AUTHORIZATION TO OBTAIN INFORMATION

MAIL TO: American Family Life Assurance Company of New York
22 Corporate Woods Boulevard • Suite 2
Albany, New York 12211

I authorize American Family Life Assurance Company of New York, American Family Life Assurance Company of Columbus, and Continental American Insurance Company (collectively, "Aflac") to make a brief report of my personal health information to MIB, Inc. (formerly known as the Medical Information Bureau).

I authorize the following to give information (as defined below) to American Family Life Assurance Company of New York, American Family Life Assurance Company of Columbus, and Continental American Insurance Company (collectively, "Aflac"): any medical professional, medical care institution, pharmacy-related service organizations, insurer (including Aflac, with respect to other Aflac coverages), reinsurer, government agency (including departments of public safety and motor vehicle departments), MIB, Inc. (formerly known as the Medical Information Bureau), consumer reporting agency, or employer.

"Information" includes facts or opinions relating to my past, present, or future physical or mental health or condition (excluding psychotherapy notes), employment, other insurance coverage, driving record, or any other medical or nonmedical facts that are required as part of the underwriting process in order to determine eligibility for insurance or to evaluate a claim for benefits during the time this authorization is valid.

I understand that any disclosure of health information to Aflac for the purpose of determining eligibility for coverage other than health plan coverage means the information may no longer be protected by federal privacy regulations. I further understand, however, that such information may be redisclosed only in accordance with other applicable laws or regulations.

I understand that this information will be used by Aflac for enrollment or to determine eligibility for insurance or for underwriting or risk rating (where applicable) purposes and, should coverage be issued, the information may be used to contest a claim for benefits or the issuance of the policy itself during the contestability period provided in the policy.

I understand that Aflac is conditioning the issuance of coverage on the provision of this authorization, and that, while I may refuse to sign this authorization, my refusal to do so could result in coverage not being issued.

I understand that I may revoke this authorization at any time, except to the extent that (1) Aflac has taken action in reliance on this authorization, or (2) other law provides Aflac with the right to contest a claim under the policy or the policy itself. My revocation must be submitted in writing to Aflac New York, Policy Service, 22 Corporate Woods Boulevard, Suite 2, Albany, New York 12211.

Unless otherwise revoked, I agree that this authorization will expire on the earlier of the date Aflac notifies me of its declination of my application for coverage or, if a policy is issued, two years from the date of this authorization.

I agree that a copy of this authorization is as valid as the original and that I or an authorized representative may request a copy of this authorization.

_____
Printed Name of Individual Subject to Disclosure

_____ _____
Signature Date

If this authorization has been signed by a personal representative on behalf of an individual, his/her authority to act on behalf of the individual must be set forth here:

_____ _____
Printed Name of Legal/Personal Representative Legal Relationship
(e.g. Power of Attorney, Estate Executor)