We've got you under our wing.℠

Pasco County Schools AFLAC Products Guide

SUNBELT
WORKSITE MARKETING, INC.

Peace of Mind *and* Real Cash Benefits

GROUP CRITICAL ILLNESS

CI G

Aflac®

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CAI2175FL IC(3/10)

GROUP CRITICAL ILLNESS

Policy Series CI2100-C-FL

CI[G]

You can win the battle against a critical illness, but can you handle the added costs?

A group critical illness plan helps prepare you for the added costs of battling a specific critical illness.

The good news is that many people with a critical illness survive these life-threatening battles. Unfortunately, as the recovery process begins, people become aware of the medical bills that have piled up.

Your recovery doesn't have to be spoiled by medical bills.

With this plan, our goal is to help you and your family cope with and recover from the financial stress of surviving a critical illness.

COVERAGE WORKSHEET

Employee Benefit:	$ _____
Spouse Benefit:	$ _____
Child Benefit: (25 percent of the primary insured amount)	$ _____
Total Weekly Deduction:	$ _____

This worksheet is for illustration purposes only. It is not an implication of coverage.

BENEFITS

COVERED CRITICAL ILLNESSES[1]:

CANCER	100%	RENAL FAILURE (End Stage)	100%
HEART ATTACK (Myocardial Infarction)	100%	CARCINOMA IN SITU[2]	25%
STROKE (Apoplexy or Cerebral Vascular Accident)	100%	CORONARY ARTERY BYPASS SURGERY[2]	25%
MAJOR ORGAN TRANSPLANT	100%		

FIRST OCCURENCE BENEFIT

After the waiting period, a lump sum benefit is payable upon initial diagnosis of a covered critical illness. Employee benefit amounts available from $5,000 to $50,000. Spouse coverage is also available in benefit amounts up to $25,000. If you are deemed ineligible due to a previous medical condition you still retain the ability to purchase Spouse coverage.

No benefits are payable for each Specified Critical Illness after the first unless its date of diagnosis is separated from the prior Specified Critical Illness by at least 90 days.

CHILD COVERAGE AT NO ADDITIONAL COST

Each Dependent Child is covered at 25 percent of the primary insured amount at no additional charge.

$50 HEALTH SCREENING BENEFIT
(Employee and Spouse only)

After the waiting period, an insured may receive a maximum of $50 for any one covered health screening test per calendar year. We will pay this benefit regardless of the results of the test. Payment of this benefit will not reduce the critical illness benefit payable under your certificate. There is no limit to the number of years the insured can receive the health screening benefit; it will be paid as long as the certificate remains in force. This benefit is payable for the covered Employee and Spouse. This benefit is not paid for Dependent Children.

OVER **1.4** MILLION

FACT

The number of new cancer cases that were expected to be diagnosed in 2009[3].

[3]*Cancer Facts & Figures 2009*, American Cancer Society. Society.

COVERED HEALTH SCREENING TESTS INCLUDE:

- Mammography
- Colonoscopy
- Pap smear
- Breast Ultrasound
- Chest X-ray
- PSA (blood test for prostate cancer)
- Stress test on a bicycle or treadmill
- Bone Marrow Testing
- CA 15-3 (blood test for breast cancer)
- CA 125 (blood test for ovarian cancer)
- CEA (blood test for colon cancer)
- Flexible sigmoidoscopy
- Hemocult stool analysis
- Serum protein electrophoresis (blood test for myeloma)
- Thermography
- Fasting blood glucose test
- Serum cholesterol test to determine level of HDL and LDL

[1]All covered conditions are subject to the definitions found in your certificate.

[2]If a benefit is paid for Carcinoma in Situ, the Internal Cancer benefit will be reduced by 25 percent. If a benefit is paid for coronary artery bypass surgery, the heart attack benefit will be reduced by 25 percent.

WHAT IS NOT COVERED, LIMITATIONS AND EXCLUSIONS, AND TERMS YOU NEED TO KNOW.

IF DIAGNOSIS OCCURS AFTER THE AGE OF 70, HALF OF THE BENEFIT IS PAYABLE.

The plan contains a 30-day waiting period. This means that no benefits are payable for any insured who has been diagnosed before your coverage has been in force 30 days from the effective date. If an insured is first diagnosed during the waiting period, benefits for treatment of that critical illness will apply only to loss starting after two years from the Effective Date or the Employee can elect to void the coverage and receive a full refund of premium.

The applicable benefit amount will be paid if: the date of diagnosis is after the waiting period; the date of diagnosis occurs while the certificate is in force; and the cause of the illness is not excluded by name or specific description.

EXCLUSIONS

Benefits will not be paid for loss due to:

- Intentionally self-inflicted injury or action;
- Suicide or attempted suicide while sane or insane;
- Illegal activities or participation in an illegal occupation;
- War, whether declared or undeclared or military conflicts, participation in an insurrection or riot, civil commotion;

- Substance abuse; or
- Pre-Existing Conditions (except as stated below).

PRE-EXISTING CONDITION LIMITATION

"Preexisting Condition" means a sickness or physical condition which, within the 6-month period prior to the Effective Date of the certificate which resulted in an insured person's receiving medical advice or treatment.

We will not pay benefits for any condition or illness starting within 12-months of the Effective Date of the certificate which is caused by, contributed to, or resulting from a Preexisting Condition.

A claim for benefits for loss starting after 12-months from the Effective Date of the certificate will not be reduced or denied on the grounds that it is caused by a Preexisting Condition.

The Certificate may have been issued as a replacement Certificate previously issued to you under the Plan. If so, then the pre-existing condition limitation provision of the Certificate applies only to any increase in benefits over the prior Certificate. Any remaining period of pre-existing condition limitation of the prior Certificate would continue to apply to the prior level of benefits.

TERMS YOU NEED TO KNOW

The **Effective Date** of your insurance will be the date shown in your Certificate Schedule.

Employee means the insured as shown the Certificate Schedule.

Spouse means an employee's legal wife or husband.

Dependent Children Means your natural children, step-children, legally adopted children, foster children or children placed for adoption, who are younger than twenty-five (25) years of age if the child meets the following: the child is dependent upon you for support; and the child is living with you; or the child is a full-time or part-time student. "Children" also includes dependent children, regardless of age, who: are incapable of self-sustaining employment by reason of mental retardation or physical handicap; and are chiefly dependent upon you or your spouse for support and maintenance.

If your children are covered under this rider, your children born after the Effective Date of this rider will also be covered from the moment of live birth. Adopted Children shall be covered from the time of placement in your residence. If you enter into an adoption agreement before a child's birth, coverage shall begin for that child from the moment of birth regardless of the validity of the adoption agreement. Ultimate placement of the child with you is required. No notice or additional premium is required.

A child of a covered dependent, other than your spouse, will be covered for 18 months from birth, adoption, or placement.

Treatment means consultation, care or services provided by a physician including diagnostic measures and taking prescribed drugs and medicines.

Major Organ Transplant means undergoing surgery as a recipient of a transplant of a human heart, lung, liver, kidney, or pancreas.

Myocardial Infarction (Heart Attack) means the death of a portion of the heart muscle (myocardium) resulting from a blockage of one or more coronary arteries. Heart Attack does not include any other disease or injury involving the cardiovascular system. Cardiac arrest not caused by a Myocardial Infarction is not a Heart Attack. The diagnosis must include all of the following criteria: 1. New and prior, if any, Electrocardiographic (EKG) findings consistent with Myocardial Infraction; and 2. Elevation of cardiac enzymes above generally accepted laboratory levels of normal in case of creatine phosphokinase (CPK), a CPK-MB measurement must be used. 3. Confirmatory imaging studies such as thallium scans, MUGA scans, or stress echocardiograms. 4. Chest Pain.

Stroke means apoplexy (due to rupture or acute occlusion of a cerebral artery), or a cerebral vascular accident or incident which is first manifested on or after your Effective Date. Stroke does not include transient ischemic attacks and attacks of verterbrobasilar ischemia. We will pay a benefit for Stroke which produces permanent clinical neurological sequela (persisting for at least 30 days) following an initial diagnosis made after any applicable Waiting Period. We must receive evidence of the permanent neurological damage provided from Computed Axial Tomography (CAT scan) or Magnetic Resonance Imaging (MRI). Stroke does not mean head injury, transient ischemic attack, or chronic cerebrovascular insufficiency.

Cancer means a malignant tumor characterized by the uncontrolled growth and spread of malignant cells and the invasion of distant tissue. Cancer includes leukemia. Excluded are Cancers such as 1. Pre-malignant tumors or polyps; 2. Carcinoma in Situ (non-invasion); 3. Any skin cancers except melanomas; 4. Stage 1 Hodgkin's Disease and Stage A Prostate Cancer; 5. Basal cell carcinoma and squamous cell carcinoma of the skin; and 6. Melanoma that is diagnosed as Clark's Level I or II or Breslow less than .77mm.

Cancer which meets the diagnosis criteria of malignancy established by The American Board of Pathology after a study of the histocytologic architecture or pattern of the suspect tumor, tissue or specimen.

Carcinoma in Situ means Cancer that is in the natural or normal place, confined to the site of origin without having invaded neighboring tissue.

Renal Failure (Kidney Failure) means the end stage renal failure presenting as chronic, irreversible failure of both of your kidneys to function. The Kidney Failure must necessitate regular renal dialysis, hemo-dialysis or peritoneal dialysis (at least weekly); or which results in kidney transplantation. Renal failure is covered, provided it is not caused by a traumatic event, including surgical traumas.

Coronary Artery Bypass Surgery means undergoing open heart surgery to correct narrowing or blockage of one or more coronary arteries with bypass grafts, but excluding procedures such as, but not limited to balloon angioplasty, laser relief, stints or other non-surgical procedures.

A doctor, physician, or pathologist does not include an insured or a family member.

PORTABLE COVERAGE

When coverage would otherwise terminate under this Plan because an employee ends employment with the employer, they may elect to continue their coverage. An employee must have been continuously insured for at least twelve months under this Plan and/or the prior plan just before the date their employment terminated. The coverage that may be continued is that which the employee had on the date their employment terminated, including dependent coverage then in effect. 1. Coverage may not be continued for any of the following reasons: a. the employee failed to pay any required premium; b. the employee attained age 70; c. this Group Policy terminates. 2. To keep the certificate in force the employee must: a. make written application to the Company within 31 days after the date their insurance would otherwise terminate; b. pay the required premium to the Company no later than 31 days after the date the certificate would otherwise terminate; and 3. Insurance will cease on the earliest of these dates: a. the date the employee fails to pay any required premium; b. the date this Group Policy is terminated;

If an employee qualifies for this Portability Privilege as described, then the same benefits, Plan provisions, and premium rate as shown in their certificate as previously issued will apply.

TERMINATION

Coverage will terminate on the earliest of: (1) The date the master policy is terminated; (2) On the 31st day after the premium due date if the required premium has not been paid; (3) On the date the insured ceases to meet the definition of an Employee as defined in the master policy; or (4) On the date the Employee is no longer a member of the class eligible.

Coverage for an insured Spouse or Dependent Child will terminate the earliest of: (1) The date the master policy is terminated; (2) On the 31st day after the premium due date if the required premium has not been paid; (3) The premium due date following the date the Spouse or Dependent Child ceases to be a dependent; or (4) The premium due date following the date we receive a written request to terminate coverage for a Spouse and/or Dependent Children.

Personal Cancer Protector Plan

A CANCER EXPENSE INSURANCE POLICY

Level 1

Plan Benefits

- First-Occurrence
- Hospital Confinement
- Radiation and Chemotherapy
- Cancer Screening Wellness
- Surgical/Anesthesia
- NCI Evaluation and Consultation
- Home Health Care
- Plus ... much more

AFLAC Without it, no insurance is complete.

A-59175R1-FL

RC(5/02)

Personal Cancer Coverage

Cancer Insurance Only; Policy Series A-59100

FIRST-OCCURRENCE BENEFIT

AFLAC will pay a $1,500 FIRST-OCCURRENCE BENEFIT to any covered person when diagnosed as having 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. When the hospitalization is based on tentative diagnosis, benefits are payable from the date of tentative diagnosis, at the time and date that a positive diagnosis is obtained. In addition to the pathological or clinical diagnosis required by the policy, AFLAC may require additional information from the attending physician and hospital. Any covered person who has had a previously diagnosed 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

(This includes confinement in a U.S. government hospital.)
AFLAC will pay $200 for each day any covered person is hospitalized and charged as an inpatient for the first 30 days for cancer treatment. Benefits increase to **$400** per day beginning with the 31st day of continuous confinement. The wording "for each day any covered person is charged as an inpatient" does not apply to confinements in U.S. government hospitals. **No lifetime maximum.**

For treatment of cancer: Radiation and Chemotherapy, Experimental Treatment, Anti-Nausea, Nursing Services, Surgical/Anesthesia, Skin Cancer Surgery, Prosthesis, and In-Hospital Blood and Plasma Benefits are not payable when a covered person is confined in a U.S. government hospital unless the covered person is actually charged and is legally required to pay for such services.

RADIATION AND CHEMOTHERAPY BENEFIT

AFLAC will pay the charges incurred up to $200 per day when any covered person 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 — administration by medical personnel in a doctor's office, clinic or hospital; self-injected medications or medications dispensed by a pump will be limited to the actual cost of the drugs up to **$200** per prescription; oral chemotherapy, regardless of where administered, will be limited to the actual cost of the drugs up to **$200** per prescription (monthly maximum of **$800**); (2) radiation therapy; or (3) the insertion of interstitial or intracavitary application of radium or radioisotopes in sealed or nonsealed sources. (The Surgical/Anesthesia Benefit provides additional amounts payable for insertion and removal. Benefits will not be paid for each day the radium or radioisotope remains in the body.) This benefit does not pay for laboratory tests, diagnostic X-rays, immunoglobulins, immunotherapy, colony-stimulating factors, therapeutic devices, simulation, dosimetry, treatment planning or other procedures related to these therapy treatments. This benefit is not payable on the same day that the Experimental Treatment Benefit is paid and is limited to $200 per day. **No lifetime maximum.**

EXPERIMENTAL TREATMENT BENEFIT

AFLAC will pay the charges incurred up to $200 per day for a covered person who receives experimental cancer treatment for the purpose of modification or destruction of abnormal tissue. The treatments must be consistent with one or more National Cancer Institute-sponsored protocols. This benefit does not pay for laboratory tests, diagnostic X-rays, immunoglobulins, immunotherapy, colony-stimulating factors, and 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. **No lifetime maximum.**

ANTI-NAUSEA BENEFIT

AFLAC will pay the charges incurred up to $100 per calendar month when a covered person receives anti-nausea drugs that are prescribed while receiving radiation or chemotherapy treatments. **No lifetime maximum.**

NURSING SERVICES BENEFIT

AFLAC will pay the charges incurred up to $100 per 24-hour day to a covered person while confined to a hospital for full-time private care by RNs, LPNs or LVNs 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 related to any covered person. This benefit is payable for only the number of days the Hospital Confinement Benefit is payable. **No lifetime maximum.**

AFLAC®

Without it, no insurance is complete.

SURGICAL/ANESTHESIA BENEFIT

AFLAC will pay $95 to $3,000 of the indemnity listed when a surgical operation is performed on a covered person for a diagnosed internal cancer (depending on type of surgery performed). Two or more surgical procedures performed through the same incision will be considered one operation, and benefits will be paid for the most expensive procedure. If any operation for the treatment of cancer 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 (surgery for skin cancer will be payable under the Skin Cancer Surgery Benefit). **AFLAC will pay an indemnity benefit equal to 25%** of the amount shown on 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 shall not exceed $3,750. **No lifetime maximum** on number of operations. See Schedule of Operations.

SKIN CANCER SURGERY BENEFIT

AFLAC will pay $100 to $600 of the indemnity listed (depending on the procedure performed) for surgery (with or without anesthesia) to any covered person when a surgical operation is performed for a diagnosed skin cancer. **No lifetime maximum** on number of operations.

PROSTHESIS BENEFIT

(1) AFLAC will pay the charges incurred up to $2,500 to any covered person for surgically implanted prosthetic devices that are prescribed as a direct result of surgery for cancer treatment. **Lifetime maximum of $2,500 per covered person. (2) AFLAC will pay up to $200** to any covered person for the charges incurred per person for nonsurgically implanted prosthetic devices that are prescribed as a direct result of cancer treatment. Examples of these include voice boxes, hair pieces and removable breast prosthetics. **Lifetime maximum of $200 per covered person.**

IN-HOSPITAL BLOOD AND PLASMA BENEFIT

AFLAC will pay the charges incurred up to but not exceeding $50 times the number of days of covered hospital confinement if a covered person receives blood/plasma, blood processing, blood administration, crossmatching and transfusion during a hospital confinement. This benefit does not pay for immunoglobulins, immunotherapy or colony-stimulating factors. **No lifetime maximum.**

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

This brochure is for illustration purposes only.

OUTPATIENT BLOOD AND PLASMA BENEFIT

AFLAC will pay the charges incurred up to $200 for blood/plasma, processing, blood administration, crossmatching and transfusion for each day a covered person receives blood transfusions for the treatment of cancer as an outpatient in a doctor's office, clinic, hospital or ambulatory surgical center. This benefit does not pay for immunoglobulins, immunotherapy or colony-stimulating factors. **No lifetime maximum.**

SECOND SURGICAL OPINION BENEFIT

AFLAC will pay the charges incurred up to $200 to any covered person for a second surgical opinion concerning cancer surgery for a diagnosed cancer by a licensed physician not related to the covered person. This benefit is not payable the same day the NCI Evaluation/Consultation Benefit is payable. **No lifetime maximum.**

NATIONAL CANCER INSTITUTE (NCI) EVALUATION/CONSULTATION BENEFIT

AFLAC will pay $500 when a covered person seeks evaluation or consultation at an NCI-sponsored 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. **AFLAC will also pay $250** for the transportation and lodging of the person receiving the evaluation/consultation if the cancer center is more than 100 miles from the covered person's residence. This benefit is not payable the same day the Second Surgical Opinion Benefit is payable. This benefit is payable once per covered person. NCI-sponsored cancer centers include but are not limited to:

- M.D. Anderson Cancer Center
- Norris Comprehensive Cancer Center at USC
- Mayo Cancer Center
- Johns Hopkins Oncology Center
- Memorial Sloan-Kettering Cancer Center
- St. Jude Children's Research Hospital

This is a partial listing of NCI-designated cancer centers, and AFLAC does not endorse any center over another. Please see insert Form A-59276 for a complete listing of the current facilities and their locations.

This benefit is also payable at the AFLAC Cancer Center at Children's Healthcare of Atlanta.

AMBULANCE BENEFIT

AFLAC will pay you or any covered person the charges incurred for transportation in a licensed ambulance to and from a hospital within 100 miles of the covered person's residence where confined overnight for cancer treatment. This benefit is limited to two trips per confinement. **No lifetime maximum.**

TRANSPORTATION BENEFIT

AFLAC will pay 40 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 special cancer treatment has been prescribed by the local attending physician. Reimbursement will be made only for the method of transportation actually taken. **Benefits are limited to $1,200 per round trip.** This benefit will be paid only for the covered person for whom the special cancer treatment is prescribed; or if the treatment is for a dependent child and commercial travel is necessary, **AFLAC will pay for up to two adults** to accompany the dependent child. This benefit is not payable for transportation to any hospital located within a 100-mile radius of the residence of the covered person.

LODGING BENEFIT

AFLAC will pay the charges incurred up to $50 per day for lodging for you or any one adult family member when a covered person receives special cancer treatment at a hospital or medical facility. The hospital or medical facility and lodging must be more than 100 miles from the covered person's residence. This benefit is not payable for lodging occurring more than 24 hours prior to treatment nor for lodging occurring more than 24 hours following treatment. **This benefit is limited to 60 days per calendar year.**

BONE MARROW TRANSPLANTATION BENEFIT

AFLAC will pay the charges incurred up to $10,000 if a covered person receives a bone marrow transplantation for the treatment of cancer during a covered hospital confinement. It does not include the harvesting of peripheral blood cells or stem cells and subsequent reinfusion. If the bone marrow transplant is performed on an outpatient basis, **AFLAC will pay the charges incurred up to $5,000. AFLAC will pay the bone marrow donor the greater of $1,000 or medical costs** to the same extent and limitations as costs associated with the insured person for a covered bone marrow transplant. This benefit is not payable for the same procedure as the Stem Cell Transplantation Benefit. **Lifetime maximum of $10,000 per covered person.**

STEM CELL TRANSPLANTATION BENEFIT

AFLAC will pay the charges incurred up to $2,500 if a covered person receives a peripheral stem cell transplantation for the treatment of cancer. This benefit is payable once per covered person. This benefit is not payable in conjunction with the payment of the Bone Marrow Transplantation Benefit. **Lifetime maximum of $2,500 per covered person.**

EXTENDED-CARE FACILITY BENEFIT

AFLAC will pay $100 per day if a covered person is hospitalized and receives the Hospital Confinement Benefit and is later confined, within 30 days, to a section of the hospital used as an extended-care facility, a skilled nursing facility, a rehabilitation unit or facility, a transitional care unit, or to any bed designated as a swing bed, for such continued confinement. Benefits are limited to the same number of days that the covered person receives the Hospital Confinement Benefit. For each day this benefit is payable, benefits under the Hospital Confinement Benefit 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 $100 per day for the first 60 days and **$50** per day for days over 60 for care provided by a hospice organization for any covered person when medical evaluation determines that cancer treatment is no longer appropriate and the covered person's medical prognosis is one in which there is a life expectancy of six months or less as the direct result of cancer. This benefit does not cover nonterminally ill patients or organizations not qualifying as hospices. This benefit is payable once per covered person and is not payable the same day as the Home Health Care Benefit. **Lifetime maximum for each covered person is $12,000.**

HOME HEALTH CARE BENEFIT

AFLAC will pay the charges incurred up to $50 per visit 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 number of visits shall not exceed 10 per hospitalization. This benefit will not be payable unless the attending physician prescribes such services to be performed in the home of the insured person and certifies that if these services were not available, the insured person would have to be hospitalized to receive the necessary care, treatment and services. Home health care and health supportive services must be performed by or under the supervision of 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 30 visits per calendar year for each covered person.**

AFLAC's Cancer Screening Wellness Benefit is a preventative benefit.

CANCER SCREENING WELLNESS BENEFIT:

AFLAC will pay $40 per calendar year for each covered person when a charge is incurred for one of the following: mammogram, breast ultrasound, Pap smear (lab and procedure), 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 or colonoscopy. These tests must be performed to determine if cancer exists in a covered person. This benefit is limited to one payment per calendar year per covered person. **No lifetime maximum.**

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.

NEWBORN TRANSPORTATION BENEFIT

Under a family policy, if cancer in a newborn child requires the newborn to receive treatment to protect his/her health and safety, we will pay transportation charges as follows: Actual transportation costs to and from the nearest available facility appropriately staffed and equipped to treat the condition of the newborn. The transportation must be certified by the attending physician as necessary to protect the health and safety of the newborn child. The coverage for such transportation costs shall not exceed the usual and customary charges up to $1,000.

CONTINUATION OF COVERAGE BENEFIT

AFLAC will waive all monthly premiums due for the policy and riders for up to two months if you meet all of the following conditions: (1) Your policy was in force for at least six months. (2) We receive premiums for at least six consecutive months. (3) Your premiums were paid through payroll deduction. (4) You or your employer notifies us in writing within 30 days of the date your premium payments ceased due to your leaving employment. (5) You re-establish premium payments through your new employer's payroll deduction process or direct payment to AFLAC. You will again become eligible to receive this benefit after you re-establish your premium payments through payroll deduction for a period of at least six months and we have received premiums for at least six consecutive months. *Payroll deduction* means your premium is remitted to AFLAC for you by your employer through a payroll deduction process.

GUARANTEED-RENEWABLE

This policy is guaranteed-renewable for life subject to AFLAC's right to change applicable table of premium rates for all policies of this class.

EFFECTIVE DATE

The effective date of the policy will be 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. Payroll rate may be retained after one month's premium payment on payroll deduction.

FAMILY COVERAGE

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

IMPORTANT NOTICE

When you receive your policy and application, please examine them thoroughly. If you are not satisfied, you may return the policy and application within 30 days for a full refund.

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 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 cancer treatment. This policy contains a 30-day waiting period. This means that no benefits are payable for any covered person who has cancer diagnosed before coverage has been in force 30 days from the effective date shown in the Policy Schedule. If a covered person has cancer diagnosed during the waiting period, 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 subsequent recurrence, extension or metastatic spread of such internal cancer that is diagnosed or treated after 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. 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. No benefits are payable for immunoglobulins or colony-stimulating factors.

AFLAC's Personal Cancer Protection Plan

FINANCIAL SOLUTIONS: CORPORATE COMMITMENT

AFLAC is a world leader in providing an important safety net in fighting the financial consequences of cancer that result beyond traditional health insurance. We are also a prominent corporate advocate in the fight against this disease through our aggressive support of facilities like the AFLAC Cancer Center at Children's Healthcare of Atlanta and the Norris Comprehensive Cancer Center at USC (Los Angeles).

THE FIRST STEP IN PREPARATION: APPRECIATING THE RISKS

According to the American Cancer Society* …

- Approximately 8.9 million Americans with a history of cancer were alive in 1997.
- About 1,284,900 new cancer cases are expected to be diagnosed in 2002.
- In the United States, men have a little less than 1-in-2 lifetime risk of developing cancer; for women the risk is a little more than 1-in 3.
- Since 1990, approximately 16 million new cases have been diagnosed.

SCIENCE AND MEDICINE HAVE MADE WONDERFUL ADVANCES IN THE TREATMENT OF CANCER.

But while survival rates and expectations grow each year … so do the costs of new and advanced treatments. In fact, over $56 billion is spent each year to treat cancer.*

**Cancer Facts & Figures* – 2002, American Cancer Society

— Without it, no insurance is complete.

MANY COSTS NORMALLY HAVE TO BE PICKED UP BY YOU:

Deductibles – Most standard health insurance plans have hefty deductibles — some as high as $300, $500 or $1,000 — that must be paid before your coverage kicks in.

Cost-sharing expenses – Once your deductible is satisfied, you may still be responsible for 10% or 20% of the bills as part of your copay arrangement.

Nonmedical expenses – Beyond the doctor and hospital bills are incidental costs including:

- travel
- food
- lodging
- long-distance calls
- household help

Out-of-pocket expenses – Normal everyday living costs include:

- car payments
- mortgage or rent payments
- utility bills
- groceries

Managed care restrictions – If you seek medical services outside your approved network, you may incur additional expense.

Loss of earning power – If you're seriously injured or ill, the paychecks will eventually stop. And if your spouse has to leave work to care for you, your family may face a double loss of income.

AFLAC MAKES YOUR HEALTH INSURANCE COVERAGE MORE "COMPLETE" BY PAYING BENEFITS DIRECTLY TO YOU.

These cash benefits, unless assigned, are paid to you regardless of any other insurance you may have — to be used where you decide.

AFLAC®

Without it, no insurance is complete.

AFLAC, the insurance industry leader in cafeteria plan services,* is ...

- A Fortune 500 company with assets exceeding $37 billion insuring more than 40 million people worldwide.
- Rated "AA" in insurer financial strength by Standard & Poor's (December 2000), "Aa3 (Excellent)" in insurer financial strength by Moody's Investors Service (December 2001), "A+ (Superior)" by A.M. Best (July 2001) and "AA" in insurer financial strength by Fitch, Inc. (November 2001).**
- A world leader in guaranteed-renewable insurance with more than 200,000 national payroll accounts.
- Number one in guaranteed-renewable accident and cancer insurance sales.
- Outstanding in claimant recommendations as validated by an Opinion Research Corporation poll indicating that 9 out of 10 claimants agree that AFLAC paid their claims fairly and promptly, and they would recommend the purchase of cancer insurance to others (July 2001).
- Uncompromising in fast, efficient service. Our toll-free line puts you in touch with a decision-maker immediately.
- Named by *Fortune* magazine to its list of "The 100 Best Companies to Work for in America" for the fourth consecutive year in January 2002.

* *Employers Council on Flexible Compensation (ECFC), 3/00*

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

Your local AFLAC representative

1-800-99-AFLAC
(1-800-992-3522)

En español:
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(1-800-742-3522)

Visit our Web site at www.aflac.com.

Personal Cancer Protector Plan

A CANCER EXPENSE INSURANCE POLICY

Levels 2 & 3

Plan Benefits

- First-Occurrence
- Hospital Confinement
- Radiation and Chemotherapy
- Cancer Screening Wellness
- Surgical/Anesthesia
- NCI Evaluation and Consultation
- Home Health Care
- Plus ... much more

AFLAC Without it, no insurance is complete.

A-59275R1-FL

RC(8/02)

Optional First-Occurrence Building Benefit Rider Summary Page

Series A-59050

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 will be increased by $100 for each unit purchased on each rider anniversary date while this rider remains in force. 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 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 shall accrue for a period of at least five years unless internal cancer is diagnosed prior to the fifth year of coverage. (If this is individual coverage, no further premium will be billed for this rider after the payment of benefits.)

TERMINATION

This rider will terminate if the policy to which it is attached terminates or if the premiums for this rider are 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.

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

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

Personal Cancer Coverage

Cancer Insurance Only; Policy Series A-59000

☐ **$2,000 FIRST-OCCURRENCE BENEFIT** ***(Policy Series A-59200)***

☐ **$5,000 FIRST-OCCURRENCE BENEFIT** ***(Policy Series A-59300)***

AFLAC will pay the FIRST-OCCURRENCE BENEFIT selected above to any covered person when diagnosed as having 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. When the hospitalization is based on tentative diagnosis, benefits are payable from the date of tentative diagnosis, at the time and date that a positive diagnosis is obtained. In addition to the pathological or clinical diagnosis required by the policy, AFLAC may require additional information from the attending physician and hospital. Any covered person who has had a previously diagnosed cancer will not be eligible for a First-Occurrence Benefit under this policy for a recurrence, extension or metastatic spread of that same cancer.

The benefits listed below are payable for either the A-59200 Policy Series or the A-59300 Policy Series.

HOSPITAL CONFINEMENT BENEFIT

(This includes confinement in a U.S. government hospital.) AFLAC will pay $300 for each day any covered person is hospitalized and charged as an inpatient for the first 30 days for cancer treatment. Benefits increase to **$600** per day beginning with the 31st day of continuous confinement. The wording "for each day any covered person is charged as an inpatient" does not apply to confinements in U.S. government hospitals. **No lifetime maximum.**

For treatment of cancer: Radiation and Chemotherapy, Experimental Treatment, Anti-Nausea, Nursing Services, Surgical/Anesthesia, Skin Cancer Surgery, Prosthesis, and In-Hospital Blood and Plasma Benefits are not payable when a covered person is confined in a U.S. government hospital unless the covered person is actually charged and is legally required to pay for such services.

RADIATION AND CHEMOTHERAPY BENEFIT

AFLAC will pay the charges incurred up to $300 per day when any covered person 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 — administration by medical personnel in a doctor's office, clinic or hospital; self-injected medications or medications dispensed by a pump will be limited to the actual cost of the drugs up to **$300** per prescription; oral chemotherapy, regardless of where administered, will be limited to the actual cost of the drugs up to **$300** per prescription (monthly maximum of **$1,200**); (2) radiation therapy; or (3) the insertion of interstitial or intracavitary application of radium or radioisotopes in sealed or nonsealed sources. (The Surgical/Anesthesia Benefit provides additional amounts payable for insertion and removal. Benefits will not be paid for each day the radium or radioisotope remains in the body.) This benefit does not pay for laboratory tests, diagnostic X-rays, immunoglobulins, immunotherapy, colony-stimulating factors, therapeutic devices, simulation, dosimetry, treatment planning or other procedures related to these therapy treatments. This benefit is not payable on the same day that the Experimental Treatment Benefit is paid and is limited to $300 per day. **No lifetime maximum.**

EXPERIMENTAL TREATMENT BENEFIT

AFLAC will pay the charges incurred up to $300 per day for a covered person who receives experimental cancer treatment for the purpose of modification or destruction of abnormal tissue. The treatments must be consistent with one or more National Cancer Institute-sponsored protocols. This benefit does not pay for laboratory tests, diagnostic X-rays, immunoglobulins, immunotherapy, colony-stimulating factors, and 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. **No lifetime maximum.**

ANTI-NAUSEA BENEFIT

AFLAC will pay the charges incurred up to $100 per calendar month when a covered person receives anti-nausea drugs that are prescribed while receiving radiation or chemotherapy treatments. **No lifetime maximum.**

NURSING SERVICES BENEFIT

AFLAC will pay the charges incurred up to $100 per 24-hour day to a covered person while confined to a hospital for full-time private care by RNs, LPNs or LVNs 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 related to any covered person. This benefit is payable for only the number of days the Hospital Confinement Benefit is payable. **No lifetime maximum.**

AFLAC®

Without it, no insurance is complete.

SURGICAL/ANESTHESIA BENEFIT

AFLAC will pay $100 to $5,000 of the indemnity listed when a surgical operation is performed on a covered person for a diagnosed internal cancer (depending on type of surgery performed). Two or more surgical procedures performed through the same incision will be considered one operation, and benefits will be paid for the most expensive procedure. If any operation for the treatment of cancer 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 (surgery for skin cancer will be payable under the Skin Cancer Surgery Benefit). **AFLAC will pay an indemnity benefit equal to 25%** of the amount shown on 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 shall not exceed $6,250. **No lifetime maximum** on number of operations. See Schedule of Operations.

SKIN CANCER SURGERY BENEFIT

AFLAC will pay $100 to $600 of the indemnity listed (depending on the procedure performed) for surgery (with or without anesthesia) to any covered person when a surgical operation is performed for a diagnosed skin cancer. **No lifetime maximum** on number of operations.

PROSTHESIS BENEFIT

(1) AFLAC will pay the charges incurred up to $3,000 to any covered person for surgically implanted prosthetic devices that are prescribed as a direct result of surgery for cancer treatment. **Lifetime maximum of $3,000 per covered person. (2) AFLAC will pay up to $200** to any covered person for the charges incurred per person for nonsurgically implanted prosthetic devices that are prescribed as a direct result of cancer treatment. Examples of these include voice boxes, hair pieces and removable breast prosthetics. **Lifetime maximum of $200 per covered person.**

IN-HOSPITAL BLOOD AND PLASMA BENEFIT

AFLAC will pay the charges incurred up to but not exceeding $100 times the number of days of covered hospital confinement if a covered person receives blood/plasma, blood processing, blood administration, crossmatching and transfusion fees during a hospital confinement. This benefit does not pay for immunoglobulins, immunotherapy or colony-stimulating factors. **No lifetime maximum.**

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

This brochure is for illustration purposes only.

OUTPATIENT BLOOD AND PLASMA BENEFIT

AFLAC will pay the charges incurred up to $250 for blood/plasma, processing, blood administration, crossmatching and transfusion fees for each day a covered person receives blood transfusions for the treatment of cancer as an outpatient in a doctor's office, clinic, hospital or ambulatory surgical center. This benefit does not pay for immunoglobulins, immunotherapy or colony-stimulating factors. **No lifetime maximum.**

SECOND SURGICAL OPINION BENEFIT

AFLAC will pay the charges incurred up to $250 to any covered person for a second surgical opinion concerning cancer surgery for a diagnosed cancer by a licensed physician not related to the covered person. This benefit is not payable the same day the NCI Evaluation/Consultation Benefit is payable. **No lifetime maximum.**

NATIONAL CANCER INSTITUTE (NCI) EVALUATION/CONSULTATION BENEFIT

AFLAC will pay $500 when a covered person seeks evaluation or consultation at an NCI-sponsored 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. **AFLAC will also pay $250** for the transportation and lodging of the person receiving the evaluation/consultation if the cancer center is more than 100 miles from the covered person's residence. This benefit is not payable the same day the Second Surgical Opinion Benefit is payable. This benefit is payable once per covered person. NCI-sponsored cancer centers include but are not limited to:

- M.D. Anderson Cancer Center
- Norris Comprehensive Cancer Center at USC
- Mayo Cancer Center
- Johns Hopkins Oncology Center
- Memorial Sloan-Kettering Cancer Center
- St. Jude Children's Research Hospital

This is a partial listing of NCI-designated cancer centers, and AFLAC does not endorse any center over another. Please see insert Form A-59276 for a complete listing of the current facilities and their locations.

This benefit is also payable at the AFLAC Cancer Center at Children's Healthcare of Atlanta.

AMBULANCE BENEFIT

AFLAC will pay you or any covered person the charges incurred for transportation in a licensed ambulance to and from a hospital within 100 miles of the covered person's residence where confined overnight for cancer treatment. This benefit is limited to two trips per confinement. **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 special cancer treatment has been prescribed by the local attending physician. Reimbursement will be made only for the method of transportation actually taken. **Benefits are limited to $1,500 per round trip.** This benefit will be paid only for the covered person for whom the special cancer treatment is prescribed; or if the treatment is for a dependent child and commercial travel is necessary, **AFLAC will pay for up to two adults** to accompany the dependent child. This benefit is not payable for transportation to any hospital located within a 100-mile radius of the residence of the covered person.

LODGING BENEFIT

AFLAC will pay the charges incurred up to $60 per day for lodging for you or any one adult family member when a covered person receives special cancer treatment at a hospital or medical facility. The hospital or medical facility and lodging must be more than 100 miles from the covered person's residence. This benefit is not payable for lodging occurring more than 24 hours prior to treatment nor for lodging occurring more than 24 hours following treatment. **This benefit is limited to 60 days per calendar year.**

BONE MARROW TRANSPLANTATION BENEFIT

AFLAC will pay the charges incurred up to $10,000 if a covered person receives a bone marrow transplantation for the treatment of cancer during a covered hospital confinement. It does not include the harvesting of peripheral blood cells or stem cells and subsequent reinfusion. If the bone marrow transplant is performed on an outpatient basis, **AFLAC will pay the charges incurred up to $5,000. AFLAC will pay the bone marrow donor the greater of $1,000 or medical costs** to the same extent and limitations as costs associated with the insured person for a covered bone marrow transplant. This benefit is not payable for the same procedure as the Stem Cell Transplantation Benefit. **Lifetime maximum of $10,000 per covered person.**

STEM CELL TRANSPLANTATION BENEFIT

AFLAC will pay the charges incurred up to $2,500 if a covered person receives a peripheral stem cell transplantation for the treatment of cancer. This benefit is payable once per covered person. This benefit is not payable in conjunction with the payment of the Bone Marrow Transplantation Benefit. **Lifetime maximum of $2,500 per covered person.**

EXTENDED-CARE FACILITY BENEFIT

AFLAC will pay $100 per day if a covered person is hospitalized and receives the Hospital Confinement Benefit and is later confined, within 30 days, to a section of the hospital used as an extended-care facility, a skilled nursing facility, a rehabilitation unit or facility, a transitional care unit, or to any bed designated as a swing bed, for such continued confinement. Benefits are limited to the same number of days that the covered person receives the Hospital Confinement Benefit. For each day this benefit is payable, benefits under the Hospital Confinement Benefit 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 $100 per day for the first 60 days and **$50** per day for days over 60 for care provided by a hospice organization for any covered person when medical evaluation determines that cancer treatment is no longer appropriate and the covered person's medical prognosis is one in which there is a life expectancy of six months or less as the direct result of cancer. This benefit does not cover nonterminally ill patients or organizations not qualifying as hospices. This benefit is payable once per covered person and is not payable the same day as the Home Health Care Benefit. **Lifetime maximum for each covered person is $12,000.**

HOME HEALTH CARE BENEFIT

AFLAC will pay the charges incurred up to $50 per visit 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 number of visits shall not exceed 10 per hospitalization. This benefit will not be payable unless the attending physician prescribes such services to be performed in the home of the insured person and certifies that if these services were not available, the insured person would have to be hospitalized to receive the necessary care, treatment and services. Home health care and health supportive services must be performed by or under the supervision of 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 30 visits per calendar year for each covered person.**

AFLAC's Cancer Screening Wellness Benefit is a preventative benefit.

CANCER SCREENING WELLNESS BENEFIT: **AFLAC will pay $75** per calendar year for each covered person when a charge is incurred for one of the following: mammogram, breast ultrasound, Pap smear (lab and procedure), 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 or colonoscopy. These tests must be performed to determine if cancer exists in a covered person. This benefit is limited to one payment per calendar year per covered person. **No lifetime maximum.**

NEWBORN TRANSPORTATION BENEFIT

Under a family policy, if cancer in a newborn child requires the newborn to receive treatment to protect his/her health and safety, we will pay transportation charges as follows: Actual transportation costs to and from the nearest available facility appropriately staffed and equipped to treat the condition of the newborn. The transportation must be certified by the attending physician as necessary to protect the health and safety of the newborn child. The coverage for such transportation costs shall not exceed the usual and customary charges up to $1,000.

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.

CONTINUATION OF COVERAGE BENEFIT

AFLAC will waive all monthly premiums due for the policy and riders for up to two months if you meet all of the following conditions: (1) Your policy was in force for at least six months. (2) We receive premiums for at least six consecutive months. (3) Your premiums were paid through payroll deduction. (4) You or your employer notifies us in writing within 30 days of the date your premium payments ceased due to your leaving employment. (5) You re-establish premium payments through your new employer's payroll deduction process or direct payment to AFLAC. You will again become eligible to receive this benefit after you re-establish your premium payments through payroll deduction for a period of at least six months and we have received premiums for at least six consecutive months. *Payroll deduction* means your premium is remitted to AFLAC for you by your employer through a payroll deduction process.

GUARANTEED-RENEWABLE

This policy is guaranteed-renewable for life subject to AFLAC's right to change applicable table of premium rates for all policies of this class.

EFFECTIVE DATE

The effective date of the policy will be 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. Payroll rate may be retained after one month's premium payment on payroll deduction.

FAMILY COVERAGE

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

IMPORTANT NOTICE

When you receive your policy and application, please examine them thoroughly. If you are not satisfied, you may return the policy and application within 30 days for a full refund.

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 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 cancer treatment. This policy contains a 30-day waiting period. This means that no benefits are payable for any covered person who has cancer diagnosed before coverage has been in force 30 days from the effective date shown in the Policy Schedule. If a covered person has cancer diagnosed during the waiting period, 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 subsequent recurrence, extension or metastatic spread of such internal cancer that is diagnosed or treated after 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. 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. No benefits are payable for immunoglobulins or colony-stimulating factors.

AFLAC's Personal Cancer Protection Plan

FINANCIAL SOLUTIONS: CORPORATE COMMITMENT

AFLAC is a world leader in providing an important safety net in fighting the financial consequences of cancer that result beyond traditional health insurance. We are also a prominent corporate advocate in the fight against this disease through our aggressive support of facilities like the AFLAC Cancer Center at Children's Healthcare of Atlanta and the Norris Comprehensive Cancer Center at USC (Los Angeles).

THE FIRST STEP IN PREPARATION: APPRECIATING THE RISKS

According to the American Cancer Society* …

- Approximately 8.9 million Americans with a history of cancer were alive in 1997.
- About 1,284,900 new cancer cases are expected to be diagnosed in 2002.
- 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.
- Since 1990, about 16 million new cancer cases have been diagnosed.

SCIENCE AND MEDICINE HAVE MADE WONDERFUL ADVANCES IN THE TREATMENT OF CANCER.

But while survival rates and expectations grow each year … so do the costs of new and advanced treatments. In fact, about $56 billion is spent each year to treat cancer.*

**Cancer Facts & Figures – 2002*, American Cancer Society

— Without it, no insurance is complete.

MANY COSTS NORMALLY HAVE TO BE PICKED UP BY YOU:

Deductibles – Most standard health insurance plans have hefty deductibles — some as high as $300, $500 or $1,000 — that must be paid before your coverage kicks in.

Cost-sharing expenses – Once your deductible is satisfied, you may still be responsible for 10% or 20% of the bills as part of your copay arrangement.

Nonmedical expenses – Beyond the doctor and hospital bills are incidental costs including:

- travel
- food
- lodging
- long-distance calls
- household help

Out-of-pocket expenses – Normal everyday living costs include:

- car payments
- mortgage or rent payments
- utility bills
- groceries

Managed care restrictions – If you seek medical services outside your approved network, you may incur additional expense.

Loss of earning power – If you're seriously injured or ill, the paychecks will eventually stop. And if your spouse has to leave work to care for you, your family may face a double loss of income.

AFLAC MAKES YOUR HEALTH INSURANCE COVERAGE MORE "COMPLETE" BY PAYING BENEFITS DIRECTLY TO YOU.

These cash benefits, unless assigned, are paid to you regardless of any other insurance you may have — to be used where you decide.

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- Rated "AA" in insurer financial strength by Standard & Poor's (December 2000), "Aa3 (Excellent)" in insurer financial strength by Moody's Investors Service (December 2001), "A+ (Superior)" by A.M. Best (July 2001) and "AA" in insurer financial strength by Fitch, Inc. (November 2001).**
- A world leader in guaranteed-renewable insurance with more than 200,000 national payroll accounts.
- Outstanding in claimant recommendations as validated by an Opinion Research Corporation poll indicating that 9 out of 10 claimants agree that AFLAC paid their claims fairly and promptly, and they would recommend the purchase of cancer insurance to others (July 2001).
- Uncompromising in fast, efficient service. Our toll-free line puts you in touch with a decision-maker immediately.
- Named by *Fortune* magazine to its list of "The 100 Best Companies to Work for in America" for the fourth consecutive year in January 2002.

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Level 1

Personal Accident Indemnity Plan

Accident-Only Insurance

Plan Benefits

- Emergency Treatment
- Follow-Up Treatment
- Initial Hospitalization
- Hospital Confinement
- Physical Therapy
- Accidental-Death
- Wellness
- Plus ... much more

Form A34175B2FL IC(2/09)

Aflac®

Personal Accident Indemnity Plan

Policy Series A-34000

Benefits are payable for a covered person's death, dismemberment, or injury caused by a covered accident that occurs on or off the job.

Accident Emergency Treatment Benefit

Aflac will pay $135 for the insured and the spouse, and $80 for children if a covered person receives treatment for injuries sustained in a covered accident. This benefit is payable for X-rays, treatment by a physician, 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.

Accident Follow-Up Treatment Benefit

Aflac will pay $30 for one treatment per day for up to a maximum of six treatments per covered accident, per covered person for follow-up treatment received for injuries sustained in a covered accident. 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.

Initial Accident Hospitalization Benefit

Aflac will pay $1,650 when a covered person is confined to a hospital for at least 24 hours for injuries sustained in a covered accident. If the covered person is admitted directly to an intensive care unit, ***Aflac will pay $2,750***. This benefit is payable only once per hospital confinement* or intensive care unit confinement and is payable only once per calendar year, per covered person.

Accident Hospital Confinement Benefit

Aflac will pay $325 per day for which a covered person is charged for a room for hospital confinement* of at least 18 hours for treatment of injuries sustained in a covered accident. This benefit is payable up to 365 days per covered accident, per covered person.

Intensive Care Unit Confinement Benefit

Aflac will pay an additional $650 per day for each day a covered person is receiving the Accident Hospital Confinement Benefit and is confined to and charged for a room in an intensive care unit. This benefit is payable up to 15 days per covered accident, per covered person. Confinements must start within 30 days of the accident.

Accident Specific-Sum Injuries Benefit

Aflac will pay $30–$11,000 for:

Dislocations	Burns	Skin Grafts
Eye Injuries	Lacerations	Fractures
Broken Teeth	Comas	Brain Concussions
Paralysis	Surgical Procedures	

Treatment must be performed on a covered person for injuries sustained in a covered accident. We will pay for no more than two dislocations per covered accident, per covered person. Dislocations must be diagnosed by a physician within 72 hours after the covered accident. Benefits are payable for only the first dislocation of a joint. If a physician reduces a dislocation with local or no anesthesia, we will pay 25 percent of the amount shown for the closed reduction dislocation. A physician must treat burns within 72 hours after a covered accident. A total of 50 percent of the burn benefit will be paid for one or more skin grafts. Lacerations requiring sutures must be repaired under the attendance of a physician within 72 hours after the covered accident. Fractures must be diagnosed by a physician by X-ray within 14 days after a covered accident. For chip fractures and other fractures not reduced by open or closed reduction, we will pay 25 percent of the benefit amount shown for the closed reduction. We will pay for no more than two fractures per covered accident, per covered person. We will pay no more than one benefit for broken teeth per covered accident, per covered person. Coma duration must be at least seven days and must require intubation for respiratory assistance. Paralysis must result from spinal cord injuries that are received in a covered accident and that result in complete and total loss of use of two or more limbs for a period of at least 30 days, and the loss must be confirmed by a physician. Surgical procedures 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. Only one miscellaneous surgery benefit is payable per 24-hour period even though more than one procedure may be performed.

*Hospital confinement is defined as a covered person's confinement to a bed in a hospital for which a room charge is made. The 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. Confinement must start within 30 days of the accident.

Major Diagnostic Exams

Aflac will pay $165 if a covered person requires one of the following exams for injuries sustained in a covered accident: CT (computerized tomography) scan, MRI (magnetic resonance imaging), or EEG (electroencephalogram). The exam must be performed in a hospital, a physician's office, or an ambulatory surgical center, and a charge must be incurred. This benefit is limited to one payment per calendar year, per covered person. No lifetime maximum.

Physical Therapy Benefit

Aflac will pay $30 for one treatment per day up to a maximum of ten treatments per covered accident, per covered person if a physician advises the person to seek treatment from a physical therapist. 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. 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.

Appliances Benefit

Aflac will pay $110 if a covered person requires, as advised by a physician, the use of a medical appliance as an aid in personal locomotion resulting from injuries sustained in a covered accident. This benefit is payable for crutches, wheelchairs, leg braces, back braces, and walkers, and is payable once per covered accident, per covered person.

Prosthesis Benefit

Aflac will pay $550 if a covered person requires a prosthetic device as a result of injuries sustained in a covered accident. This benefit is payable once per covered accident, per covered person and is not payable for hearing aids, wigs, or dental aids, to include false teeth.

Blood/Plasma/Platelets Benefit

Aflac will pay $110 if a covered person requires blood, plasma, or platelets for the treatment of injuries sustained in a covered accident. This benefit is not payable for immunoglobulins and is payable only once per covered accident, per covered person.

Ambulance Benefit

Aflac will pay $165 for ground ambulance transportation or $1,100 for air ambulance transportation if a covered person requires ambulance transportation to a hospital or emergency center for injuries sustained in a covered accident. A licensed professional ambulance company must provide the transportation within 72 hours of the covered accident.

Transportation Benefit

Aflac will pay $450 per round trip to a hospital if a covered person requires special treatment and hospital confinement* for injuries sustained in a covered accident. The hospital must be more than 100 miles from the covered person's residence or site of the accident. This benefit will be paid for only the covered person for whom the treatment is prescribed, or if the treatment is for a dependent child and commercial travel is necessary, one of the dependent child's parents or legal guardians who travels with the child will also receive this benefit. The local attending physician must prescribe the treatment, and the treatment must not be available locally. This benefit is payable for up to three round trips per calendar year, per covered person. This benefit is not payable for transportation by ambulance or air ambulance to the hospital.

Family Lodging Benefit

Aflac will pay $110 per night for one motel/hotel room for a member of the immediate family to accompany the covered person if treatment of injuries sustained in a covered accident requires hospital confinement.* The hospital and motel/hotel must be more than 100 miles from the covered person's residence. This benefit is payable up to 30 days per covered accident and only during the time the covered person is confined in the hospital.

Accidental-Death and -Dismemberment Benefits

Aflac will pay the following benefit for death if it is the result of injuries sustained in a covered accident:

	Insured/Spouse	Child
Common-Carrier Accidents	$192,500	$33,000

A covered person must be a passenger at the time of the common-carrier accident, and a proper authority must have licensed the vehicle 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. Taxis are not included.

	Insured/Spouse	Child
Other Accidents	$55,000	$16,500

(Other accidents are accidents that are not classified as common-carrier accidents and that are not specifically excluded in the limitations and exclusions of the policy.)

Aflac will pay the following benefit for dismemberment resulting from injuries sustained in a covered accident:

	Insured/Spouse	Child
Both arms and both legs	$27,500	$8,250
Two eyes, feet, hands, arms, or legs	$27,500	$8,250
One eye, foot, hand, arm, or leg	$ 6,875	$2,075
One or more fingers and/or one or more toes	$ 1,375	$ 550

Death or dismemberment must be independent of disease, bodily infirmity, or any other cause other than a covered accident and must occur within 90 days of the accident. 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. Loss of use does not constitute dismemberment, except for eye injuries resulting in permanent loss of vision such that central visual acuity cannot be corrected to better than 20/200.

Wellness Benefit

After the policy has been in force for 12 months, Aflac will pay $60 if you or any one family member undergoes routine examinations or other preventive testing during the following policy year. Eligible family members are your spouse and the dependent children of you or your spouse. 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 the policy anniversary date. Service must be under the supervision of or recommended by a physician and received while your policy is in force, and a charge must be incurred.

Guaranteed-Renewable

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

This brochure is for illustration purposes only.

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

What Is Not Covered

We will not pay benefits for services rendered by a member of the immediate family of a covered person or for an accident that occurs while coverage is not in force.

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

- 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);
- Driving any taxi for wage, compensation, or profit;
- 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 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.

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, care or treatment for persons suffering from mental disease or disorders, or care for the aged, drug addicts, or alcoholics.

Family Coverage

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

Accidents Happen

- Unintentional injuries are the fifth leading cause of death overall and first among persons in age groups from 1 to 44.
- On the average, there are 14 unintentional-injury deaths and about 2,990 disabling injuries every hour during the year.
- A disabling injury occurs every second.
- In 2005 about 36 percent of all hospital emergency department visits in the United States were injury-related.

Injury Facts, 2008 Edition, National Safety Council.

Aflac is ...

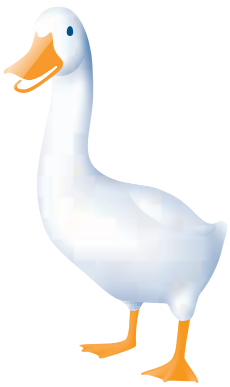
- A Fortune 500 company with nearly $66 billion in assets, insuring more than 40 million people worldwide.
- Named by Fortune magazine to its list of America's Most Admired Companies for the seventh consecutive year in March 2007.
- A premier provider of insurance policies with premiums payroll deducted 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.

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

WHAT IS NOT COVERED, LIMITATIONS AND EXCLUSIONS, AND TERMS YOU NEED TO KNOW.

PRE-EXISTING CONDITION LIMITATION

Pre-existing Condition Limitation
Pregnancy is a "pre-existing condition" if conception was before the effective date of coverage. Pregnancy will be covered as any other sickness when the date of conception is after the Insured effective date.

EXCLUSIONS

We will not pay benefits for loss caused by pre-existing conditions (except as stated in the pre-existing condition limitation provision above).

We will not pay benefits for loss contributed to, caused by, or resulting from:

1. War – declared or undeclared or military conflicts, participation in an insurrection or riot, or civil commotion. This exclusion does not include acts or terrorism. We will return the prorated premium for any period not covered by this certificate when the insured is in such service.
2. Suicide - committing or attempting to commit suicide, while sane or insane.
3. Self-Inflicted Injuries - injuring or attempting to injure yourself intentionally.
4. Traveling - traveling more than 40 miles outside the territorial limits of the United States, Canada, Mexico, Puerto Rico, the Bahamas, Virgin Islands, Bermuda, and Jamaica.
5. Racing - Riding in or driving any motor-driven vehicle in a race, stunt show or speed test.
6. Aviation - operating, learning to operate, serving as a crewmember on, or jumping or falling from any aircraft, including those, which are not motor-driven.
7. Intoxication - being legally intoxicated, or being under the influence of any narcotic, unless such is taken under the direction of a physician.
8. Illegal Activities or participation in an illegal occupation.
9. Sports - participating in any organized sport: professional or semi-professional.
10. Custodial care. This is care meant simply to help people who cannot take care of themselves.
11. Treatment for being overweight, gastric bypass or stapling, intestinal bypass, and any related procedures, including complications.
12. Routine physical exams and rest cures.
13. Services performed by a relative.
14. Services related to sex change, sterilization, in vitro fertilization, and reversal of a vasectomy or tubule ligation.
15. A service or a supply furnished by or on behalf of any government agency unless payment of the charge is required in the absence of insurance.
16. Elective abortion.
17. Treatment, services, or supplies received outside the United States and its possessions or Canada.
18. Dental services or treatment.
19. Cosmetic surgery, except when due to medically necessary reconstructive plastic surgery.
20. Injury or Sickness covered by Worker's Compensation.
21. Mental or emotional disorders without demonstrable organic disease.
22. Substance abuse.

Peace of Mind *and* Real Cash Benefits

GROUP HOSPITAL INDEMNITY

HI G

Aflac®

We've got you under our wing.®

CAI8575FL IC(5/10)

GROUP HOSPITAL INDEMNITY

Supplemental Hospital Indemnity
Policy Series CA8500-MP

HI[G]

Will your major medical insurance cover all of your bills?

Supplemental hospital indemnity insurance provides financial help to enhance your current coverage.

Your health insurance plan may pay only a portion of the total expenses a hospital stay or medical treatment requires. That likely would leave the rest of the bill for you to pay, plus any deductible or other expenses that are not covered by the plan. As a result, you could incur significant out-of-pocket expenses if you or a family member were hospitalized.

You don't want to be caught unprepared in a medical emergency and have to rely on your family's savings to cover the extra expenses you may face. This plan can help cover those expenses and protect your savings.

COVERAGE WORKSHEET

PAYROLL DEDUCTION

Deductions Begin: _____

Effective date: _____

Total Deduction: _____

This worksheet is for illustration purposes only. It is not an implication of coverage.

BENEFITS

HOSPITAL CONFINEMENT (UP TO 30 DAYS PER CONFINEMENT)

Plan 1 - $200 per day, Plan 2 - $400 per day, Plan 3 - $600 per day, and Plan 4 - $1,000 per day

This benefit is paid when a Covered Person is confined to a hospital as a resident bed patient because of a Covered Sickness or as the result of injuries received in a Covered Accident. To receive this benefit for Injuries received in a Covered Accident, the Covered Person must be confined to a hospital within 6 months of the date of the Covered Accident.

This benefit is payable for only one hospital confinement at a time even if caused by more than one Covered Accident, more than one Covered Sickness, or a Covered Accident and a Covered Sickness.

HOSPITAL ADMISSION

Plan 1 - $250 per admission, Plan 2 - $500 per admission, Plan 3 - $750 per admission, and Plan 4 - $1,000 per admission

The benefit is paid when a Covered Person is admitted to a hospital and confined as a resident bed patient because of Injuries received in a Covered Accident or because of a Covered Sickness. In order to receive this benefit for Injuries received in a Covered Accident, the Covered Person must be admitted to a hospital within 6 months of the date of the Covered Accident.

We will not pay benefits for confinement to an observation unit, or for emergency treatment or outpatient treatment. We will pay this benefit once for a period of confinement. We will only pay this benefit once for each Covered Accident or Covered Sickness. If a Covered Person is confined to the hospital because of the same or related Injury or Sickness, we will not pay this benefit again.

HOSPITAL INTENSIVE CARE (30 DAY MAXIMUM FOR ANY ONE PERIOD OF CONFINEMENT.)

Plan 1 - $250 per day, Plan 2 - $500 per day, Plan 3 - $750 per day, and Plan 4 - $1,000 per day

This benefit is paid when a Covered Person is confined in a hospital intensive care unit because of a Covered Sickness or due to an Injury received from a Covered Accident. To receive this benefit for injuries received in a Covered Accident, the Covered Person must be admitted to a hospital intensive care unit within 6 months of the date of the Covered Accident.

We will pay benefits for only one confinement in a hospital intensive care unit at a time, even if it is caused by more than one Covered Accident, more than one Covered Sickness, or a Covered Accident and a Covered Sickness. If we pay benefits for confinement in a hospital intensive care unit and a Covered Person becomes confined to a hospital intensive care unit again within 6 months because of the same or related condition, we will treat this confinement as the same period of confinement.

SURGICAL AND ANESTHESIA BENEFIT

Plan 1 - N/A
Plan 2 - Surgery up to $500; Anesthesia $125
Plan 3 - Surgery up to $1,500; Anesthesia $375
Plan 4 - Surgery $3,000; Anesthesia $500

This benefit is paid when a Covered Person has surgery performed by a physician due to an Injury received in a Covered Accident or because of a Covered Sickness, surgical and anesthesia benefits are available subject to plan definitions. If two or more surgical procedures are performed at the same time through the same or different incisions, only one benefit, the largest, will be provided. (The anesthesia benefit will be 25% of the surgical benefit performed.)

HOSPITAL EMERGENCY ROOM/PHYSICIAN BENEFIT (MEDICAL FEES)

If an insured is injured in a Covered Accident or has treatment as the result of a Covered Sickness, he will receive the following (total combined benefit maximum per visit is up to $75, depending on plan chosen):

Physician (per visit) – $50
Laboratory fees (per visit) – $25
X-ray (per visit) – $50
Injections/medications (per visit) – $25
Family calendar year maximum (per insured) – $250 to $1,000, depending on plan chosen.

WELLNESS BENEFIT

Plan 1 and 2 - $50 per calendar year
Plan 3 and 4 - $75 per calendar year

We will pay this benefit when an insured visits a doctor and is neither sick nor injured.

ACCIDENTAL DEATH BENEFIT

Plan 1 - $5,000
Plan 2 - $7,500
Plan 3 - $10,000
Plan 4 - $12,500

We will pay this benefit if an insured is injured in a covered accident and the injury results in death within 90 days after the covered accident.

Peace of Mind *and* Real Cash Benefits

GROUP WHOLE LIFE INSURANCE

WL G

Aflac®

We've got you under our wing.®

CAI9875 IC(3/10)

GROUP WHOLE LIFE INSURANCE

Policy Series WL9800MP

WL G

Don’t leave your family unprotected, provide for them now with whole life insurance.

Many employees choose our whole life insurance products because they offer the flexibility to meet a variety of personal needs. With whole life insurance plans, employees have a choice of benefit and premium amounts that fit their paychecks and life styles.

Employees also have access to the cash value accumulated in their policies and may use these savings for loans or withdrawals. And with our voluntary plans, employees own their coverage and can keep them in force even when they retire or change employers.

- **FLEXIBILITY TO MEET YOUR NEEDS**
  Employee–Coverage amount: up to $100,000.
  Spouse–Coverage amount: up to $50,000 (not to exceed employee’s coverage).
  Children (ages 15 days-24 years)–$10,000 child term life rider covers all your dependent children for only $1.38 per week.
- **BUILDS CASH VALUE**
  In addition to having valuable life insurance protection, you can accumulate savings at a guaranteed rate of return. You have access to your cash value and have the ability to make loans or withdrawals.
- **NO MEDICAL EXAMS REQUIRED**
  Employees and their families may apply for benefit amounts by answering only a few medical questions.
- **PERMANENT INSURANCE PROTECTION**
  Once your insurance application has been approved and payroll deductions have started, the coverage is yours to keep by continuing to pay premiums. Your premium will never increase.
- **PORTABILITY**
  Take your coverage with you if you leave the company.

BENEFITS

WAIVER OF PREMIUM RIDER (EMPLOYES ONLY; ISSUE AGES 18-55)

Waives entire premium amount for employee coverage after the insured has been totally disabled for 4 months and continues throughout the duration of the disability. Any recurrence of a prior disability will be covered, provided the prior disability continued for at least 6 consecutive months, it begins within 30 days of recovery, and is due to the same or related causes. The Waiver of Premium is also available for loss of sight or loss of limbs even though the employee may be able to engage in an occupation. The rider terminates on the employee's certificate anniversary coinciding with or next following his 60th birthday.

ACCIDENTAL DEATH BENEFIT RIDER (EMPLOYEE AND SPOUSE ONLY; ISSUE AGES 18-60)

The benefit provides an additional benefit equal to the face amount if the insured dies within 90 days from injuries received in an accident. If the Insured dies in an Accidental Common Carrier Death, the benefit is twice the face amount. The maximum coverage available under the rider is $100,000. The Accidental Death Benefit terminates at age 65.

ACCELERATED BENEFIT RIDER

This offers one-half of the death benefit to be paid prior to death, when the insured is diagnosed with a terminal illness. This is a life insurance rider, which pays, Accelerated Death Benefits at your option under conditions specified in this rider. This rider is not intended to provide health, nursing, home or long term care insurance. Benefit payments may affect your eligibility to receive Medicaid and other government benefits or entitlements. Employees and/or spouses are eligible for this benefit. Receipt of Accelerated Benefits may be taxable. The Insured should consult with his personal tax advisor.

42% FACT

of people use life insurance to pay bills and final expenses.*

*"Every Excuse in the Book," LIMRA International, April 2007.

COVERAGE WORKSHEET

	AGE	S/NS	INSURANCE AMOUNT	INSURANCE W/ACCIDENTAL DEATH	WEEKLY COST
Employee:					
Spouse:					
Children:					
				Total:	

This worksheet is for illustration purposes only. It is not an implication of coverage.

LIMITATIONS AND EXCLUSIONS

SUICIDE EXCLUSION

If the insured commits suicide within two years from the certificate date, we will limit the death benefit proceeds to the premiums paid less any loans and loan interest.

WAIVER OF PREMIUM RIDER EXCLUSION

No benefits will be provided by the rider if Total Disability:
1. is caused by an intentionally self inflicted injury; or
2. results from an act of war, declared or undeclared; while the employee is in the military service of any country.

ACCIDENTAL DEATH RIDER EXCLUSION

The Accidental Death Benefit provided by this rider shall not be payable if the insured's death results from any of the following causes: Operating, learning to operate, serving as a crew member on, or jumping or falling from any aircraft, including those which are not motor-driven.

1. war or any act of war (including any armed aggression resisted by the armed forces of any country or combination of countries), whether such war is declared or undeclared;
2. suicide;
3. any bodily or mental infirmity or disease, except a bacterial infection occurring with or through an accidental injury;
4. committing or attempting to commit an assault or felony;
5. the voluntary taking of: a. any drug, medication, or sedative unless as prescribed by a physician; or b. any poison (except for food poisoning), including carbon monoxide;
6. operating, riding in, or descending from any kind of aircraft, or subsequent drowning, if the insured; a. is a pilot, officer, or member of the crew; or b.is in an aircraft which is being flown for the purpose of descent from such aircraft while in flight; or c. is giving or receiving any kind of training or instructions; or d. has any duties aboard such aircraft.

Accelerated Benefit Rider is not available in all states.

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

THE ACCELERATED BENEFIT RIDER WILL NOT BE PAYABLE:

1. If either the owner or the insured is required by a government agency to use the Accelerated Benefit in order to apply for, obtain, or otherwise keep a government benefit or entitlement;
2. If either the owner or the insured is required by law to use the Accelerated Benefit to meet the claims of creditors, whether in bankruptcy or otherwise;
3. If the terminal illness results from intentionally self-inflicted injuries;
4. If the Certificate is in force as either Extended Term Insurance or Reduced Paid-Up Insurance;
5. If the certificate is legally or equitably assigned, except to the company as security for the lien;
6. If any part of the Death Benefit under the certificate is contestable;
7. If the certificate is not in force or the Death Benefit under the certificate is not payable for any reason;
8. If the amount of the Accelerated Benefit, plus the amount of all Accelerated Benefits on the insured from all certificates issued by the company, exceeds $250,000;
9. If there has already been an Accelerated Benefit paid on the certificate.

PORTABLE COVERAGE

When coverage would otherwise terminate because the employee ends employment with the employer, coverage may be continued. The employee will continue the coverage that is in-force on the date employment ends, including dependent coverage then in effect.

If the Master Policy is terminated, you will become members of a Group of Insureds. The members will continue to have coverage, and your coverage will remain in force. Please refer to your certificate for terms and conditions.

EFFECTIVE DATE

The certificate issued under the policy will take effect as of the insured's application date, if the insured is eligible for it; the application is signed; the first premium is paid to us; and the information provided in the application is acceptable to us for issuance of the coverage under our rules and practices.

We've got you under our wing.®

aflacgroupinsurance.com | 1.800.433.3036

Underwritten by:
Continental American Insurance Company
2801 Devine Street | Columbia, South Carolina 29205