American Family Life Assurance
Company of New York
(herein referred to as Aflac New York)
22 Corporate Woods Boulevard, Suite 2
Albany, New York 12211

ELIGIBLE MEMBER ENROLLMENT/TERMINATE/CHANGE FORM
ACTIVE EMPLOYEE

FOR ADMINISTRATIVE USE ONLY				
☐ Initial Enrollment	☐ New Hire	☐ Re-Enrollment	☐ New Eligible	☐ Re-Submission
Deduction start date _____				

Member/Group Information **A: Add (enroll) T: Terminate C: Change (change of name or coverage) Gender - M: Male F: Female N: Nonbinary**

Applicant Name (First, MI, Last)	☐ A ☐ T ☐ C	Social Security #	Gender ☐ M ☐ F ☐ N	Date of Birth
Street Address		City	State	ZIP
Group Policyholder/District Name		Location	Date of Hire	
E-mail address (optional)		Daytime Phone No.		
Spouse's or Lawful Domestic Partner's Name (if coverage is requested)		Spouse's or Lawful Domestic Partner's Gender	Spouse's or Lawful Domestic Partner's Date of Birth	

LIST ALL ELIGIBLE CHILDREN UNDER AGE 26 FOR WHOM YOU ARE PROPOSING COVERAGE (FROM YOUNGEST TO OLDEST)
A: Add (enroll) T: Terminate C: Change (change of name or coverage)

Last Name, First Name M.I.	Action	Gender	Date of Birth
	☐ A ☐ T ☐ C		
	☐ A ☐ T ☐ C		
	☐ A ☐ T ☐ C		
	☐ A ☐ T ☐ C		
	☐ A ☐ T ☐ C		
	☐ A ☐ T ☐ C		

NOTE: Eligible Members that waive coverage at initial enrollment (within 31 days of effective date) or in the new eligibility period and/or terminate coverage may not enroll until next open enrollment period, unless there is a qualifying event.

GROUP HOSPITAL INSURANCE: I elect the following coverage(s): ☐Member ☐Member + Spouse or Lawful Domestic Partner ☐Member + Children ☐Member + Family

☐ New Coverage ☐ Change in Coverage ☐ Waive Coverage* ☐ Cancel Coverage _ Termination Date:_____

I acknowledge that I have Comprehensive Hospital, Surgical, and Medical Health Insurance (Minimum essential coverage). ☐ Yes ☐ No

GROUP VISION INSURANCE: I elect the following coverage(s): ☐Member ☐Member + Spouse or Lawful Domestic Partner ☐Member + Children ☐Member + Family

☐ New Coverage ☐ Change in Coverage ☐ Waive Coverage* ☐ Change in Coverage _ Termination Date:_____

By signing this application, I understand and agree:

- The certificate(s) enrolled in will be effective as of the date approved by Aflac New York. I understand no insurance will be in effect unless I am Actively at Work on the Effective Date of coverage, and until my application is approved and the necessary premium is paid. If I am not Actively at

© 2019 Aflac New York All Rights Reserved

Work on the Effective Date of coverage, coverage will become effective on the date I return to an active work status. Coverage may be contingent upon the Group meeting participation requirements. If so, coverage will not be effective until the participation requirements are met.

- Once covered, dependent children will continue to be covered until their 26th birthday. If a covered child reaches a limiting age as specified in the certificate or a rider, it is your responsibility to notify Aflac New York.
- The dental plan I am enrolling in contains different waiting periods for benefits listed in the Schedule of Covered Procedures. This means no benefits are payable during the listed waiting period. The waiting period begins on the effective date of my certificate.
- I have received the following document(s) for each certificate I have selected, as applicable:
  Replacement Notice, Outline of Coverage, Electronic Delivery Notice, *Guide to Health Insurance for People with Medicare*, Notice to Persons on Medicare, Customer Privacy Policy.
- I have read, or had read to me, the application. All answers are complete and true. Any statements are deemed representations and not warranties, and any false statement, material misrepresentation, or omission of any information may result in loss of coverage under the certificate.
- The premium amount listed on this application represents the premium amount the Group will remit to Aflac New York on my behalf. This amount, because of my Group's billing/payroll practices, may differ from the amount being deducted from my paycheck or otherwise collected by the Group from me, or the premium amount quoted to me.
- If I am applying to replace existing Aflac New York coverage with this certificate(s), the coverage may have different benefits and that I should compare them to determine which is best for me. I am terminating my current Aflac New York coverage and its benefits for the benefits provided in this Aflac New York certificate.
- The certificate(s) of insurance I am now enrolling in will be issued based upon the written answers to the questions and information asked for in this application, and any other pertinent information Aflac New York may require for proper underwriting.
- I have reviewed and acknowledged all limitations and exclusions pertaining to the coverage(s) in which I am enrolling, including all those pertaining to any waiting periods, pregnancies, or pre-existing conditions, if applicable.
- I also understand and agree my certificate may be delivered or made available to me in an electronic format. I affirmatively consent to receiving communications about this coverage electronically, including through email. ❑ Yes ❑ No By consenting to receiving my certificate and related communications electronically, I am also consenting to receiving my privacy notices electronically. A copy of the privacy notices will be included within the electronic certificate packet. The privacy notices are not part of the contract but are provided to me as required by federal and/or state laws.

I hereby agree I have reviewed the benefits and premium of the coverage I am enrolling in and agree to the following:

- I understand the impact the premium for this coverage has on my paycheck/income;
- I understand the impact the total Aflac New York premium for this coverage and any other Aflac New York coverage has on my paycheck/income and believe it to be appropriate for me; and
- I have considered all of my existing health insurance coverage, with Aflac New York and/or with other carriers, and believe this additional coverage is appropriate for my insurance needs. I further understand I can contact Aflac New York and/or other insurance carriers to assist in evaluating the suitability of insurance coverage for me.

Proposed Insured's Initials _____

A person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the state value of the claim for each such violation.

Date _____ Signature of Applicant _____

This form is not complete unless signed and dated as indicated.

© 2019 Aflac New York All Rights Reserved