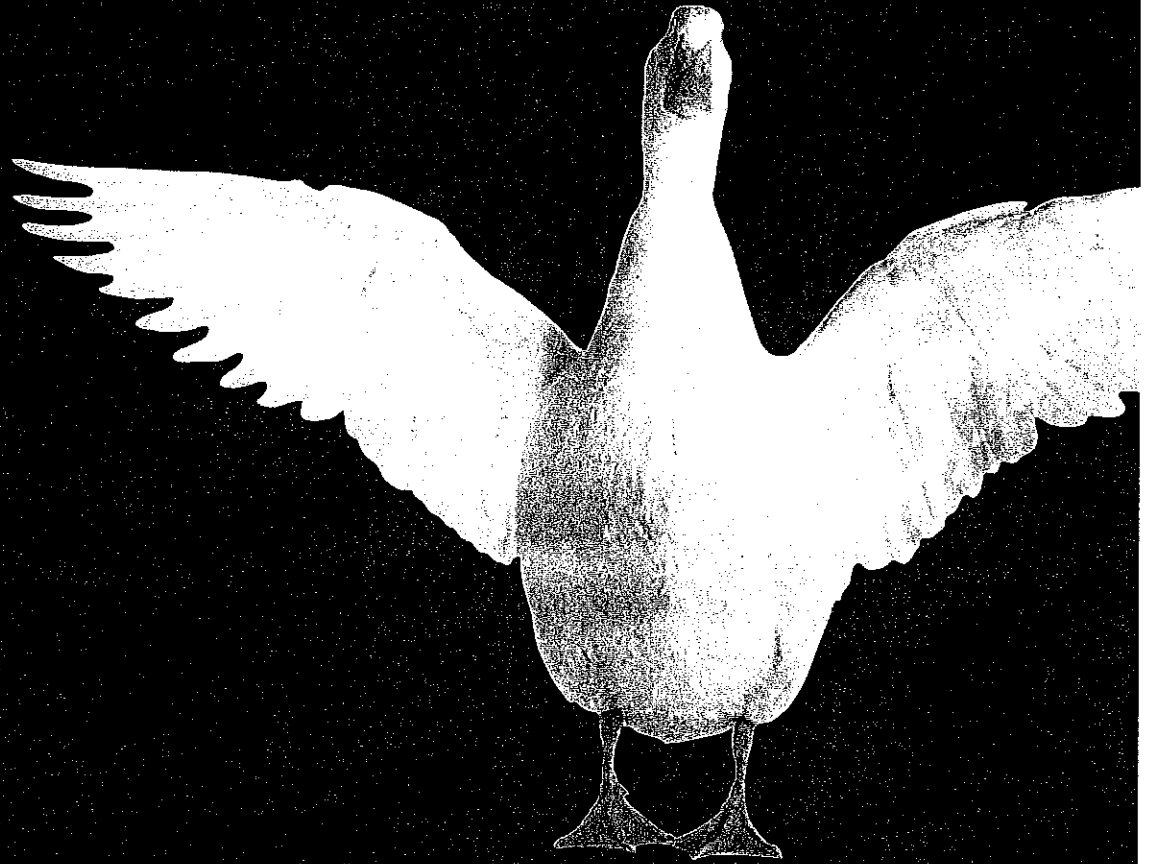


▶ **If Disability Stops Your Pay,**  
*Will You Have the Ability to  
Pay Your Bills?*



SHORT-TERM DISABILITY INSURANCE

**Aflac**®

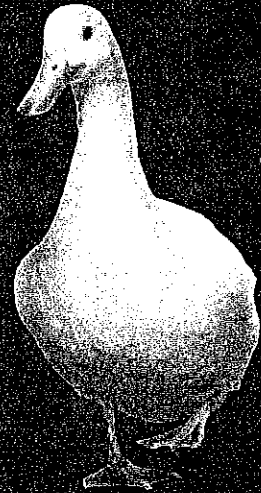
We've got you under our wing.\*

# SHORT-TERM DISABILITY INSURANCE

Policy Series A57600

## Helping Pay Your Bills, While You Pay Attention to Your Health

Imagine this. One day, not very far in the future, you become disabled. And you can't go to work. It could happen to you. In fact, last year millions of families found themselves in this situation.\* How would you pay the mortgage? Buy groceries? Make your car payment? And pay all the other bills that won't go away, just because your paycheck is gone? That's where Aflac's short-term disability insurance policy can help make the difference. The difference that means you will still have a source of income and you will know Aflac is helping take care of your bills while you're taking care of yourself.



Aflac herein means American Family Life Assurance Company of Columbus.

### THE FACTS\* SAY YOU NEED THE PROTECTION OF AFLAC SHORT-TERM DISABILITY:

**3 in 10**

FACT NO. 01

ALMOST ONE-THIRD OF AMERICANS ENTERING THE WORK FORCE TODAY WILL BECOME DISABLED BEFORE THEY RETIRE.

NEARLY

**90%**

FACT NO. 02

OF DISABILITIES AREN'T WORK-RELATED AND THEREFORE DON'T QUALIFY FOR WORKERS' COMPENSATION BENEFITS.

OVER

**10%**

FACT NO. 03

OF AMERICANS BETWEEN THE AGES OF 18 AND 64 HAVE A DISABILITY.

**100**

FACT NO. 04

MILLION AMERICANS ARE NOT PROTECTED BY PRIVATE DISABILITY INSURANCE.

\*"CDA 2010 Consumer Disability Awareness Study," Council for Disability Awareness, 2010.

# Why Aflac Short-Term Disability may be the best choice for you

Aflac is a market leader with over 50 years of experience in the insurance industry. We've been there before for others, and we'll be there for you when you need us. Aflac helps you choose what best fits your individual needs.

- Aflac short-term disability is sold on an individual basis. So you actually choose the plan that's right for you. We'll give you what you need based on your financial needs and income.
- We now offer the option of guaranteed-issue short-term disability coverage. That means no medical questionnaire is required. That should help give you some peace of mind.
- Your Aflac plan stays with you even when you change or leave your job. You don't get that kind of portability everywhere else.
- We pay you a cash benefit for each day you are disabled.\*\*
- Aflac does not coordinate benefits. Regardless of any other disability insurance benefits you may have, including Social Security, we will pay you directly.
- Aflac provides benefits for both Total and Partial Disability. Even if you're able to work, Partial Disability Benefits may be available to help compensate for lost income.
- Premiums may be waived when you have a prolonged disability.\*\*

*Benefits may vary by state.*

*\*\*Subject to your benefit period and elimination period.*

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## COVERAGE OPTIONS

### Choose the Policy You Need

- **Monthly Benefit: \$500-\$6,000 (subject to income requirements)**
- **Total Disability Benefit Periods: 3, 6, 12, 18, or 24 months**
- **Partial Disability Benefit Period: 3 months**
- **Elimination Periods (Injury/Sickness): 0/7, 0/14, 7/7, 7/14, 14/14, 0/30, 30/30, 60/60, 90/90, 180/180**
- **Optional rider available for on-the-job injuries.**

*Coverage options may vary by state.*

THE POLICY HAS LIMITATIONS AND EXCLUSIONS THAT MAY AFFECT BENEFITS PAYABLE. THIS BROCHURE IS FOR ILLUSTRATIVE PURPOSES ONLY. REFER TO THE POLICY FOR COMPLETE DETAILS, DEFINITIONS, LIMITATIONS, AND EXCLUSIONS.



## NW Allen

### Short-Term Disability Rates (20 deductions over 10 months)

Elimination Period Accident/Sickness (0/7 days)

Annual Income		\$19,000	\$29,000	\$39,000	\$49,000
<b>Monthly Benefit</b>	<b>Age</b>	<b>\$1,000</b>	<b>\$1,500</b>	<b>\$2,000</b>	<b>\$2,500</b>
Benefit Period	18-49	\$17.16	\$25.74	\$34.32	\$42.90
3 Months	50-64	\$17.94	\$26.91	\$35.88	\$44.85
	65-74	\$21.84	\$32.76	\$43.68	\$54.60

# Northwest Allen County Schools

## Aflac Benefit Offering



PLEASE FILL IN ALL HIGHLIGHTED AREAS

### Insured's Information

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

SS#: \_\_\_\_\_ Date of Hire: \_\_\_\_\_ Gender: \_\_\_\_\_ Annual Salary: \_\_\_\_\_ Tobacco User: Y/N

### Beneficiaries

Primary Beneficiary: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_

### 0/7 SHORT- TERM DISABILITY

Monthly Benefit Amount	Benefit Period
\$ _____	<input checked="" type="checkbox"/> 3 Month <input type="checkbox"/> 18 Month <input type="checkbox"/> 6 Month <input type="checkbox"/> 24 Month <input type="checkbox"/> 12 Month
<b>ON THE JOB ACCIDENT DISABILITY RIDER</b> <input type="checkbox"/> Add Rider <input type="checkbox"/> No Rider	<input checked="" type="checkbox"/> 3 Month <input type="checkbox"/> 18 Month <input type="checkbox"/> 6 Month <input type="checkbox"/> 24 Month <input type="checkbox"/> 12 Month

**\*SEE AFLAC RATE SHEET FOR WEEKLY RATES ACCORDING TO YOUR AGE AS OF YOUR EFFECTIVE DATE\***

My signature below indicates that I participated in the Voluntary Benefits Enrollment and enrolled in or waived coverage as indicated above. I understand that as an employee, if I choose to waive coverage today, I may sign up during the open enrollment period of each year to follow.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_