

STATE INSURANCE SPECIFIC ACCESS REQUEST FORM

This right does not extend to information that relates to a claim or to a civil or criminal proceeding.

This form is applicable to American Family Life Assurance Company of Columbus, American Family Life Assurance Company of New York, Continental American Life Insurance Company, and Tier One Life Insurance Company (collectively, “we,” “our,” or “Aflac”).

You have the right of access to copy or inspect certain parts of your personal information held by Aflac. We must provide you with the option of accessing your personal information either in person or in writing. To ensure the security of information in our files, we may require positive identification before we allow access to that information. As further discussed below, we are not always required to grant such access, but each request will be carefully reviewed. You will be notified when your request has been approved or denied. Information that is within the scope of your right of access will be made available to you within 30 days after the date of your request. Should you choose to review your information in person; you may inspect it, obtain a copy of it, or do both. If you decide to obtain a copy, we will arrange for copying and may charge you a cost-based fee for supplies and labor.

I. Individual Whose Records Are Being Accessed:

Name: _____

SSN (last four digits): _____ Date of Birth: _____

Policy or Certificate Number(s): _____

Primary Policyholder’s Name (if different from above): _____

II. Information Being Requested:

Please provide as much detail as possible regarding the personal information you wish to review.

III. Delivery Preference:

I would like to:

- make a personal visit to Aflac to inspect my records and/or obtain a copy.
- receive my information by regular U.S. mail at the address Aflac has on file.
- authorize Aflac to mail my personal information to the medical provider/facility listed below. I confirm that this medical provider/facility is licensed to provide medical care for the condition indicated in my records. Aflac will notify me once these records are mailed.

Name of medical provider/facility: _____

Address: _____

Phone Number: _____

IV. Right to Deny Access:

We are permitted by law to deny part or your entire request for access to these records for one or more of the following reasons:

- Your access request form is not signed by you or your representative;
- Your access request form is signed by your representative and the representative has not provided information on the source of his/her authority to act for you;
- We do not maintain the information you have requested to copy or inspect;
- The information you have requested is not part of your records;
- Your request is for mental health records but access is denied by your provider;
- Your request includes information compiled for litigation;
- A licensed health professional has determined that the requested access is likely to either endanger your or another person's life or safety or cause substantial harm to you or another person;
- Your request is to copy information and you are an inmate in a correctional facility (you retain the right to inspect the information);
- Your request relates to certain information that was obtained from a confidential source and we are not required to provide access to it by law.

Signature

Date

Printed Name of Legal/Personal Representative
(If Signed by a Legal/Personal Representative)

Legal Relationship
(e.g., Legal Guardian, Power of Attorney)

Note: We will not process this request if the form has not been signed by you or your personal representative. If this document is being signed by a Legal/Personal Representative, please provide us with the court appointed documents granting this authority.

Select the company through which you have coverage.	Mail To:
<input type="checkbox"/> American Family Life Assurance Company of Columbus	Aflac Attn: Privacy Office 1932 Wynnton Road Columbus, GA 31999
<input type="checkbox"/> American Family Life Assurance Company of New York	
<input type="checkbox"/> Tier One Life Insurance Company	
<input type="checkbox"/> Continental American Life Insurance Company	Aflac Attn: Privacy Office PO Box 427 Columbia, SC 29202