Aflac Sales Guide:

- **Final Expense**
- **Medicare Supplement**

IMPORTANT:
To perform a search of this document, use CTRL + F.

NOTE: Not all agents have access to submit paper applications. Please disregard information related to paper apps if you or your agency use only online business.

Content subject to change to ensure compliance with Tier One Insurance Company and Aetna Life Insurance Company requirements. To the extent there is any conflict between the descriptions in this guide and the terms of your contract with Tier One Insurance Company, the terms of the contract control.

The content within is for informational purposes, for agent-facing audiences only. This information is not approved to distribute to prospective insureds, to prospective accounts, or to use as a solicitation. Misrepresenting this, or any, information to solicit or induce an insured to lapse, forfeit, or surrender an insurance policy is prohibited by law. Any use not specifically permitted herein is strictly prohibited.

Aflac Medicare Supplement insurance, policy series AFLMS, may not be available in all states. Information herein is considered an overview, does not provide full disclosure, and is not an exact description of any policy or rider. Furthermore, the material may not reflect the most current version of the policy or rider. Aflac's family of insurers include Aflac, Aflac New York, Continental American Insurance Company, and Tier One Insurance Company.

Aflac Medicare Supplement and Aflac Final Expense insurance coverage is underwritten by Tier One Insurance Company, a subsidiary of Aflac Incorporated and is administered by Aetna Life Insurance Company. In California, Tier One conducts business as Tier One Life Insurance Company.

Table of Contents

I. FAQs

What are the product names and who is the carrier?	Aflac Medicare Supplement and Aflac Final Expense insurance are underwritten by Tier One Insurance Company, a subsidiary of Aflac Incorporated.
Who is the administrator of the products?	Both products are administered by Aetna Life Insurance Company.
Aflac Tier One offers other products. Can I sell them?	Yes, you may sell the additional products, if you are properly licensed for the products and appointed in the appropriate states.
What states are available to sell?	Final Expense is available in all states except NY. Aflac Medicare Supplement is available in 41 states; the product will not be filed in AK, CT, DC, HI, MA, ME, MN, NY, WA. Aflac Tier One is not licensed in New York. Coverage maps are available on sellaflacseniorinsurance.com to see available states for Medicare Supplement.
Where can I find additional information about Aflac Final Expense and Medicare Supplement?	Visit the website sellaflacseniorinsurance.com for product resources. An overview of Final Expense is provided in this section of the Sales Guide. An overview of Medicare Supplement is provided in this section of the Sales Guide.
What Medicare Supplement plans or benefits are available?	Plans A, F, G and N are available in most states. Plan F, where available, is only available for people first eligible for Medicare before 1/1/2020.
What carrier do I need a contract with?	Coverage is underwritten by Tier One Insurance Company, a subsidiary of Aflac Incorporated. An appointment is required with Tier One.
How do I get contracted with the carrier?	The contract and appointment process begins with an upline agent inviting you to contract. Invitations to contract are sent by one of two systems, the Aflac onboarding tool or SuranceBay.
Whom do I contact for questions or concerns with my contract or appointment? Claims? New Business? Other questions?	**Click here to view the full contact directory.**
What are the Agent Services team hours of operation?	Monday-Friday, 8:00am-5:00pm CT
Where can I find commission rates and my compensation?	You can find your commission information on the Aflac Senior Agent Portal (www.sellaflacseniorplans.com).
What is the preferred method for taking applications?	The eApp is preferred to take applications and submit business. This will expedite underwriting, new business processing, policy issue, and commissions. An applicant email address is

	required for eApps. See this section for detailed eApp procedures.
Is there a mobile app for applications?	No.
Does the eApp check for approved states?	The application must be from an approved state where the applicant is a resident.
Can a non-legal resident apply for coverage?	No. All applicants must be legal residents of the United States. A Social Security Number is required to apply for coverage. An Individual Tax ID Number (ITIN) is not acceptable.
How is underwriting handled?	Real-time decision underwriting is available for both products. Once you submit an application through Aflac Quote & Enroll, you will receive an approval, decline or additional review status. See this section for full details.
Are applications subject to a prescription drug database review?	Yes. You can access the most up to date drug list through the Aflac Senior Agent Portal. Please refer to this list often to stay abreast of changes. See this section for information on how the Drug List is displayed in the portal.
For enrollment tracking, is there a report or key that explains what each status or field means?	Yes. See the Enrollment Tracker on the Aflac Senior Agent Portal in the Pending Business Dashboard.
Is the electronically completed application available for agent and client review before submission?	The agent can always review applications prior to submission. If the authorization code signature is used, the client cannot review the application before submission. For email signatures, the client can review the application before submission.
What are the billing options for this product?	Billing modes include Monthly, Quarterly, Semi-Annually and Annually. Payment methods include EFT and accommodate special Social Security billing.
Can an agent submit requests for policy changes or cancellations on behalf of a policyholder?	The policyholder can send written requests to the agent for the agent to submit to the policyholder service team. Documents or written requests can be mailed or faxed.

II. Agent Resources

Agent Resources

Click here to view the full contact directory.

Aflac Senior Agent Website

Aflac Final Expense and Medicare Supplement product information is available at https://sellaflacseniorinsurance.com.

Additional information about the product requires agent appointment to access the Aflac Senior Agent Portal (ASAP).

Aflac Senior Agent Portal (ASAP)

The Aflac Senior Agent Portal URL is www.sellaflacseniorplans.com.

The site includes information such as product availability, commission dashboard, underwriting drug list, alerts and messages, an enrollment tracker, the ability to order product materials, and much more.

Additionally, the portal is the gateway to the Quote and Enroll tool.

Agent secure log-in

Under the Secure Login section, click on “Agents” and sign in with the username and password you created during onboarding. If this is the first time you’ve used our website, click on the “Register Now” button after you click “Agents” to register your account.

If you need assistance logging in to the agent secure site, please contact the Agent Services team at **833-504-0336**.

Agency secure log-in

If you’re an individual agent who owns an agency, you’ll need to register on the website twice. Register once for you, and once for your agency.

Agent communications

It’s quick and easy to stay in the know. Just make sure you have a current email address on file with us and we’ll keep you updated about: products, training, operations, and more.

We send communications to the email address you gave us when you first contracted with Tier One, as well as sharing on the Aflac Senior Agent Portal. To start receiving our communications at a new email address, or if you’re not getting our communications, you can update your email by logging in to the Aflac Senior Portal or by contacting the Agent Services team.

You can choose which email alerts you’ll through this site as well.

Agent Services team

The Agent Services team is focused on your needs as a new or experienced agent/agency. We want to help you grow your business.

Services Offered

The Agent Services team can help answer your questions about:

- Product details and benefits
- Placing sales supply orders, such as brochure requests)
- Agent and agency communications
- Navigation and login support for Aflac Senior Agent Portal
- Submitting a new application using the Aflac Quote and Enroll tool or using paper

Additional assistance available:

- New application rate quotes
- Drug/formulary lookup
- Checking active appointment status for products and states
- Providing contact information for other departments
- Updating agent email and mailing addresses

The Agent Services team

- Phone: **833-504-0336**
- Email: information@aflac.aetna.com
- Hours: Monday through Friday, 8:00 a.m. - 5:00 p.m. CT
- Phone Tree (as of 9/15/23): After calling **833-504-0336**, press 3 for Agent Services. Further selections are:
    - Press 1 for contracting or commission questions, or for any other issue.
    - Press 2 for login, password resets, or agent portal questions.
    - Press 3 for new enrollment questions, pending applications, or declined applications.
    - Press 4 for active member Medicare policy questions.
    - Press 5 for active member Final Expense policy questions.

  The selections could change over time.

III. Licensing, Contracting and Appointment

Key terms

- License: The state Department of Insurance will issue a license to producers who submit an application to solicit business in that state. The agent must receive their license from the state before they request to contract with Tier One Insurance Company (Tier One).
- Contract: An agreement between the agent and Tier One that must be signed. Once executed, the contract is a legally binding document.
- Appointment: A registration with state insurance departments that a producer is acting on behalf of Tier One and has the right to sell Tier One products in that state.
- Upline: A firm, agency, organization or person with downline agents.
- Downline: A person or entity whose contract connects to one or more uplines; or a licensed-only agent.

Contract types

- Agent contract: A Licensed Only Agent (LOA) contract is available to agents who are assigned to and supervised by a General Agent or a Managing General Agent (upline). We don't pay commissions directly to LOA agents. LOA compensation is paid by an LOA's upline.
- General Agent contract: A General Agent (GA) contract is available to agents and managing general agents (MGAs). We pay commissions directly to GA agents.

Contracting

Initial contracting

The contract and appointment process begins with an upline agent inviting you to contract. Invitations to contract are sent by one of two systems, the Aflac onboarding tool (Aflac Senior Agent Portal) or SuranceBay.

Agent background check and review process

As part of the contracting process, we perform standard background checks that include, but are not limited to:

- Criminal Search
- Professional License Verification

If the background report is clear, we'll complete the final steps of the contracting process. If a background report is not clear, it will be reviewed by our contract review team to decide whether Tier One will move forward with the contracting process or if the application to contract will be declined.

When an applicant is under review, we'll send a pre-adverse action letter and a copy of the applicant's background report to the applicant's email address. If no email address is available, the letter and report will be mailed to the applicant. During the review process, the applicant has ten business days from the date of the letter to provide a response.

If the applicant wishes to dispute the accuracy of the information in the background report, the applicant should contact Applicant Insight, the consumer reporting agency that provided the report, at **1-800-771-7703 x 2048**.

The applicant may submit any additional documentation for review with background findings by email to information@aflac.aetna.com.

- If the applicant is approved, we'll send a welcome letter to the agent/agency and their upline.
- If the applicant is not approved, we'll send a decline letter to the agent/agency and their upline.
- If the application is not approved, the applicant can re-apply any time that they feel their background has changed and would like to start a new application and review process.

Appointments

After contracting, we'll appoint you with Tier One Insurance Company for the products for which you are licensed.

When we launch new products or change entities, we'll auto-appoint you if you're licensed and have submitted business in the past 12 months.

Just in Time Appointment (JIT)

In JIT states, once contracting is completed and a new business application is submitted, Aflac will process your appointment with the appropriate JIT state. This means we submit the appointment agreement to a state Department of Insurance (DOI) once you've submitted your first application in that state.

Non-appointment states

The following states do not require producer appointments (Tier One will maintain a list of licensed agents):

- Alabama
- Arizona
- Colorado
- Illinois
- Indiana
- Maryland
- Missouri
- Oregon

Pre-appointment states

If an application is submitted in a pre-appointment state with an agent signature date that's earlier than the state appointment date, the application will not be accepted. The following states require pre-appointment:

- Alabama
- Kentucky
- Louisiana
- Montana
- Ohio
- Pennsylvania
- Utah
- Vermont
- Washington
- Wisconsin

For states requiring pre-appointment, you can submit your request on the Aflac Senior Agent Portal.

Please note the following guidelines for upline licensing/appointments.

Upline license and appointment guide

State	Upline Agent License Needed?	Upline Agent Appt Needed?	Upline Agency License Needed?	Upline Agency Appt Needed?	State	Upline Agent License Needed?	Upline Agent Appt Needed?	Upline Agency License Needed?	Upline Agency Appt Needed?
AK	Y		Y		MT	Y	Y	Y	Y
AL	Y	Y	Y	Y	NC	Y	Y	Y	
AR	Y	Y	Y	Y	ND	Y	Y	Y	Y
AZ	Y		Y		NE	Y	Y	Y	
CA	Y	Y	Y	Y	NH	Y	Y		
CO	Y		Y		NJ	Y	Y	Y	Y
CT	Y	Y	Y	Y	NM	Y	Y	Y	
DC	Y	Y	Y	Y	NV	Y	Y	Y	Y
DE	Y	Y	Y		NY	Y	Y	Y	Y
FL	Y	Y	Y		OH	Y	Y	Y	Y
GA	Y	Y	Y		OK	Y	Y	Y	Y
HI	Y	Y	Y	Y	OR	Y		Y	
IA	Y	Y			PA	Y	Y	Y	Y
ID	Y	Y	Y	Y	RI	Y			
IL	Y		Y		SC	Y	Y	Y	
IN	Y		Y		SD	Y	Y	Y	Y
KS	Y	Y	Y		TN	Y	Y		
KY	Y	Y	Y	Y	TX	Y	Y	Y	Y
LA	Y	Y	Y	Y	UT	Y	Y	Y	Y
MA	Y	Y	Y	Y	VA	Y	Y	Y	Y
MD	Y		Y		VT	Y	Y		
ME	Y	Y	Y	Y	WA	Y	Y	Y	Y
MI	Y	Y	Y	Y	WI	Y	Y		
MN	Y	Y	Y		WV	Y	Y	Y	
MO	Y		Y		WY	Y	Y	Y	Y
MS	Y	Y	Y						

Appointment Status, Demographic changes, Terminations

Checking on appointment status

An agent's upline may use Aflac Senior Agent Portal to see updates made to an agent's contracting status and appointments, which will appear 24 hours after being completed.

Contracted agents may go to "Agent Management" section to see products and state appointment approval status.

Demographic changes

Email name change requests **to** information@aflac.aetna.com with a copy of your license showing your new name and a completed W-9. All other demographic change requests should be submitted through the Aflac Senior Agent Portal (address, email and other changes).

If your agency name is changing, you'll need to send us a detailed request and a copy of your agency license showing the new agency name.

If your agency Tax ID is changing, it is considered a hierarchy change and we'll have to issue your agency a new writing number.

Terminations

All agent/agency appointment terminations are reviewed by our business leadership. In order to comply with state timing requirements, appointment terminations are processed in our system on the same day we send the termination letter to the agent. Typically, the effective date of the termination is 15 days after the notice is sent. The effective date may vary depending on the reason for the termination.

In the event an agent terminates by choice or for a reason other than “for cause,” we require a six-month waiting period before they can reapply.

A termination notice will be emailed on behalf of Contracting.

Hierarchy changes and transfers

Hierarchy changes

Situations that require a hierarchy change:

- Changing agent commission type (LOA to GA, GA to LOA)
- Changing agent commission level (level may require review for approval)
- Adding or removing intermediaries
- Adding or removing an agency
- Recent termination (within 6 months)
- New upline/NMO
- Principal agent changes
- When an agent or agency buys another

If you or one of your agents needs a hierarchy change, here are tips to help speed up the process.

- If moving GA to GA, the GA must remain at the same commission level they were for 6 months
- If moving LOA to GA, the new GA can start at any commission level (level may require review for approval)
- If remaining under the same hierarchy, the level can be changed without any waiting period
- Agency name/Tax ID change (requires court documents with new Tax ID number conversion and licenses with new agency name)

Uplines can submit hierarchy changes through the Aflac Senior Agent Portal.

Transfers

Required documents for single agent transfers:

- Contract
- Producer information form (PIF)
- Commission advance addendum
- W-9
- A release letter from the current upline (if agent produced within previous 6 months) or intent to transfer (the transferring agent must email an Aflac Relationship Manager and copy their current upline; the agent can continue to produce for 6 months, then the new upline will email hierarchy change paperwork to the Regional Sales Specialist)

Required documents for agent/agency transfers with a downline:

- Contract
- Producer information form (PIF)
- Commission advance addendum
- W-9
- A release letter from the current upline (if agent/agency produced within previous 6 months) If you have any questions, contact the Agent Services team at **833-504-0336**.

Agent of Record (AOR)

The writing agent is considered the agent of record and cannot be changed or transferred by the GA or MGA. An agent may add a servicing agent to assist with their policy management.

IV. Compensation

Compensation overview

"Compensation" means first year, renewal and override commissions and other forms of remuneration earned by an agent in connection with the sale of our insurance products.

In addition to the following overview, be sure to refer to your contract. To the extent there is any conflict between the description below and the terms of your contract with Tier One, the terms of the contract apply.

Commission levels can be reassigned at Tier One's discretion.

Commission

General Agents are paid a commission for each policyholder they enroll in an Aflac product in accordance with their contract.

Commissions for licensed-only agent (LOA) sales are paid directly to their upline.

We calculate commissions on the commission cycle after the premium is applied to the policy. When a policyholder pays modal premium, our system calculates commission payment based on your commission schedule and will disburse on the next available commission cycle.

Commission information can be found on the Aflac Senior Agent Portal.

Payment frequency

The compensation year is January 1 through December 31.

We strongly recommend signing up for EFT. Life commissions pay daily when on EFT and monthly when not on EFT, once the payable amount reaches $25. This does not mean payment upon issuance. Due to your individual bank's internal procedures, it may take up to 48 hours before you receive your commission payment.

We send your payment using the address or EFT information we have on record.

If you need to change the address or EFT information for an agent/agency, send your changes to **commissions@aflac.aetna.com**. You may also update EFT details using the Agent Management tool on the Aflac Senior Agent Portal.

- EFT updates require submission of the **Agent EFT authorization form**.
- Address changes will apply as applicable to LOAs as well.

Based on your contract, you have 45 days to object to payment and calculations on a commission statement.

Commission Splits

If agents listed on an application have agreed to split the commissions earned on the policy:

- All agents must be properly licensed and appointed with the company in the policy's state of issue.
- Split commissions are calculated as a percentage of commissionable premium and will apply while the policy remains in force.
- The percentage of the premium spit can be for any amount but must be stated in whole numbers and total 100%. **Example: the percentage for the premium split can be from 1% to 99% but cannot be 0% or 100%.**
- The calculation of each agents' commissions is based on their respective company commission schedule.
- Changes to AOR or splits will **not** be made if the request is submitted more than 30 days after the application signature date.
- By completing the split commission section, the writing agent agrees to split his/her commission with the secondary agent as indicated above.

Advance commissions

- Advance commissions are paid one time per Aflac-affiliated policyholder.
- You must be setup for EFT to be eligible for advance commissions. If setup for advance commissions, but your EFT commission payment is rejected twice, the commissions advance will charge back to your agent commissions account and change from "advance" to "paid as earned."
- Only policy premiums paid by EFT are eligible for advance commissions. If your policyholder is paying their premium by direct bill, that policy is not eligible for advance commissions.
- Advance commissions are not paid on policies issued to the agent and the agent's immediate family members. We define immediate family members as your spouse, domestic partner, child, mother, father, sister or brother.
- Interest is charged on Medicare Supplement advanced commissions.

Chargebacks and unearned commissions

If you are advanced commission for a policy and the policy is cancelled, the advance will be considered unearned commission. Unearned commission will charge back to your agent commission account. If a chargeback causes your agent commission account balance to be negative, you won't receive commission payments until commissions from new submitted business bring your agent commission account positive again.

Commission transactions are based on premiums drafted or refunded on a policy. Regardless of the reason for termination, if the termination date on a policy is before the paid to date, premium will be refunded and commissions (corresponding to the premium) charged back.

- If a policy is cancelled within the free look period, all premiums are refunded and all commissions reversed.
- If a policy is beyond the free look period and cancelled/terminated, any premiums paid back to the policy holder will automatically result in commission chargeback.
- If a policy is rescinded for material misrepresentation within the two-year contestability period, commissions will charge back to the agent.

Replacements
Replacement policy commissions are paid as earned; no advance commissions are paid on a replacement policy, regardless of how long it has been since termination.

Conversions
No commission is paid on the conversion to term insurance by a child covered on a children's term insurance rider.

How termination affects compensation
If you are terminated, but still in good standing, you will continue to receive renewal commissions according to your commission schedule.

If you are terminated for cause, we will cancel your compensation payments in accordance with your contract.

Recovery process for terminated agents with debit balances
If you are terminated and have a debit balance on your agent commission account, we will pursue collection of debt.

Assignment of compensation
An assignment of compensation (AOC) is an agreement between two parties to direct commissions to another agent or agency. Both the assignor and assignee must be currently contracted before you submit the AOC for processing.

You can verify agent writing numbers and contracting status by reaching out the Agent Services team at **(833) 504-0336**. If the assignee needs to be contracted, reach out to your upline to send out contracting paperwork.

Notes before submitting the AOC:

- You can revert commissions to your agency (GA to GA) or to personal individual account.
- You can sell your block of business to another agent or agency.
- Your status and state appointments will be terminated.
- If you request to be re-contracted, you must submit new contract paperwork.
- Any and all debit or advance balances must be paid in full, or both parties must agree to move the full balance before the AOC is completed. If the full balance is moved, all new business commissions will be applied towards the balance before commissions are paid.
- The assignee will assume the tax liability for the reverted commissions. The commissions will be reported to the IRS under the Assignee Tax ID# or SSN from the date the assignment was completed. These commissions are considered renewals only.

Items needed:

- Assignment of Compensation form — Pages 1 & 2
- W-9 form — required for new agencies
- Explanation of reason(s) requesting Assignment of Commission
- Bill of Sale — if applicable
- Legal documents — if applicable
- EFT Authorization form — for direct deposit

Assignment of commissions for a deceased agent

A deceased agent's commissions will be payable to his/her surviving spouse per agent contract. If the agent does not have a surviving spouse, commissions will be paid to the agent's estate, or their personal representative appointed by the court to probate their estate via Letter of Testamentary. If the agent does not have a will, a copy of the court-ordered Letter of Administration, stating the name of the person appointed to administer the estate, is required.

Items needed:

- Death Certificate of deceased agent
- W9 form — for surviving spouse
- Other legal documents as noted above

1099 forms

Commissions are reported via the Internal Revenue Service (IRS) 1099 process. 1099 NEC forms are postmarked to all eligible recipients by January 31 of a given year and mailed to the payee address on file.

A 1099 NEC form will only generate to an agent if annual earnings from Tier One are $600 or above.

If earnings are less than $600, agents can obtain earning totals by visiting our secure agent website and viewing their commission reports. Note: The last statement date in December pays in January, so those earnings count toward the following tax year. (Example: A 12/22/22 statement date will count toward 2023 taxes, as payment is not generated and sent until after 1/1/23.)

- Aflac will mail 1099s on January 31 for the prior tax year.
- If you need another copy of your 1099, we can fax or mail you a duplicate.
- We can't send your 1099 to your email address.
- It is your responsibility to ensure we have your current mailing address on file for all agent writing numbers. This will help ensure proper deliver of your 1099 form.
- **Pennsylvania requires withholding for anyone who sells business in Pennsylvania but doesn't live there.** If this applies, the withholding will be processed in December. You will receive an email when the withholding is processed, and you'll receive a second 1099 that reflects the total tax withheld based on your total earnings in Pennsylvania.
- If you need to change information on your 1099, please contact the Agent Servicing team. If the error is confirmed, a corrected 1099 will be sent.
- No tax advice will be given. If you have tax filing questions, please contact your tax consultant.

Commissions questions

Contact the Agent Services team with any commissions questions or issues that cannot be resolved by your upline.

V. Final Expense Policy and Rider Information

Policy Information

Policy Resources

Various product resources are available on sellaflacseniorinsurance.com/, including coverage maps, brochures, marketing materials, recruiting fliers and emails.

Available Plans

The Aflac Whole Life Final Expense product offers Level Plan options and a Modified Plan option.

The Level Plans provides the full face value from date of policy issue if death is due to an accident or natural causes.

The Modified Plan provides the full face value from date of policy issue if death is due to an accident. For non-accidental death, a limited benefit is paid in policy years one and two, with the full benefit payable if death occurs in the third policy year or later. See policy Limitations and Exclusions for further details.

Plan eligibility is determined by the medical questions on the application.

- Preferred: All “No” on application
- Standard: Yes in Section C only
- Modified: Yes in Section B only
- Ineligible: Yes in Section A

Each plan has an annual administration fee of $48 that is included in the annual premium.

Face Amounts

Level plans are available with face amount from $5,000 to $50,000. Modified plans are available with face amount from $2,000 to $25,000. Face amounts are offered in increments of $1,000. Face amounts vary by issue age as of the applicant’s last birthday.

Level benefit amounts:

Issue age	Min. death benefit	Max. death benefit
45 – 55	$5,000	$50,000
56 – 65	$5,000	$40,000
66 – 75	$5,000	$30,000
76 – 80	$5,000	$25,000

Modified benefit amount:

Issue age	Min. death benefit	Max. death benefit
45 – 75	$2,000	$25,000

Available Riders

Riders are available only for Level Plans.

Accelerated Death Benefits Rider

- This rider pays up to 50% of the death benefit (less policy loan) if a physician provides written certification that the insured meets the definition for a qualifying event, which is a medical condition that results in a terminal illness with a life expectancy of less than 12 months.
- The minimum benefit is $1,000, and the maximum benefit is $15,000.
- An administrative fee not to exceed $200 will be taken from the benefit amount.
- This rider must be selected at the time of application.
- This rider is not available in California.

Accidental Death Benefit Rider

- This rider pays 100% of the base policy’s face amount for accidental death for issue ages 45 through 70.
- This rider must be selected at the time of application.

Children’s Term Insurance Rider

- This rider provides coverage for a child, stepchild, legally adopted child, grandchild, legally adopted grandchild, or great grandchild.
- This benefit is available from $2,500 up to a maximum of $10,000 per child, in $2,500 increments. Coverage amount selected will be the same for all covered children and may not exceed the face amount of the base policy.
- Issue ages begin at 30 days through less than 18 years old.
- The policy becomes convertible to a whole life policy between the ages of 22 to 25. If the child does not convert to his/her own policy, they will be removed at age 26.
- The Children’s Term Insurance Rider Application is required to add children or grandchildren to the base policy at the time of application or to add a child after the base policy is issued. A new base application is not required. In the event a child listed on the original application does not qualify, a new base application and child application are required, excluding the child that does not qualify.
- Adding a child after the base policy issuance requires a new application for that child.
- Up to nine children can be added to a Children’s Term Insurance Rider.
- The benefit must be the same for all children and cannot be higher than the primary insured’s coverage.
- A Social Security number is required for any children and grandchildren applying for this rider.

VI. Medicare Supplement Policy and Rider Information

Policy Information

Policy Resources

Various policy resources are available on sellaflacseniorinsurance.com, including the Medicare Supplement coverage map, brochures, marketing materials, recruiting fliers and emails.

Available Plans

In most states, available plans include Plans A, F, G and N. Note that Plan F, where available, is only available for people first eligible for Medicare before 1/1/2020.

Household Discount

Unlike some other carriers who only offer a Medicare Supplement household discount if each resident enrolls in their Medicare Supplement Plan, Aflac offers a household discount in many states if your clients meet either of the following conditions:

- reside with their spouse, including civil union/domestic partner; **or**
- have been living with a family member who is age 50 or older for the last twelve months.

Reference each state's outline of coverage for details of the household discount; see the Product Availability section of Aflac Senior Agent Portal for a list of states' household discounts. For the purpose of this discount, a civil union partner or domestic partner will be considered a legal spouse when such partnerships are valid and recognized in the applicant's state of residence.

Key Features

- No pre-certification or pre-authorization needed for care: clients may visit any provider that accepts Medicare. A physician referral may be required for specialist, diagnostic, laboratory, or other facility care.
- Benefits stay the same: with a standardized plan, benefits remain the same year after year.
- Portable coverage: clients are not restricted to the use of a provider network. If they move or travel, the coverage goes with them.
- 12-month rate guarantee: no rate increases for the first 12 months: on each anniversary of the effective date, premiums will increase due to an increase in age. The renewal premium for the policy will be the renewal premium then in effect for your client's attained age.
- Guaranteed renewable: as long as premiums are paid, benefits will remain the same for the life of the policy. Your clients will not have to worry about reduced benefits or canceled coverage, regardless of their age or health.
- 30-day free look: clients can return any policy for any reason within 30 days after receipt for a full refund of all premiums paid.

See policies and outline of coverage for each state for specific details, limitations and exclusions.

VII. Marketing and Agent Communications

How to order sales supplies

1. Log in to Aflac Senior Agent Portal.
2. Click Products > Order Supplies.
3. Order materials based on your applicant's **residence** state since items may vary by state.
4. Choose a Kit instead of individual items to assure you have all required documents to provide to your applicant and submit an application.

Receipt of supplies will vary depending on delivery state. Orders are shipped from our fulfillment center in Charlotte, North Carolina. If you have time sensitive needs, consider downloading materials instead.

Make sure you're ordering materials based on your applicant's state of residence since sales materials and availability vary by state.

Agent Communications and Marketing

- California requires your agent license number to be included on all emails.
- Arkansas, California and Texas require your license number to be included on all advertisements, including business cards, letterhead, stationary or any other printed materials.

VIII. General Application Information

Application Options

Applications may be submitted using the electronic application process or paper (paper app submissions are not available to all agents). Applications must include all pages of the application, HIPAA form, replacement form (if applicable) and any state-required forms. Applications cannot be submitted by SFTP.

Electronic applications are efficient and expedite underwriting, new business processing and policy issue.

Electronic Applications (eApp)

You can complete and submit online applications for Aflac Medicare Supplement using the Quote and Enroll tool. Go to Aflac Senior Agent Portal and click Quote and Enroll from the Home page Quick Links.

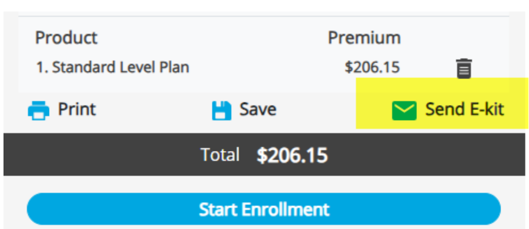
Key features include:

- One login – from http://www.sellaflacseniorplans.com
- Multi-device capability — runs on laptops, desktops and tablets, as well as mobile
- Authorization code and email signature options
- Applicant-specific guidance — based on answers to questions
- Submit in real time — processing begins immediately
- Real-time decision — available for most applications
- Rapid visibility to submitted applications — an online report in 30 minutes

A mobile rate quote is not available at this time.

eAPP Process

1. **Rate Quote:**
   a. Enter basic applicant information to determine product availability.
   b. Select from available products. **Note:** More than one product can be selected when using eApp; licensing rules apply. Once one product application is completed, the application process will flow to the next product. Core applicant information only needs to be entered once.
   c. For a Med Supp application, proceed to step 1d. For a Final Expense application, proceed to step 1e.
   d. **For Med Supp:**
      i. **E**nter the applicant's Medicare Part A eligibility date.
      ii. Indicate application type (underwritten, open enrollment, guaranteed issue). See this section for information on application types
      iii. Choose from available Medicare plans, and move to step 1f.
   e. **For Final Expense:**
      i. Input the requested benefit amount.
      ii. Select the **lowest** plan the applicant would be interested in purchasing, as well as any optional riders. See this section for information on application types, coverage downgrades, etc.
      iii. N**OTES:**
         1. While you must select a coverage amount and policy type at the start of the electronic application/enrollment, you may adjust the coverage amount upon completion of the application health questions.
         2. The "Money Quote button will allow the applicant to select a premium amount and show which plan options/face amounts are available at that payment level.
   f. Select the Quote button for a preliminary quote.
   g. Choose payment mode, send an E-kit, and select Start Enrollment.



2. **Start Enrollment:**
    a. Plan Eligibility: For Med Supp, proceed to step 2b. For Final Expense, proceed to step 2c.
    b. **For Med Supp:**
        i. Enter Medicare information for the applicant. Ensure no spaces are in the Medicare card number.
        ii. Provide answers to Medicare eligibility questions.
        iii. *Health History:* Complete history questions for underwritten applications to determine the applicant's eligibility.
        iv. *Benefits and Plans*: Enter household discount information as applicable and confirm Medicare Supplement plan selection.
        v. Proceed to step 2d.
    c. For Final Expense:
        i. Provide answers to Final Expense eligibility questions.
        ii. Check eligibility.
        iii. Answer rider questions, if applicable.
        iv. Answer replacement questions. If not replacing a policy, answer no to all yes/no questions, and leave fill-in-the-blank options blank.
        v. *Health History:* Include any applicable information.
        vi. *Benefits and Plans*: Advise whether a downgrade in coverage is acceptable if necessary, and choose whether to adjust the face amount or the premium. Complete all additional fields, requoting if needed.
        vii. Review the final quote.
        viii. Proceed to step 2d.
    d. *Proposed Insured*: Enter applicant details. Social Security Number is a **required** field, and applicants must be U.S. citizens. An Individual Tax ID Number (ITIN) is not permitted.
    e. *Payment Information*: Enter applicant's payment details select Add button, then complete additional fields to select payment method, initial premium draft date, and requested EFT draft date.
    f. *Agent Information*: Enter agent information.
    g. *Review and Signature*:
        i. Review the applicant information and sign.
        ii. **Med Supp:** For guaranteed issue applications for Medicare Supplement, upload supporting documentation. **TIP:** To increase the likelihood of receiving a real-time decision, ensure all required documents are submitted. See this section for list of required documentation.

Real Time Decision

Almost all applications will receive an automatic underwriting decision within minutes, instead of waiting several days for a "Routed to UW" status to be reviewed and approved or declined.

Once you submit an application through Aflac Quote & Enroll, you will receive one of the following statuses:

- Approval
- Decline
- Additional review

If you receive the "additional review" status, you will then have the option to choose the "Real Time Decision" button. A list of reflexive questions replaces a telephone interview process. This process improves point of sale experience and shortens the time it takes for underwritten applications to be issued.

Important: This new process does not mean 100% of applications are auto-approved. As with applications that do not require additional review, some applications requiring additional review will be auto-approved and some will be auto-declined. Also, if an application is auto-approved at the point of enrollment, it does not mean the policy is or will be issued; each application and agent appointment is reviewed to assure they are in good order.

Final Expense Preferred, Standard and Modified Coverage

When determining which level of Final Expense coverage to select in the application (Preferred, Standard or Modified, keep the following in mind.

The underwriting engine will only offer the applied for rate or a downgraded rate, not an upgraded rate. For example, if the client chooses to apply for Standard coverage, but the client is healthy enough to be approved for Preferred, Preferred will not be offered as an option after completing underwriting.

- When an applicant indicates he/she will accept a downgrade, there is no approval request of the downgrade in the application process. The application is processed, either adjusting the face amount to match premium or increasing the premium to match face amount. **Note:** A future enhancement will add an opt out for Modified, or a way for the applicant to withdraw the application if the applicant is only being considered for Modified.
- If an applicant does not indicate acceptance of a downgrade, and the application for requested coverage is declined, there are no concerns with immediately submitting a new application for a lower coverage level.
- When using real-time decision, the underwriting engine will ask reflexive questions for the first benefit level where the initial underwriting decision is Review. This is a limitation of the current system. We are evaluating potential future enhancements to proceed and review for all levels
- For example:
    - if the applicant applies for Preferred and will accept a downgrade, if the Applicant is Review for Preferred, Review for Standard, Review for Modified, reflexive questions will be asked only for the Preferred level benefit. The decision will be based only on Preferred.
    - if the applicant applies for Preferred and will accept a downgrade and the initial underwriting decisions are Decline Preferred, Review Standard, Review Modified, reflexive questions will be asked only for Standard level. The decision will be based only on Standard. We will not ask questions for the Modified in the event the applicant is declined for Standard.

Medicare Supplement Application Types

Open Enrollment

During a person's Medicare Supplement Open Enrollment Period, an applicant cannot be refused coverage. Open Enrollment lasts for 6 months beginning on the first day of the month a person is both 65 or older and enrolled in Medicare Part B. After a person's Open Enrollment Period, an applicant will be subject to underwriting, unless eligible for guaranteed issue. Open Enrollment policies are issued with preferred (nonsmoker) rates.

An applicant can be quoted age 65 rates if they are applying during their initial open enrollment period, starting 3 months prior to their 65th birthday birth month.

Federal/state guidelines are followed with respect to initial eligibility, including the ability to apply:

- 3 months prior to 65th birthday birth month
- Within 6 months of the Part B effective date in the event of a delayed start to Part B.

Some states have additional Open Enrollment Periods for people under 65 that are Medicare eligible due to disability or End-Stage Renal Disease (ESRD). In those states, if a qualified individual applies for a policy before turning 65, the rates for ages 0-64 will apply.

Underwritten applications

Any applications that don't qualify as Open Enrollment or Guaranteed Issue are underwritten. All underwritten applications require a completed application to include the Health History section, as well as a completed authorization to obtain (HIPAA) form.

Guaranteed Issue

Guaranteed issue rights provide the opportunity to buy Medicare Supplement after the Open Enrollment Period without being subject to underwriting. Guarantee issue policies are issued with preferred (non-smoker) rates. Plan F is guaranteed issue for those eligible for Medicare prior to 1/1/2020. Plan G is guaranteed issue for those eligible for Medicare on or after 1/1/2020. Plan N is not available for guaranteed issue in most states.

Guaranteed Issue Rights and Requirements

Applications for coverage under guaranteed issue rights must be submitted within 63 days of coverage loss. Applications must include:

- Completed application; Health History questions should not be answered.
- A replacement form, if prior coverage is noted within the Plan Eligibility section.
- Proof of creditable coverage.

Guaranteed issue (GI) applications **must** be submitted with the required creditable coverage documentation. Federal and state guidelines outline eligibility for GI applications. Please consult the applicable department of insurance for qualifying events in the applicant's state.

The most common situations and creditable coverage documentation for guaranteed issue are as follows.

Qualifying event	Documentation required
Involuntary loss of own group coverage	Termination letter or creditable coverage on provider letterhead — should include applicant name and dates of coverage
Involuntary loss of dependent group coverage	Same as above, but if individual not named on letter, will also require ID (benefit) card
Medicare Advantage plan leaving area	Notice of termination from provider — should include applicant name and date coverage will end
Medicare Advantage plan stops providing care	Notice of termination from provider — should include applicant name and date coverage will end
Medicare Select policyholder moves out of the service area	One of the following: Notice of termination letter (preferred), copy of utility bill or driver's license with old address
Medicare Advantage plan policyholder, who joined the plan when first eligible for Medicare Part A at 65, wants to switch to Original Medicare within the first year of Medicare Advantage coverage	Guidelines vary by state. Check with the state's DOI for information.
Prior Medicare Supplement coverage went to Medicare Advantage plan and disenrolled within 12 months	1) Proof of Medicare Supplement: schedule page, copy of original application or copy of ID card 2) Proof of Medicare Advantage Plan: Medicare Advantage ID card, copy of cancellation request letter from applicant to Medicare Advantage carrier 3) Statement from the agent explaining why the applicant cannot go back to the prior Medicare Supplement plan
Birthday and anniversary rules	Refer to your state's Department of Insurance for specific rules, such as birthday and anniversary rules. Most states require documentation including plan description and effective date, such as an ID card or schedule page.
Loss of Medicaid (GI eligibility is only available in the following states: KS, ME, OR, TN, TX, UT, WI, MT	Copy of Medicaid termination letter — should include applicant name and date coverage will end
Involuntary loss of COBRA	Copy of proof that applicant was on COBRA or just came off of COBRA. Proof must include name and end date.

Medicare Supplement Rating Types

Rates for Medicare Supplement are based on attained or issued age, or are community rated, depending on the regulations of each state.

- Attained age: Premiums always reflect your age at last birthday, so premiums start low and increase over time.
- Issue age: Premiums are determined based on the age at which the policy is purchased.
- Community age: Premiums are the same regardless of age or gender.

Annual Rate Increases

Regardless of which rating type is used by a state, Medicare Supplement rates are generally adjusted each year. There will be no rate increases for policyholders during the first 12 months of coverage. On each anniversary of the policy effective date, premiums will increase due to an increase in age. The renewal premium for the policy will be the renewal premium then in effect for your client's attained age.

Policyholders will be notified of rate increases in advance; the number of days in advance may vary by state but will follow state requirements. New rates will go into effect on the anniversary date that falls on or after the effective date for the rate change.

For new applications:

- If the policy effective date is **before** the effective date of the new rates, the previous year's rates will be charged for the first year of the policy.
- If the policy effective date is **on or after** the new rate effective date, **and** the application signature date is 31+ days **before** the new rate effective date, the previous year's rates will be charged for the first year of the policy.
- If the policy effective date is **on or after** the new rate effective date, **and** the application signature date is **after** the 31-day app cutoff date, the new rates will be charged.

Agents will be notified of upcoming rate increases through the Aflac Senior Agent Portal.

Special Underwriting Rules

Some states have anniversary or birthday rules, allowing special underwriting considerations for those moving from one carrier's Medicare Supplement plan to another. Birthday/anniversary rules apply to those under age 65 in some states but not all. **Refer to your state's Department of Insurance for guidelines.**

All states utilizing birthday or anniversary rules require that the applicant be currently enrolled in a Medicare Supplement plan as well as proof of current Medicare Supplement coverage. Requirements may vary by state. See this section for general guidelines.

This table outlines how policies are issued and commissions paid if enrolled during special enrollment periods.

State	Rule	Window	Issued As
CA	OE for Equal or Less Value	Begins 30 days before birthday; ends up to 60 days after	OE
ID	OE for Equal or Less Value	Begins 30 days before birthday; ends 63 days after	GI
IL	Applies only if 65<>75, same entity	Begins 30 days before birthday; ends 45 days after	GI
KY	OE for Equal Value plan only, different entity/carrier	Begins 30 days before birthday; ends 60 days after	GI
LA	OE for Equal or Less Value	Begins 30 days before birthday; ends 63 days after	GI
MD	OE for Equal or Less Value	Begins 30 days before birthday; ends 30 days after	GI
MO	OE for Equal Value Plan Only	Begins 30 days before to policy anniversary; ends 30 days after	GI
NV	OE for Equal or Less Value	Begins 30 days before the 1st day of birth month; ends 60 days after	OE
OK	OE for Equal or Less Value	Begins 30 days before birthday; ends 60 days after	GI
OR	OE for Equal or Less Value	Begins 30 days before the 1st day of birth month; ends 30 days after	GI

Application Tips

- Use the online rate quote tool or manually calculate the premium using the modal factors outlined.
- All health questions must be asked exactly as included on the application, and the answers must be recorded as given by the applicant.
- You must select the premium mode and payment method on the application.
- The “age last birthday” is the applicant’s age at the time of **effective** date.
- Effective date is defaulted to application signature date unless one is chosen.
- While all dates on forms do not have to be the same, all dates on a form should be less than two months in the past so we have current information.
- Before completing an application, the agent must have an agent writing number.
- You should review the policy details and ensure that your applicant understands the costs and benefits.
- Always take enough time with your applicant to ensure they fully understand all application questions and terminology.

Paper Application Considerations

- **Not all agents have access to submit paper applications. If an agent writes online business only, please disregard this section.**
- Paper applications must be submitted within 30 days of the application signature date.
- Applications must be submitted within 15 days from the pre-approval date.
- If you make corrections to the application before the application is submitted, your applicant must strike over and initial the correction. Do not use white-out.
- If your applicant is paying by check, the application and check must be submitted together by mail.
- Do not fax the application and mail the check.
- Paper application may be faxed to 1-**855-291-0553** or mailed to **Aflac, P. O. Box 14863, Lexington, KY** If submitting a paper application via fax, use of the below cover sheet is required.

  Fax Cover Sheet.pdf

- A paper application can be entered in the eApp system upon completion, and a decision provided. You should **not** send in the paper application but should keep it in your business files.
- For paper apps, a completed HIPAA form is required with all application submissions.

Key Dates on the Application

Choosing an effective date

All applications must contain a requested effective date, prior to the signature date. The effective date is defaulted to application signature date unless a different date is chosen.

For Medicare Supplement, although you may select an effective date up to 90 days past the signature date, we recommend effective dates be within 30 days of the signature date, with respect to Medicare eligibility. This increases the chance of successful first payment and minimizes the risk of application responses becoming outdated. See this section for information on choosing an effective date in states with birthday or anniversary rules.

For **Medicare Supplement**, application submission for AEP clients (currently Medicare or Med Advantage clients wishing to enroll in Med Supp, and who will undergo underwriting) will begin on 10/1.

Signature and signature date

Applications must be signed by the primary insured (policy owner) and the spouse/domestic partner, if applicable. Power of Attorney signature is not acceptable.

For paper apps, signature dates must be:

- prior to receipt of the application.
- less than 30 days before we receive the application.
- prior to the effective date.

Initial draft date

Initial premium for Electronic Funds Transfer will either be drafted on the issue date or on the effective date of the policy. Although you can select either, we recommend selecting the effective date for first payment.

If the first attempt to draft the initial premium is not successful, we will make a second attempt to draft the initial premium. If the second attempt to draft the initial premium is not successful, the policy will be changed to quarterly direct bill. The policyholder will need to pay the premium in full before their policy is active. If we don't receive payment within 45 days, the policy will not be effective and a new application is required with payment to activate coverage.

If a draft is rejected, a letter will be sent to the policyholder and a copy mailed to the agent. The agent may also receive an email alert by signing up at Aflac Senior Agent Portal.

Know your bill date

If your applicant wants the bill date for their policy to be different than the Initial draft date, they may request a subsequent bill date on the application at the time of submission. If a future bill date is chosen greater than 15 days following the policy effective date, our system will draft the policyholder's account twice the first month to make sure the policy doesn't lapse before the next bill date.

The following are not available options for recurring bill dates: 29th, 30th or 31st of the month.

Application signatures

Whether taking an application in person or over the phone, it is important to read the Applicant's Statements and Agreements section in its entirety to the applicant.

Signatures and Power of Attorney

Applications must be signed by the primary insured (policy owner) and the spouse/domestic partner, if applicable.

Power of attorney signature is not permitted on underwritten Medicare Supplement applications but is permissible on guaranteed issue and open enrollment applications. An application signed by power of attorney must follow the format of either "Mary Smith by John Smith, Attorney-in-Fact" or "John Smith, Attorney-in-Fact, for Mary Smith."

It is important to read the Applicant's Statements and Agreements section in its entirety to the applicant.

There are two signature methods to complete an application.

Telesales

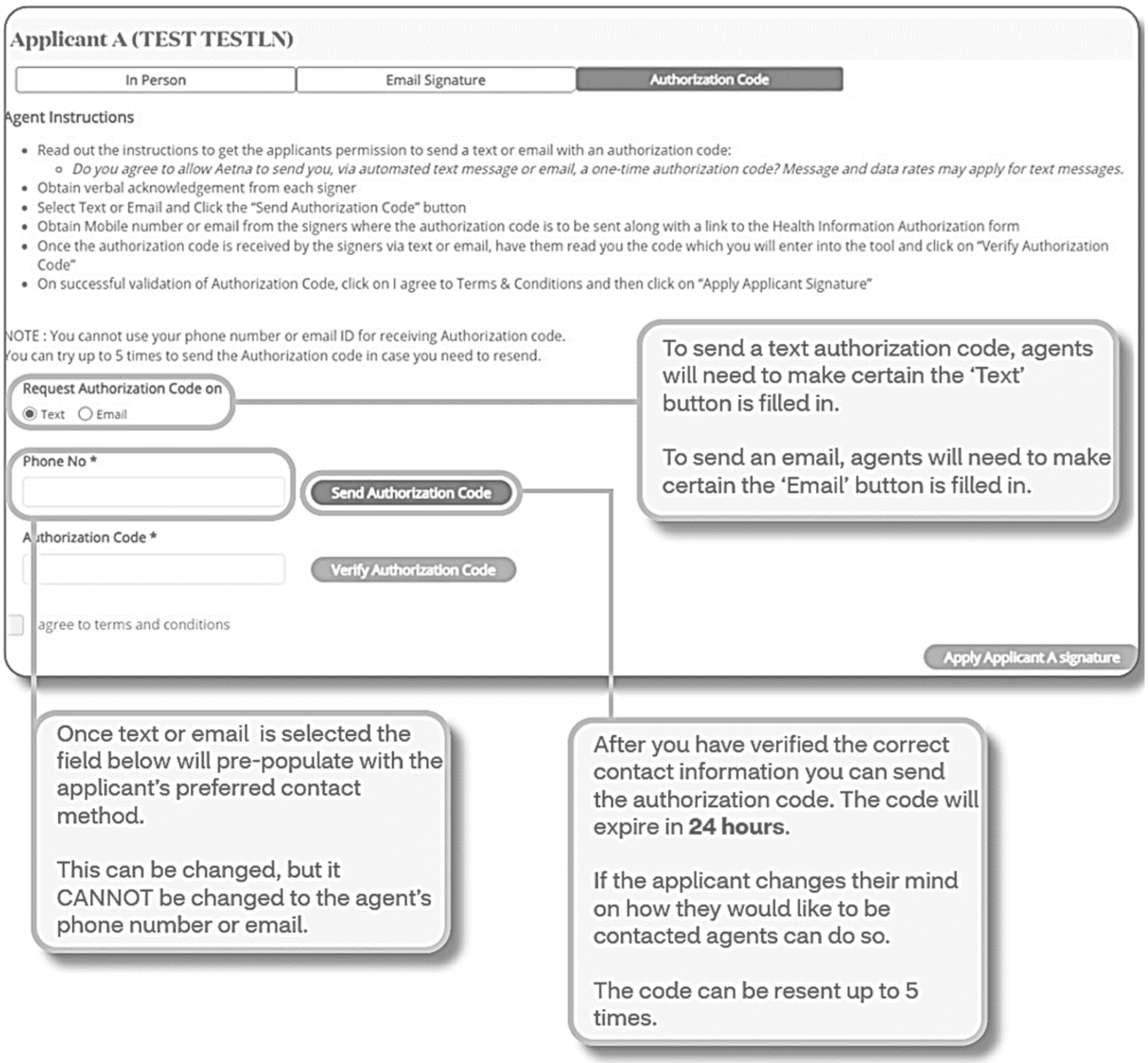
In the event you cannot meet face-to-face with an applicant, you may use the Quote and Enroll process to take an application over the phone. Go to Aflac Senior Agent Portal and select Quote and Enroll from the Home page.

There are two ways to obtain a signature when taking an application over the phone.

Option 1: Authorization Code Signature (see screen shot)

1. The Quote and Enroll system will generate an authorization code for agents to send the applicant by email or SMS text.
2. The applicant will read the authorization code to the agent to enter into Quote and Enroll for validation.
3. After applicant signature is applied, the agent can sign the application by checking the box next to “I agree to terms and conditions” and clicking the “Apply agent signature” button.
4. Click on the “Submit application” button to complete and submit the application.

IMPORTANT: If you choose to have the policy mailed to you rather than the applicant, the authorization code signature option is disabled.



Option 2: Email Signature

1. To use the Email Signature option the agent must first check the box “I agree to terms and conditions” and click the button “Apply agent signature.”
2. Follow the on screen instructions to enter and verify the applicant’s email address.
3. Under the email address, there are two check boxes with statements to be read to the applicant. Check each box only after reading the statements and hearing the applicant respond “I agree.”
4. To use the Email Signature option the agent must first check the box “I agree to terms and conditions” and click the button “Apply agent signature.”
5. Next, click the “Send to applicants for signature” button.
6. The applicant will receive an email requesting they review and sign the application. Clicking “review and sign” will launch the application in a browser for electronic signature (powered by Adobe Acrobat Sign). The last four digits of the applicant’s Social Security Number will be the password to open the application documents.

Payment methods

EFT Payments:

- The EFT section of a paper application must be completed, signed and dated.
- If the owner of the bank account is someone other than your applicant, the bank account owner must sign where indicated on the application.
- All modes of premium may be drafted.

Social Security payments

- Social Security billing allows us to pull the premium payment via EFT on the 2nd, 3rd or 4th Wednesday of each month, which may allow the policyholder to align the payment with their Social Security payments.
- The current schedule may be attained from the SocialSecurity.gov website.
- If the applicant began receiving Social Security prior to May 1997, timing will occur as follows:
  - If the applicant was born on the 1st through the 10th of the month, select the second Wednesday of the month;
  - If the applicant was born on the 11th through the 20th of the month, select the third Wednesday of the month; and
  - If the applicant was born after the 20th of the month, select the fourth Wednesday of the month.

Requirement for direct bill payments:

- The payment should be submitted at the same time as the application.
- If payment is not made at the time of application, the policy will be issued and an invoice will be sent to the policyholder.
- Direct bill is only available for quarterly, semi-annual and annual modes.
- No commissions payments and no claims are processed until the initial payment is received.
- Credit cards and debit cards of any kind are not accepted. This includes the Social Security Direct Express debit card.

Changing payment methods

If a policyholder wishes to change from direct bill to EFT payments or vice versa, you should work with the policyholder to submit a Billing Change Request.

Net billing

If there is a shortage on the initial payment, we'll send a bill notice to the applicant and the agent.

Application Status

Policy status codes are shown in the this Agent Guide table, located on the Aflac Senior Agent Portal under Enrollment Tracker.

Note that this is an Aetna-branded guide, and the codes are created and maintained by Aetna as the policy administrator. Active codes can mean that the policy has been processed, not paid. Questions about the status of specific applications or policies should be directed to the Agent Services line.

Additional notes:

- The average time for processing an application is 3 business days. If an application is pending longer, reasons could include things such as the need for a telephonic interview, missing documentation, or corrected pages needed.
- If a code indicates "LM", the LM means "Landmark", our third party administrator for final expense whole life insurance. An enrollment status of enrollment status "LM app approved" indicates that the application has been approved and will be sent to Landmark for issue.
- If a policy is in policy processing, it has met the underwriting requirements. On very few occasions, the application will still need further review due to a Lexis Nexis search hit (name, dob, SSN match fail) and will need to be verified with the applicant or the agent.
- The enrollment status "Check Auto UW" indicates that there are pending Real Time Decision questions for the applicant to answer through the agent. The agent should click the button, ask the applicant additional questions, and record the responses. A decision should be provided at that time.

IX. Underwriting

Underwriting Guidance

Applications are subject to underwriting up until the time the policy is issued AND first premium is paid. If a declinable health condition is discovered between the time the application is taken and the time the policy is issued, the application will be declined.

All applications are underwritten up until the time the policy is issued and the first premiums paid.

- All applications are subject to a prescription drug database review and an MIB review.
- Refer to the drug list located on Aflac Senior Agent Portal for any unacceptable medications.
- If the agent has additional relevant information, they may record it in the optional comments section of the application. You can record helpful underwriting information, such as the reason for using a dual-purpose medication. Entering relevant information here will not cause the application to pend automatically.

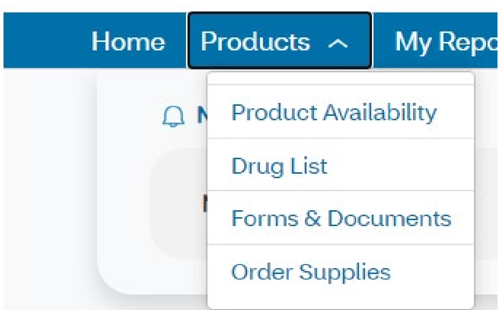
- For underwritten applications:
    - **Med Supp:** All health questions must be answered up until a “Yes” answer disqualifies the applicant. Do not submit an application with a “Yes” response to a Health Question.
    - **Final Expense:** All health questions must be answered up until a “Yes” answer in Part A (Preferred section). Yes answers are permitted in the Standard and Modified sections. Do not submit an application with a “Yes” response to a Health Question in Part A.
- Electronic applications are provided a color-coded classification at the end of the process, as follows:
    - Green: application is approved
    - Yellow: application requires additional information to complete the underwriting process
    - Red: indicates the applicant is not eligible for coverage

Drug List

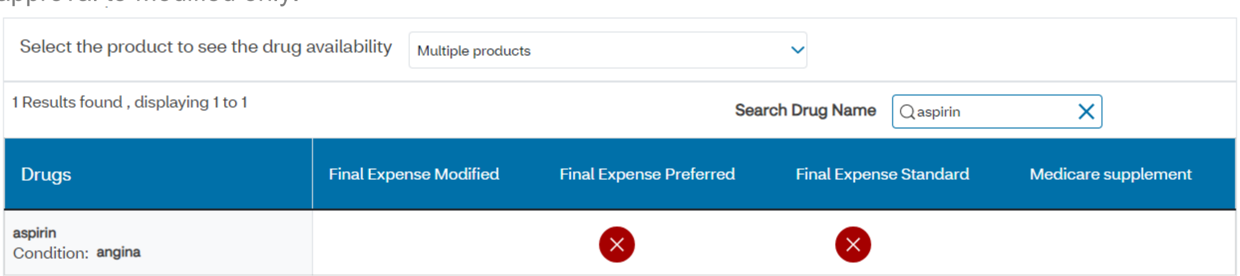
The Drug list is a searchable table in the Aflac Senior Agent Portal; if using the classic portal, the document is a pdf.

- A red **X** on the Drug List indicates a non-permitted (knockout) drug.
- If the drug does not appear in the list, the drug is not considered (not a knockout).
- If the drug has a condition specified, that is the only condition for which it is considered and may only impact certain products or level of coverage.
- If “Condition: All” is listed, the drug is a knockout regardless of the reason for taking the drug.

The Drug List is found under the Products section:



For example, aspirin is a generally accepted drug, but if taken for Angina, it would restrict Final Expense approval to Modified only.



Select the product to see the drug availability: Multiple products

1 Results found , displaying 1 to 1

Search Drug Name: aspirin

Drugs	Final Expense Modified	Final Expense Preferred	Final Expense Standard	Medicare supplement
aspirin Condition: angina		X	X	

Closed and declined applications

Reasons for closed applications

- If the application is pending more information, the application will be closed as incomplete if it is still pending after 5 business days.
- If the document is incomplete or illegible, the application will be closed and cleared, and a complete application will need to be submitted.
- Incorrect documents were submitted.
- Applicant contact information is incorrect/missing and we haven't been able to contact the applicant.
- Anyone other than the applicant supplies the answers to the questions and/or signs the application.
- The applicant did not know they applied for insurance.
- The applicant does not consent to a prescription check or does not complete a clarifying telephone interview.
    - Note: We'll attempt to call the applicant two times for a clarifying telephone interview. If we haven't been able to reach the applicant after those attempts, we'll send the applicant a letter letting them know they need to contact us within ten days of the date of the letter to schedule an interview. If the applicant does not contact us, we'll close their application and a new application will be required. Calls will come from **866-895-6487**.
    - Note: Notifications are **not** sent to an agent if a telephone interview is required, but Aflac Senior Agent Portal tracker will note that the application is pending.
- Anyone other than the applicant completes the clarifying telephone interview.
- During the telephone interview, we discover that the agent who signed the application did not speak with the applicant.
- If the application was submitted with a check from a third-party payor that has no family (spouse/partner, child, etc.) or business relationship (business owner, employee or retiree of the business).
- We receive the application at the home office more than 30 days after the applicant's signature date.
- Applicant is not a legal U.S. resident or does not have a Social Security Number. An Individual Tax ID Number (ITIN) is not acceptable.
- Multiple options were selected within the non-forfeiture options of a paper application.
- Any application submitted with white-out on any page is automatically closed. When you resubmit, new signature dates are required.

X. Policyholder Experience

Policyholder services

Policy Delivery

If a policyholder chooses to have the policy delivered by mail, the policy will be mailed after issue. If e-delivery is chosen, a physical copy of the policy will not be sent unless requested by the policyholder.

Sending documentation to policyholder services

We can't accept certain types of information via email. Mail or fax us the following types of information:

- Death certificates
- Bank information
- Anything that includes Protected Health Information (PHI)

Free-look period

The "Free-look period" is 30 days from the time the policyholder receives the policy. If they select the option for E-delivery, the 30-day Free-look period starts when we get an electronic delivery receipt. If mailed, an additional 15 days are allowed to account for mailing time.

A written request is needed to cancel within the Free-look period. The easiest and most accurate way to fulfil this requirement is to write "Cancel" on the policy and mail it back to us.

Withdrawing or canceling an application:

- If the application is in pending status, you or your applicant can call the New Business department at **833-504-0336** to withdraw the application. Whether the client is charged will depend on whether the application was submitted to be drafted upon approval, what the requested effective date is, and whether the policy is still in pending or unpaid status.
- If the application status is already active, you or your policyholder can notify Policyholder Services to terminate the policy.
  - For **Medicare Supplement**, the policyholder or agent must send written request to cancel to: Fax **855-291-0553** or **P.O. Box 14863 Lexington, KY 40512**.
  - For **Final Expense**, the policyholder or agent must send written request to cancel to: Fax **833-526-0523** or **P.O. Box 14795 Lexington, KY 40512-4795**.
- It takes at least three business days to stop or prevent a scheduled draft.
- If a policyholder is charged after withdrawing an application, the refund process will be initiated approximately 10 business days after the charge.

Changing benefit amounts

Final Expense

Within 30 days of the application signature date:

- If your policyholder wants to increase the benefit amount:
  - For paper apps, complete a new page 1 of the application, indicating the new total amount. Your policyholder must initial the change before you submit it.
  - For e-applications, a new application must be submitted.
  - We'll issue a new policy with the additional benefit amount as long as the combined policies don't exceed the maximum benefit amount.
- If your policyholder wants to decrease the benefit amount:
  - We'll need a signed, written request from your policyholder with the reason the decrease is requested.
  - We'll reissue the existing policy for the new benefit amount.
  - We'll apply any overpaid premiums toward future premiums.

If the request is greater than 30 days from the application signature date:

- If your policyholder wants to increase the benefit amount:
  - Complete a new application requesting the additional benefit amount desired; this application is underwritten separately from the original application.
  - Your applicant's current age will apply.
  - The new policy must meet the minimum benefit amount.
  - The combined policies can't exceed the maximum benefit level.
  - The two-year contestability period restarts from the new policy effective date unless another contestability period is required by state law.
- If your policyholder wants to decrease the benefit amount:
  - Complete a new application for the total of the desired benefit amount; this application is not underwritten relative to the original application.
  - Your applicant's current age will apply.
  - The existing policy will be cancelled and a new policy issued for the new benefit amount.
  - We'll refund any cash value from the cancelled policy to the policyholder.
  - The two-year contestability period restarts from the new policy effective date unless another contestability period is required by state law.
- If your policyholder wants to request a change to a non-tobacco status, a new application is required.

Mail new business applications: **Aflac P.O. Box 14863, Lexington, KY, 40512**.

Medicare Supplement

If your policyholder wants to change plans after submitting the initial application, a new application must be submitted and accepted.

Any Product

If your policyholder wants to request a change to a non-tobacco status, a new application is required.

Mail new business applications: **Aflac, P.O. Box 14863, Lexington, KY, 40512**.

Changing dates and reinstatements

Changing policy effective date

A request to change the effective date must be submitted within 60 days of the application signature date:

- A written request from your policyholder stating a reason for the change must be sent to Policyholder Services fax (**Medicare Supplement**: **833-526-0523**, **Final Expense**: **(855-291-0553)**. While the policyholder must write the information, an agent can submit on behalf of the policyholder.
- A new application is not required.

Please note: If an effective date is changed after 30 days, the policyholder's two-year contestability period restarts on the new effective date.

Changing a Payment Date

If your policyholder wants to change their premium payment date after their policy is active, they may contact our Policyholder Services department. The new payment date shouldn't be more than 15 days after the current bill date. If it is, our system will draft the policyholder's account twice the next month to make sure the policy doesn't lapse before the next bill date.

Policyholder Services phone: **833-504-0336**

Medicare Supplement Reinstatement

There will be no gap in coverage if payment is made within the state-allowed time frame.

If the policyholder does not make payment during the state-allowed time frame, a completed and signed reinstatement form is required for reinstatement consideration. Payment is required with reinstatement request.

A new application is required if payment is not made within 90 days of the paid to date.

Final Expense Reinstatement

As long as at least one good payment has been received prior to the policy lapsing, policies can be reinstated after receipt of back premiums for a period stated in the Policy. No reinstatement application is required.

If there hasn't been a good premium payment within 90 days of the application date, the applicant is required to submit a new current-dated application.

Cancellations, refunds, and claims

Canceling a policy

If your policyholder wants to cancel their policy, you or your policyholder will need to send us a written request with your policyholder's name, policy number, signature and the date your policyholder wants cancellation to take effect.

- If your policyholder requests to cancel their policy, the agent of record will be sent a notification of cancel request. This may also be received via email alert by signing up using the Aflac Senior Agent Portal.

Cancellations are normally processed within 24-48 hours; during AEP, high volumes could cause longer processing times.

Premium refunds

Before we can issue a refund for premiums, any pending payment must clear. Refunds are always mailed in the form of a paper check. Even if your policyholder is set up for EFT, we are not able to deposit money back into a bank account.

Allow 15 days for an EFT payment to clear (this is in place so last premium payment can clear first).

Policy lapse

Policies will lapse for non-payment 45 days after the due date. The first bill is sent around 28 days prior to the due date. If payment is not received, a late notice is sent ten days after the original billing date.

Final Expense claims

Notice of a life claim must be made by submitting a certified death certificate. If the death occurs within the two-year contestable period, we will conduct a claims investigation into the insured's health condition.

After claim approval, allow 20 days for a paper check or money order to clear.

A policy will be rescinded for material misrepresentation pursuant to state law.

Medicare Supplement claims

- All Medicare Supplement claims must be submitted through Medicare; we cannot process payment from balance due statements.
- Our liability is based on Medicare's approved and eligible charges. If Medicare has no coverage, then the secondary Medicare Supplement plan has no liability.
- If a policyholder does not agree with the way Medicare processed a claim, an appeal should be made directly to Medicare.
- Available Plans may require the policyholder to pay for Part B deductible or coinsurance. See the Outline of Coverage for details.
- Name changes must be made with Medicare before being changed on the Medicare Supplement policy. A mismatch will result in claims payment errors.
- After claim approval, allow 20 days for a paper check or money order to clear.

A policy will be rescinded for material misrepresentation pursuant to state law.

Online tools for policyholders

Aflac senior customer service portal

Aflac customer self-service is available at www.myaccount.aflac.com. From this Aflac login screen, customers must click the link for Aflac Medicare Supplement at the bottom of the page. This link leads to the senior customer service portal login page administered by Aetna. The login process will be enhanced in the future to allow single sign on from Aflac's login page directly to the senior customer service portal.

Once logged in, policyholders can:

- view policy details and claims
- request a duplicate policy
- update contact and bank information
- send department-specific requests

Logging into the portal

First time users need to click on the "Register Now" button to register their account. The sign-up process is quick and simple, but just in case technical assistance is required, we have a dedicated web assistance team that provides website related technical assistance. Policyholders may call a website technician at **1-800-587-5139** Monday through Friday, 8 AM to 5 PM CT.

Correspondence preference

To set correspondence preferences, policyholders may log in to the portal, click "My Notifications" on the left side of the screen, then click "Correspondence/Alert Preference" on the right side.

Policyholders are mailed EOBs on a quarterly basis if not opted out of paper delivery.

ID Cards

ID cards are available for Medicare Supplement policies only.

A temporary Medicare Supplement ID card is available to view, download, or print from our website.

XI. Contact Directory

Click here to view the full contact directory.