CANCER HISTORY FORM
PAYROLL AND UNION

Proposed Insured's/Employee's Name _____ Existing Policy Number (if applicable) _____

Address _____
Street or Post Office Box Apt. No.

City _____ State _____ ZIP _____

Account Name _____ Account Number _____

Applicants or family members with a history of a malignant condition may apply for our Cancer policy, providing there has been no recurrence or treatment for the malignancy within the five years preceding the application date.

This form must be completed for any individual who qualifies under these guidelines. The application and this completed form (which is considered part of the application) are subject to underwriting by our worldwide headquarters. If the application is not approved, any premiums paid will be refunded.

The individual must have been examined by his/her Physician within 12 months prior to the date of the application.

Please complete the following section for any individual who has had a prior history of Cancer, excluding Nonmelanoma Skin Cancer.

_____ had Cancer first diagnosed on _____ as _____
Name of Applicant or Family Member Month/Day/Year Type of Cancer

The last treatment for Cancer was on _____. Based on the medical history and the last
Month/Day/Year

examination on _____, there has been no recurrence or treatment for Cancer in the last five
Month/Day/Year

years. The last date of preventive hormonal therapy (if applicable) was on _____.
Month/Day/Year

Current Physician's Name _____

Address _____ Telephone No. _____
Street or Post Office Box

City _____ State _____ ZIP _____

1. Have you or has anyone to be covered received a health screening (such as a mammogram, Pap smear, PSA, chest x-ray or colonoscopy) that tests for the presence of Cancer or an Associated Cancerous Condition, **for which you have not received the results?** **❑ Yes ❑ No**
   If yes, was it the ❑ Named Insured ❑ Spouse ❑ Child? Name of the child(ren):

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

   If a child, are any other children to be covered? **❑Yes ❑ No**

2. Have you or has anyone to be covered been advised by a member of the medical profession to receive a follow-up test for the potential presence of Cancer, **for which you have not received the results?** **❑ Yes ❑ No**
   If yes, was it the ❑ Named Insured ❑ Spouse ❑ Child? Name of the child(ren):

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

   If a child, are any other children to be covered? **❑Yes ❑ No**

3. Have you or has anyone to be covered received abnormal test results from a Cancer or Associated Cancerous Condition screening within the past 90 days or are you or anyone to be covered waiting on the results of medical tests for an undiagnosed condition? ❑ **Yes** ❑ **No**

If yes, was it the ❑ Named Insured ❑ Spouse ❑ Child? Name of the child(ren):

_____

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

If a child, are any other children to be covered? ❑**Yes** ❑ **No**

I understand that under the new, upgraded, or converted policy _____ will
(Name of Applicant or Family Member)

NOT be eligible to receive an **Initial Diagnosis Benefit** from Aflac for a recurrence, extension, or metastatic spread of any Cancer, excluding Nonmelanoma Skin Cancer, diagnosed prior to the Effective Date of coverage.

I have read, or had read to me, the completed Cancer History Form, and I certify that the statements and answers provided herein are complete and true.

Proposed Insured's/Employee's Signature _____ Date _____

Applicant or Family Member's Signature (if other than applicant)_____ Date _____

American Family Life Assurance Company of Columbus (Aflac)
Worldwide Headquarters: Columbus, Georgia 31999
FOR INFORMATION, CALL TOLL-FREE 1-800-99-AFLAC (1-800-992-3522).
VISIT OUR WEB SITE AT AFLAC.COM.