 is available to applicants' ages 45-65. Our plan offers a choice of benefit packages and a zero elimination period. Policyholders may choose the length and amount of coverage that best suits their needs.

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Dental

Dental insurance is one of the few types of insurance for which a need already exists in the mind of the consumer. Even if a person does not see the need for accident, cancer, or specified health event insurance, he or she will often perceive a need for dental insurance. Most Americans are aware of the recommendation for dental cleanings twice per year, and they appreciate a policy to help with these costs.

The simplicity of a table of allowances, no provider network, and no precertification are important features of our dental plan. These features give our policyholders control over when and where treatment is received.

Vision

A key question asked by many policy administrators should be "How extensive is the network of the vision insurance carrier?" Our network couldn't be any more extensive. Why? There is not a provider network! Our policyholders have the complete freedom to choose any eye-care provider. This can be of significant importance when dealing with advanced eye diseases and surgeries, when a patient may prefer to visit a specialist in another town. Other vision discount plans and insurance policies may restrict policyholders to visiting only eye-care providers listed within their provider network. By providing policyholders with freedom of choice, Aflac continues to enhance the Vision Now policy.

Innovative
Unlike vision discount plans, or other vision insurance policies that simply provide benefits for exams and materials, Aflac provides benefits for these and more. Much like Aflac's value proposition of "there is only one Aflac," there is only one Vision Now!

Personal Sickness Indemnity

Aflac's Personal Sickness Indemnity insurance policy is designed to pay benefits that help an individual cover the ongoing expenses associated with sickness.

In 2005, the average length of stay for hospital inpatients was 5.6 days and the average hospital expense, adjusted per inpatient stay, was $8,534.90. In 2005, 37 percent of total surgeries were inpatient.*

Policy benefits include the following:

- Hospital Confinement
- Initial Hospitalization

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- Major Diagnostic Exams, including CT scans, EEGs, myelograms, arteriograms, MRIs, thallium stress tests, and angiograms
- Surgical
- Ambulance
- Continuation of Coverage

**Hospital Statistics 2007 Edition,* Health Forum LLC, an affiliate of the American Hospital Association.

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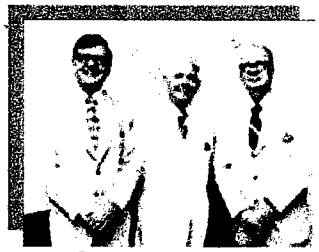
Who We Are

More Than Just The Duck

Founded in 1955, Aflac is a Fortune 500 company and a leader in voluntary insurance plans that pay cash directly to policyholders. Insuring more than 40 million people worldwide, Aflac is the principal subsidiary of Aflac Incorporated, an international holding company based in Georgia. Under the leadership of Chairman and CEO Daniel P. Amos, our company has total assets of over $79 billion, with annual revenues surpassing $16 billion (annual report, December 31, 2008).



Aflac's Founders
Brothers Paul, John, and Bill Amos

In 1958, Aflac introduced one of the world's first income protection insurance plans for people diagnosed with cancer. We initially operated in Georgia and Alabama. By the mid-1960s, we had expanded across much of the Southeast. Throughout the 1970s, 1980s, and 1990s, we continued our domestic expansion and now operate in all 50 states. Today, Aflac is a leader in guaranteed-renewable insurance policies sold at the worksite in the United States. More than 74,300 licensed agents sell our plans through more than 427,700 U.S. payroll accounts (company statistics, December 31, 2008).

We began broadening our U.S. plans in the 1980s, after primarily selling one plan for more than 20 years. In addition to our flagship income protection insurance, we now offer a variety of insurance policies to help with insurance needs. Presently, Aflac offers insurance policies for accident, short-term disability, hospital confinement indemnity, life, specified health event, dental, long-term care, and vision.

Aflac is a family-oriented company dedicated to providing a good work/life balance for our more than 8,300 full-time employees worldwide. Our programs have been recognized by *Fortune,* which listed Aflac as one of the 100 Best Companies to Work For in America for the eleventh consecutive year in 2009. Aflac Incorporated has been listed on the New York Stock Exchange since 1974 under the ticker symbol AFL.

We've Got You Under Our Wing.℠

National Recognition

Throughout our history Aflac has been recognized by numerous outside sources including but not limited to the following:

- In February 2008, Aflac was named to *Fortune* magazine's list of the 100 Best Companies to Work For in America for the tenth consecutive year.
- In July 2008, *Black Enterprise* magazine named Aflac to its list of the 40 Best Companies for Diversity for the fourth consecutive year.
- In July 2008, Aflac was named one of the World's Most Ethical Companies by *Ethisphere* magazine.
- In March 2009, *Fortune* magazine named Aflac to its list of America's Most Admired Companies for the eighth consecutive year. Aflac was ranked as the No. 1 company in the life and health insurance category.
- In February 2007, Aflac was named to *Hispanic* magazine's list of the 100 companies providing the most opportunities to Hispanics. Aflac has appeared on the annual list since 1993.
- In September 2008, Aflac is on *Information Week's* twentieth annual list of the 500 most innovative users of corporate technology.
- Aflac was named to *Latina Style* magazine's list of the 50 best companies for Latinas to work for in the United States (August/September 2008). Aflac has been featured on this annual list for nine of its eleven years.

Aflac today ...

Aflac every day

A history of excellence and respect

- **Aflac is a Fortune 500 company** (No. 164, April 30, 2007), with assets of nearly $60 billion (company statistics, December 31, 2006), insuring more than 40 million people worldwide (company statistics, May 2005).
- **Aflac has top financial credentials**, including being rated **AA** in insurer financial strength by Standard & Poor's (June 2006), **Aa2 (Excellent)** in insurer financial strength by Moody's Investors Service (January 2006), **A+ (Superior)** by A.M. Best (June 2007), and **AA** in insurer financial strength by Fitch, Inc. (June 2006).*
- **Elite company accolades include being named to:**
  - ***Fortune*** magazine's list of **America's Most Admired Companies** (March 2007).
  - ***Forbes*** magazine's elite **400 List of America's Best Big Companies** (January 2007).
  - ***InformationWeek's* 500 Top Corporate Technology Innovators** (September 2007).
- **A leader in workforce diversity**, Aflac has earned inclusion in:
  - ***Fortune*** magazine's **Top 50 Employers for Minorities** (August 2005).
  - ***Hispanic*** magazine's list of the **100 companies providing the most opportunities to Hispanics** (February 2007).
  - ***Essence*** magazine's list of **35 companies from the Fortune 1000 where African-American women are finding success** (May 2005).
  - ***Working Mother*** magazine's list of the **100 Best Companies for Working Mothers** (October 2006).
- **Aflac is a premier provider of insurance policies** with premiums payroll deducted for more than 372,000 payroll accounts nationally (company statistics, December 31, 2006) and the number one provider of individual health insurance and guaranteed-renewable insurance (*National Underwriter*, Life & Health Statistical Report, August 20/27, 2007).
- **Aflac processes most claims within four days** (company statistics, December 31, 2006).
- **Aflac is exclusively dedicated and focused** on individually owned and controlled policies offered on a voluntary basis to ensure that our policyholders are the most well-protected, well-serviced "family" in the world.
- **Aflac offers an excellent workplace environment that includes being named to:**
  - ***Fortune*** magazine's list of the **100 Best Companies to Work For in America** (January 2007).
  - ***Computerworld*** magazine's list of the **100 Best Places to Work in IT** (June 2007).
  - ***Training*** magazine's ***Training* Top 100** list of companies with outstanding workforce development programs (February 2007).

**Ratings refer only to the overall financial status of Aflac and are not recommendations of specific policy provisions, rates, or practices.*

Aflac®

American Family Life Assurance Company of Columbus (Aflac)

Worldwide Headquarters • Columbus, Georgia 31999

Visit our Web site at aflac.com.

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LIFE & HEALTH
National Underwriter
THE WEEK IN LIFE & HEALTH
August 18/25, 2008

All Health Insurers 2007

Rank	Company Name	Premiums Earned 2007	Incurred Claims 2007	Premiums Earned 2006	Incurred Claims 2006
1	United Healthcare Insurance Co	29,347,377,479	23,567,454,699	25,327,907,943	20,446,089,872
2	Humana Ins Co	12,162,598,880	9,944,473,926	9,129,847,257	7,674,611,227
3	American Family Life ASR Co Columbus	11,491,047,985	5,559,210,890	10,950,452,316	5,330,063,034
4	Aetna Life Insurance Co	9,382,324,145	7,551,019,069	7,302,002,338	5,741,901,518
5	Connecticut General Life Insurance	5,221,396,995	4,215,556,670	4,084,848,742	3,181,242,411
6	Metropolitan Life Insurance Co	5,002,628,358	3,823,481,464	4,442,385,782	3,081,463,475
7	Anthem Blue Cross Life & Hlth Ins Co	3,344,419,271	2,403,054,391	2,785,094,822	1,982,048,518
8	Guardian Life Insurance Co of Amer	3,014,641,051	2,224,354,432	3,169,383,560	2,294,672,107
9	American Life Insurance Co	2,881,003,458	733,948,770	2,653,109,865	645,010,057
10	Hartford Life & Accident Insurance	2,878,666,191	1,995,700,064	2,878,056,056	1,882,300,138
11	Principal Life Insurance Co	2,784,657,193	2,166,114,340	2,722,773,836	2,032,764,975
12	Unicare Life & Health Insurance Co	2,401,120,489	1,984,387,284	2,160,150,308	1,731,302,657
13	UNUM Life Insurance Co of America	2,253,633,927	1,785,033,300	2,607,446,151	2,509,326,276
14	Mutual of Omaha Insurance Co	1,830,098,007	1,331,014,560	2,147,020,836	1,639,473,359
15	Bankers Life & Casualty Co	1,537,187,900	1,110,609,892	1,325,807,535	908,458,926
16	Healthy Alliance Life Ins Co	1,477,778,247	1,187,177,703	1,492,419,004	1,201,993,278
17	First Health Life & Health Ins Co	1,452,595,256	1,262,587,227	469,650,781	422,935,460
18	BCBS Of KS Inc	1,398,413,157	1,331,160,420	1,289,478,197	1,235,895,818
19	Time Ins Co	1,344,385,514	839,956,078	1,311,944,262	835,741,534
20	Pacificare Life & Health Insurance	1,332,851,202	948,005,065	2,825,304,655	2,534,493,867
21	US Branch Sunlife Assur Co of Canada	1,324,794,258	1,046,324,190	631,894,497	457,230,985
22	Standard Insurance Co	1,297,304,057	961,260,682	1,225,894,897	957,960,423
23	Combined Insurance Co of America	1,173,335,109	440,297,279	1,140,367,367	449,676,844
24	Golden Rule Insurance Co	1,120,612,690	684,598,383	989,064,478	590,195,706
25	Life Insurance Co of North America	1,107,525,943	768,650,674	958,446,021	717,920,196
26	Health Net Life Ins Co	1,058,000,655	837,062,969	814,418,619	606,370,740
27	Union Security Ins Co	1,010,219,625	729,029,271	1,086,697,353	765,887,237
28	Genworth Life Ins Co	990,249,803	443,124,846	921,204,544	404,555,590
29	Prudential Insurance Co of America	941,288,517	681,677,248	892,636,294	687,106,595
30	John Hancock Life Ins CO	931,598,653	400,650,975	877,714,285	417,497,370
31	United American Insurance Co	927,113,547	624,184,216	917,019,296	595,915,148
32	Lincoln National Life Insurance Co	922,356,228	671,955,201	-5,328	-1,288,565
33	Pyramid Life Insurance Co	904,668,497	754,233,210	131,108,077	96,581,226
34	Mega Life & Health Insurance Co The	904,647,449	488,157,713	1,244,021,121	529,921,596
35	WEA Insurance Corp	897,723,058	796,434,519	909,894,670	813,473,076
36	Northwestern Mutual Life Insurance	816,158,953	484,681,482	771,331,547	595,116,581
37	Colonial Life & Accident Insurance	758,969,809	316,229,395	707,945,967	314,180,359
38	Monumental Life Insurance Co	664,397,180	326,852,469	361,412,680	236,490,145
39	Pennsylvania Life Insurance Co	658,013,409	468,982,784	328,407,740	260,074,304
40	Reliastar Life Insurance Co	652,663,791	561,688,764	597,382,886	511,335,950
41	Hcc Life Ins Co	642,655,171	498,691,617	490,621,004	509,840,530
42	General Re Life Corp	594,128,370	488,897,305	588,139,828	431,920,749
43	Great West Life & Annuity Insurance	589,968,762	564,008,178	930,553,060	881,098,231
44	Reliance Standard Life Insurance Co	555,955,062	444,096,381	472,381,835	372,803,795
45	Provident Life & Accident Insurance	555,085,596	253,852,252	792,192,937	768,711,794
46	John Alden Life Insurance Co	536,287,553	362,087,646	556,004,094	351,986,791
47	United Healthcare Insurance Co of OH	529,574,056	412,024,281	409,037,914	337,100,125
48	American Republic Insurance Co	528,140,480	378,540,488	468,388,213	345,272,591
49	Cuna Mutual Insurance Society	528,108,637	210,063,779	459,831,818	206,890,736
50	New York Life Insurance Co	475,935,098	337,123,404	477,677,280	315,950,222

Note: Claims figures do not include reserves set aside for future claims.

THE NU TOP 200 Life & Health Statistical Report

Individual Health Leaders 2007

Rank	Company Name	Indiv. Premiums Earned 2007	Incurred Claims 2007	Indiv. Premiums Earned 2006	Incurred Claims 2006
1	American Family Life ASR Co Columbus	11,484,757,138	5,554,492,248	10,943,351,617	5,324,119,105
2	Humana Ins Co	8,978,308,442	7,414,564,823	6,502,182,705	5,535,086,806
3	United Healthcare Insurance Co	6,594,383,459	5,299,516,161	4,935,364,656	4,074,078,529
4	American Life Insurance Co	2,666,743,000	572,153,678	2,498,871,357	533,211,002
5	Aetna Life Insurance Co	1,611,797,119	1,326,515,942	875,571,910	696,493,961
6	Unicare Life & Health Insurance Co	1,553,579,025	1,282,433,667	1,296,939,012	1,050,449,265
7	Bankers Life & Casualty Co	1,456,454,604	1,050,050,572	1,237,119,500	843,912,451
8	First Health Life & Health Ins Co	1,227,434,970	1,072,635,541	391,709,036	368,804,558
9	Mutual of Omaha Insurance Co	1,152,130,818	789,769,460	986,511,587	679,501,894
10	Anthem Blue Cross Life & Hlth Ins Co	1,131,507,514	762,539,015	882,361,192	570,321,297
11	Combined Insurance Co of America	1,128,721,837	411,359,924	1,098,626,366	405,275,009
12	Genworth Life Ins Co	918,766,136	392,924,929	849,882,788	354,042,145
13	Pyramid Life Insurance Co	904,663,238	754,242,882	131,102,521	96,558,620
14	United American Insurance Co	874,803,701	583,951,262	869,290,789	558,305,625
15	Pacificare Life & Health Insurance	771,977,114	578,982,835	1,905,765,349	1,787,749,067
16	Northwestern Mutual Life Insurance	751,144,559	462,580,880	708,863,357	568,475,387
17	Colonial Life & Accident Insurance	734,780,171	301,993,663	686,668,623	304,260,389
18	Metropolitan Life Insurance Co	675,346,696	221,274,495	576,849,141	230,070,497
19	Pennsylvania Life Insurance Co	658,013,409	468,982,784	325,440,765	258,314,304
20	John Hancock Life Ins CO	607,580,892	302,073,904	569,013,790	258,433,868
21	Provident Life & Accident Insurance	528,890,970	224,960,025	744,683,806	741,965,025
22	General Re Life Corp	503,735,601	352,317,187	473,461,278	356,526,887
23	Health Net Life Ins Co	472,219,104	382,744,603	351,484,781	247,500,088
24	Time Ins Co	449,198,772	294,593,684	445,905,704	264,246,984
25	American Progressive L & H Ins of NY	439,628,466	364,163,924	176,761,950	138,249,745
26	Massachusetts Mutual Life Insurance	439,238,041	305,106,867	425,468,639	318,788,065
27	Physicians Mutual Insurance Co	422,291,970	265,723,425	439,428,410	273,495,632
28	Berkshire Life Ins Co of America	403,564,273	249,784,087	389,711,985	254,402,861
29	Cuna Mutual Insurance Society	379,730,955	160,117,698	372,529,734	174,432,372
30	BCBS Of KS Inc	333,428,093	314,864,673	332,306,229	319,305,802
31	Connecticut General Life Insurance	330,523,937	324,703,884	217,850,121	195,378,863
32	Sierra Health & Life Insurance Co	313,426,295	323,824,450	232,110,179	192,597,183
33	Conseco Senior Health Insurance Co	311,192,062	535,909,502	335,789,449	448,258,081
34	Life Investors Insurance Co of Amer	300,756,789	160,059,231	306,670,726	186,984,192
35	Healthy Alliance Life Ins Co	285,447,570	208,220,377	280,807,625	182,006,666
36	Riversource Life Ins Co	280,189,516	100,089,033	292,801,318	109,570,964
37	American Heritage Life Insurance Co	270,845,133	125,771,996	252,118,806	118,090,513
38	Employers Reassurance Corp	267,907,145	269,839,180	499,793,612	-262,696,691
39	Monumental Life Insurance Co	266,006,510	124,953,659	28,420,478	62,601,069
40	Union Fidelity Life Insurance Co	257,086,879	228,273,686	264,908,331	188,524,685
41	Blue Shield of CA Life & Hlth Ins Co	236,389,063	165,035,480	145,227,946	95,255,819
42	Conseco Health Insurance Co	230,435,382	114,845,602	245,994,469	127,099,855
43	Munich American Reassurance Co	204,249,035	118,300,621	179,052,810	112,145,062
44	Lifecare Assurance Co	186,446,808	49,363,829	167,794,954	40,780,369
45	American Republic Insurance Co	180,664,403	147,423,063	224,040,743	172,788,598
46	United Teacher Associates Insurance	171,414,103	119,539,644	180,120,750	124,235,521
47	Golden Rule Insurance Co	166,948,869	115,180,736	150,257,021	108,384,647
48	American Family Life ASR Co of NY	163,564,062	78,716,469	143,770,041	72,921,195
49	Continental Life Ins Co Brentwood	162,292,619	114,590,941	159,363,055	113,499,052
50	Principal Life Insurance Co	159,892,838	68,697,227	141,404,073	61,896,998

Guaranteed Renewable 2007

Rank	Company Name	Guaranteed Renewable Premiums Earned 2007	Guaranteed Renewable Incurred Claims 2007	Guaranteed Renewable Premiums Earned 2006	Guaranteed Renewable Incurred Claims 2006
1	American Family Life ASR Co Columbus	11,484,757,138	5,554,492,248	10,943,351,617	5,324,119,105
2	Unicare Life & Health Insurance Co	1,553,579,025	1,282,433,666	1,296,939,012	1,050,449,265
3	Bankers Life & Casualty Co	1,179,873,030	814,927,759	1,156,729,388	780,083,137
4	Anthem Blue Cross Life & Hlth Ins Co	1,131,507,514	762,539,015	882,361,192	570,321,297
5	Mutual of Omaha Insurance Co	1,100,199,826	779,582,831	929,352,924	650,387,827
6	Genworth Life Ins Co	918,641,194	392,833,137	850,306,841	354,172,296
7	Pacificare Life & Health Insurance	771,977,114	578,982,835	1,905,765,349	1,787,749,067
8	Colonial Life & Accident Insurance	730,069,859	299,978,909	681,286,124	302,485,378
9	United American Insurance Co	677,394,009	427,944,603	668,100,464	404,204,198
10	John Hancock Life Ins CO	607,466,164	301,117,504	568,603,207	261,004,181
11	Combined Insurance Co of America	565,594,536	179,690,260	547,243,545	177,305,454
12	General Re Life Corp	492,772,590	342,775,397	459,911,130	332,426,226
13	Metropolitan Life Insurance Co	467,297,702	91,677,407	388,263,342	80,236,836
14	Physicians Mutual Insurance Co	406,851,230	256,255,649	425,260,181	263,029,525
15	Conseco Senior Health Insurance Co	309,841,695	534,523,722	333,921,328	446,268,269
16	Life Investors Insurance Co of Amer	287,650,994	152,320,576	293,470,557	176,388,868
17	Healthy Alliance Life Ins Co	285,447,570	208,220,377	280,807,625	182,006,666
18	Employers Reassurance Corp	269,576,608	290,493,402	499,530,368	-262,601,434
19	American Heritage Life Insurance Co	255,121,999	120,254,634	237,655,743	110,773,165
20	Union Fidelity Life Insurance Co	251,498,181	226,013,502	257,045,271	188,678,385
21	Provident Life & Accident Insurance	240,748,626	72,063,619	212,808,639	66,310,030
22	Blue Shield of CA Life & Hlth Ins Co	229,063,146	160,574,363	133,987,233	87,196,483
23	Conseco Health Insurance Co	209,102,942	107,182,760	223,899,797	122,181,593
24	BCBS Of KS Inc	206,370,320	192,747,165	207,113,058	193,851,348
25	Lifecare Assurance Co	186,446,808	49,363,829	167,794,954	40,780,369
26	United Teacher Associates Insurance	166,578,401	110,895,717	175,589,066	119,663,769
27	American Family Life ASR Co of NY	163,380,321	78,710,925	143,552,959	72,896,068
28	Continental Life Ins Co Brentwood	162,219,678	114,575,520	159,255,618	113,531,842
29	Genworth Life Ins Co of NY	139,719,510	46,848,155	130,177,489	44,849,904
30	Monumental Life Insurance Co	137,362,683	48,523,698	104,783,182	46,149,319
31	Liberty National Life Insurance Co	136,752,762	63,627,708	140,376,523	51,728,386
32	New York Life Insurance Co	136,613,407	43,933,064	119,547,765	31,010,354
33	American Fidelity Assurance Co	133,030,151	65,980,782	116,935,215	60,991,243
34	Transamerica Life Ins Co	129,543,122	96,166,311	132,350,634	104,696,777
35	Washington National Insurance	128,368,768	121,667,816	149,482,200	131,285,870
36	Riversource Life Ins Co	121,035,495	69,535,773	142,625,163	63,181,576
37	USAA Life Insurance Company	120,984,616	87,213,524	120,328,533	82,961,027
38	Prudential Insurance Co of America	120,638,791	40,994,267	102,466,076	22,926,539
39	Northwestern Long Term Care Ins Co	120,076,389	8,519,787	90,543,971	6,009,753
40	Standard Life & Accident Ins Co	116,102,109	89,730,908	137,526,538	98,717,296
41	Reserve National Insurance Co	114,191,852	74,680,794	110,300,036	72,175,428
42	Pennsylvania Life Insurance Co	111,317,565	75,048,098	122,655,512	81,629,293
43	Allianz Life Ins Co of North America	110,824,080	12,979,610	91,779,385	12,506,090
44	Munich American Reassurance Co	109,695,760	82,310,316	98,587,727	80,099,994
45	Family Heritage Life Ins Co of Amer	104,518,901	18,885,289	88,482,808	15,830,563
46	Medico Life Insurance Co	104,354,489	38,619,391	13,389,333	12,108,058
47	American Republic Insurance Co	100,798,756	91,596,833	125,510,422	88,747,904
48	Equitable Life & Casualty Insurance	99,211,556	57,768,609	100,959,326	57,940,522
49	Bupa Ins Co	95,211,197	61,263,524	83,946,494	51,895,909
50	First UNUM Life Insurance Co	88,894,046	42,658,281	88,694,857	34,123,751

We've Got You Under Our Wing.℠

Diversity Focus

Aflac believes that diversity is a primary contributor to its growth. The strength we gain from different perspectives is readily demonstrated in our internal team dynamics and external recognition.

Aflacts on Diversity

- Almost 70 percent of Aflac employees are women.
- Women account for more than 50 percent of Aflac's management (supervisor level and above).
- Minorities make up over 40 percent of Aflac's workforce.
- Women account for over 30 percent of our senior executives (vice president and above).

National Recognition for Diversity

- In July 2008, *Black Enterprise* magazine named Aflac to its list of the 40 Best Companies for Diversity for the fourth consecutive year.
- In July 2008, Aflac was named one of the World's Most Ethical Companies by *Ethisphere* magazine.
- In February/March 2008, *Hispanic Trends* magazine named Aflac as one of the 50 leading companies for supplier diversity.
- In February 2007, Aflac was named to *Hispanic* magazine's list of the 100 companies providing the most opportunities to Hispanics. Aflac has appeared on the annual list since 1993.
- In January 2007, DiversityBusiness.com named Aflac to its list of the 50 Top Organizations for Multicultural Business Opportunities in 2006.

We've Got You Under Our Wing.℠

Environmental Awareness

At Aflac, we choose, use, and dispose of materials wisely. From the materials we use in our daily operations to the expansion or construction of facilities, we carefully consider the environmental impact our actions will have—not only today, but for years to come.

Aflac is involved in the following environmentally-friendly initiatives:

Recycling

Whenever possible, we try to recycle materials. Our corporate recycling program includes office paper, corrugated cardboard, aluminum cans, computer hardware components, and printer cartridges.

Paperless Alternatives

We employ technology to reduce the amount of paper we use and to allow us to operate more efficiently. The large majority of our policy applications are issued using SmartApp Next Generation software. We also use imaging technology, which utilizes software to store huge amounts of information that would otherwise be printed on paper and filed.

Energy Saving

Currently, our two campus facilities are being upgraded to include an automation system called adaptive start. This system tracks a building's heating needs and adjusts accordingly, avoiding stop-and-start inefficiencies. Throughout our campuses, we use low-mercury lights in our 25,000 fluorescent lamps. We use only those stamped with the Energy Star logo, which indicates that they are eco-friendly.

Fuel Efficiency

Many employees participate in our teleworking program, which saves fuel by eliminating or reducing their commute to the office. In addition, we work with the Georgia Regional Transportation Association to provide carpool services for employees who commute from the Atlanta area.

Eco-Friendly Areas

We have made some valuable improvements recently to our work—and play—spaces. Our task chairs and flooring are made from recycled materials, and our systems furniture is Green Guard certified. In addition, our janitorial service providers are green certified.

We've Got You Under Our Wing.℠

Virtualization Technology

Since 2005 our Information Technology department has been using VMware, a product that reduces hardware and power needs by replacing physical servers with virtual ones. We now have only 27 physical servers, versus the 448 we had before VMware.

More Change to Come

Other initiatives we have undertaken include implementing a water conservation plan and recording our carbon footprint.

We've Got You Under Our Wing.℠

Corporate Integrity

Our Commitment

We are dedicated to effective corporate governance and extensive disclosure. We encourage open communication and trust among our employees and management to help ensure that we operate in a transparent manner. At Aflac, we maintain the highest ethical standards in our business practices and financial reporting. By doing so, we hope to earn the confidence not only of the financial community and our shareholders, but also of customers, sales agents, and employees.

Aflac has been recognized by the Reputation Institute in its Global Pulse report as the most respected company in the global insurance industry and No. 123 overall in 2008*.

** Source: The World's Most Respected Companies: A Study in Corporate Reputations in 27 Countries, Reputation Institute, New York, 2008, p. 4.*

Begins With the Board

A company's dedication to solid governance begins with its board of directors. One way in which Aflac demonstrates its commitment to good governance practices is with the makeup of the board and its key committees. The independence of every board member is assessed annually. The majority of Aflac board members—9 of 17 total members—are independent directors under the New York Stock Exchange listing standards, meaning that they have no material relationship with the company.

The Corporate Governance, Nominating, and Compensation Committees of the board are composed solely of these independent directors. All nonmanagement directors meet in executive session at least once a year without any members of management present.

Say-on-Pay

Perhaps the most significant recent action of the board was its decision to pass Say-on-Pay, a resolution that gives shareholders a nonbinding vote on executive compensation. This landmark decision made Aflac the first company in the country to adopt an advisory vote on compensation.

Extends to All Employees

A board of directors can employ the best possible governance standards, but it also must work to ensure that an entire enterprise lives up to those standards. The good practices have to be adopted—and lived up to—every day by a company's leaders and employees.

We've Got You Under Our Wing.℠

Code of Conduct

At Aflac, there is an expectation that all officers, managers, and employees will conduct business in an ethical and lawful manner. This expectation is defined and enforced through our Code of Business Conduct and Ethics, which applies to all employees of the company—including executive officers. Honesty and integrity are the backbone of the trusting relationships we have developed over the years with our clients. Our Code of Business Conduct and Ethics clearly lays out Aflac's standards of ethical and legal conduct. It governs all of our business activities. All employees, officers, and directors are expected to know, understand, and comply with the policies set forth in the Code. All employees must sign statements of compliance to the Code and renew their pledge every year. The Code also has provisions that specifically apply to the chief executive officer and the chief financial officer, because their actions—including their commitment to ethical and transparent accounting procedures—are critical to the company's overall ethical behavior. Our Code's existence and our dedication to its continuous enforcement demonstrates Aflac's serious commitment to the principles of ethical and lawful business conduct.

Information Privacy

Because of the nature of our business, Aflac's commitment to ethical behavior must go even deeper than that of many other companies. To serve our customers, our employees must have access to certain private, health-related information about our policyholders. We take our responsibility to protect the privacy of our policyholders very seriously. The rules contained in the Health Insurance Portability and Accountability Act (HIPAA) govern the way we handle these issues. But we go beyond the requirements of HIPAA to ensure that our employees do everything possible to protect private information about our policyholders. To keep our employees well versed on the policies and procedures used to ensure privacy, we require every employee to take a detailed course on information security and privacy. This annual online training is designed to teach the specific responsibilities and processes we have for protecting private information.

We've Got You Under Our Wing.℠

Aflac Cares

Aflac's philanthropic efforts in our community can be seen in four areas: health, education, youth, and the arts.

Community Involvement

Aflac and our employees are involved in many philanthropic organizations throughout our community, including:

- Aflac Cancer Center
- American Cancer Society
- Boys and Girls Clubs
- Christmas Is for Kids
- Columbus State University
- Easter Seals
- Habitat for Humanity
- Juvenile Diabetes Research Foundation
- March of Dimes
- Relay For Life
- United Way

We've Got You Under Our Wing.℠

Aflac's Client Composition

Aflac markets a broad line of guaranteed-renewable insurance policies to more than 427,700 payroll accounts in the United States (company statistics, December 31, 2008).

As of December 29, 2008, the U.S. payroll accounts include:

Doctors and Dentists	26,903	Religious	834
Hospitals	1,778	Saving and Loan Associations	850
Nursing Homes	5,963	Credit Unions	2,241
Other Medical	8,094	Other Financial Institutions	1,744
Municipalities	11,236	Unions	115
State Government Depts	1,296	Colleges	1,197
Banks	3,790	School Districts	12,451
Legal	4,334	Recreation	3,818
Professional Services	36,698	Manufacturing	30,618
General Services	73,676	Textile	254
Media (newspaper, radio, TV)	4,013	Agricultural	5,581
Community Service	14,355	Construction	24,475
Food	11,775	Retail Sales	29,693
Lodging	2,972	Wholesalers	7,936
Transportation	8,425	Utilities	3,200
Auto Dealerships	9,460	Indian Tribes	104
Other Automotive	17,778	Other	17,795

We've Got You Under Our Wing.℠

Administering Aflac

With Aflac, you can have help every step of the way. From educating and enrolling employees to managing your accounts, Aflac provides solutions that help ease benefits administration for your small business.

- Each month, you'll receive a single statement.
  - After cross-checking against your payroll records and noting any discrepancies, you'll send in one payment.
  - You'll always receive invoices for payroll deductions after you make them, which means you'll never have to pay premiums out-of-pocket.

- Manage your billing information faster and easier with our Online Services; you can view and update information, reconcile invoices, and submit service requests online, anytime.

- We'll handle your employees' claims, so you don't have to.
  - Any time your employees need to file a claim, they may contact us online using our Policyholder Service Center or give us a call at our Customer Service Center.
  - Employees' checks will be sent directly to them (unless they choose otherwise), usually within four business days, so you won't have frustrated staff to deal with.

- We'll make it easier for your company to remain in compliance with COBRA/HIPAA regulations, helping to reduce your administrative duties and avoid any legal liabilities.

We've Got You Under Our Wing.℠

Employee Advantages Overview

When an injury or illness strikes, and people are full of uncertainty, we've got you. Aflac puts cash in their wallets to help keep a roof over their head and food on their table.

Freedom of Choice

Employees choose the coverage that best fulfills their own personal needs.

Employee-Owned Policies

- Portable
- Guaranteed-renewable

Rate Stability

Aflac has a history of rate stability. A policyholder will never be singled out for a rate increase.

Service After the Sale

- Local service office
- Aflac Worldwide Headquarters direct point of contact
- Aflac Worldwide Headquarters Customer Service Center

Ease of Filing Claims (Usually within four business days of submission)*

- Daily processing

Online Services for Various Employee Self-Service Transactions

- Policy changes
- Claims status

*Company statistics, December 2008.

get the Aflacts℠

Why your company needs Aflac now more than ever

These days, keeping costs under control while keeping employee morale up can be challenging. That's why there's never been a better time for you and your employees to have Aflac.

1 Aflac complements your company's existing benefits package.

Aflac is different from major medical; it's insurance for daily living. It pays cash benefits directly to your employees, unless otherwise assigned, to help them with daily expenses due to an illness or accident. With a wide range of insurance policies, your employees can choose the areas where they want additional coverage. Aflac benefits do not change or replace any of your current employee benefits; they complement them.

2 You can provide Aflac at no direct cost to your company.

Aflac policies are 100% employee-paid and are purchased on a voluntary basis. Many companies choose to make Aflac policies available as a cost-effective solution to help employees with the rising cost of out-of-pocket health care expenses.

3 Aflac helps many companies save on FICA and FUTA taxes.

Some of Aflac's tax-advantaged plans allow employees to use pretax dollars to pay for their policies. And when you lower the taxable income of your participating employees, you may also reduce your overall share of FICA and FUTA taxes.

4 Aflac policies have been designed for ease of administration.

Our policies and services are designed to be easily implemented. And with coordinated enrollment, support tools and online services, Aflac makes it easy for your employees to participate.

5 Aflac helps attract and retain employees.

Great benefits are a top priority for employees when considering where to work. Aflac policies are an easy way to boost your benefits package and increase your employees' morale at the same time.

For more Aflacts, go to aflacforbusiness.com

Aflac

We've got you under our wing.®