Group Critical Illness Insurance

You can count on Aflac to help ease the financial impact of surviving a critical illness.

Aflac® | Jackson HEALTH SYSTEM *Miracles made daily.*



AGD22FL GP-55381.PLAN-352728B 08/08/2025 1 EXP 09/27

COVERED CRITICAL ILLNESS BENEFITS:	Percentage of Face Amount
CANCER (Internal or Invasive)	100%
HEART ATTACK (Myocardial Infarction)	100%
STROKE (Ischemic or Hemorrhagic)	100%
KIDNEY FAILURE (End-Stage Renal Failure)	100%
BONE MARROW TRANSPLANT (Stem Cell Transplant)	100%
SUDDEN CARDIAC ARREST	100%
MAJOR ORGAN TRANSPLANT (25% of this benefit is payable for insureds placed on a transplant list for a major organ transplant)	100%
COMA	100%
PARALYSIS	100%
LOSS OF SIGHT	100%
LOSS OF HEARING	100%
LOSS OF SPEECH	100%
BENIGN BRAIN TUMOR	100%
TYPE I DIABETES	100%
CORONARY ARTERY BYPASS SURGERY	25%
NON-INVASIVE CANCER	25%
METASTATIC CANCER	25%

INITIAL DIAGNOSIS BENEFIT

We will pay a lump sum benefit upon initial diagnosis of a covered critical illness when such diagnosis is caused by or solely attributed to an underlying disease.

ADDITIONAL DIAGNOSIS BENEFIT

We will pay benefits for each different critical illness after the first when the two dates of diagnoses are separated by at least 6 consecutive months.

REOCCURRENCE BENEFIT

We will pay benefits for the same critical illness after the first when the two dates of diagnoses are separated by at least 6 consecutive months.

SKIN CANCER BENEFIT

We will pay $500 for the diagnosis of skin cancer. We will pay this benefit once per calendar year.

ACCIDENT BENEFIT Payable if an insured sustains a covered accident and suffers any of the following, which is solely due to, caused by, and attributed to, the covered accident:	Percentage of Face Amount
Coma	100%
Loss of Sight	100%
Loss of Speech	100%
Loss of Hearing	100%

COVERED CRITICAL ILLNESS BENEFITS:	Percentage of Face Amount
Severe Burn	100%
Paralysis	100%
WAIVER OF PREMIUM If you become totally disabled due to a covered critical illness prior to age 65, after 90 continuous days of total disability, we will waive premiums for you and any of your covered dependents. As long as you remain totally disabled, premiums will be waived up to 24 months, subject to the terms of the plan.	
SUCCESSOR INSURED BENEFIT If spouse coverage is in force at the time of the primary insured's death, the surviving spouse may elect to continue coverage. Coverage would continue at the existing spouse face amount and would also include any dependent child coverage in force at the time. See certificate for details.	
CHILD COVERAGE AT NO ADDITIONAL COST Each dependent child is covered at 50 percent of the primary insured's benefit amount at no additional charge. Children-only coverage is not available.	
HEALTH SCREENING BENEFIT (1 PER CALENDAR YEAR) Payable for health screening tests performed while an insured's coverage is in force. We will pay this benefit once per calendar year, per insured. This benefit is only payable for health screening tests performed as the result of preventive care, including tests and diagnostic procedures ordered in connection with routine examinations.	Employee/Spouse: $100 Child: $100

PROGRESSIVE DISEASES RIDER	Percentage of Face Amount
AMYOTROPHIC LATERAL SCLEROSIS (ALS OR LOU GEHRIG'S DISEASE)	50%
SUSTAINED MULTIPLE SCLEROSIS	50%
ADVANCED ALZHEIMER'S DISEASE	100%
ADVANCED PARKINSON'S DISEASE	100%
CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD)	25%
CROHN'S DISEASE	25%

We will pay the benefit shown upon diagnosis of one of the covered diseases if the date of diagnosis is while the rider is in force. The Progressive Disease benefit is payable only once per disease. For any subsequent Progressive Disease to be covered, the date of diagnosis must satisfy the Additional Diagnosis separation period outlined in the brochure, if applicable.

SPECIFIED DISEASE RIDER	Percentage of Face Amount
TIER I SPECIFIED DISEASE BENEFIT	

SPECIFIED DISEASE RIDER	Percentage of Face Amount
ADRENAL HYPOFUNCTION (ADDISON'S DISEASE), CEREBROSPINAL MENINGITIS, DIPHTHERIA, ENCEPHALITIS, HUNTINGTON'S CHOREA, LEGIONNAIRE'S DISEASE, LYME DISEASE, MALARIA, MUSCULAR DYSTROPHY, MYASTHENIA GRAVIS, NECROTIZING FASCIITIS, OSTEOMYELITIS, POLIOMYELITIS (POLIO), RABIES, SICKLE CELL ANEMIA, SYSTEMIC LUPUS, SYSTEMIC SCLEROSIS (SCLERODERMA), TETANUS, TUBERCULOSIS	50%

We will pay the benefit shown if an insured is diagnosed with one of the Tier I Specified Diseases listed, and if the date of diagnosis is while the rider is in force. For any subsequent Tier I Specified Disease to be covered, the date of diagnosis of the subsequent Tier I Specified Disease must satisfy the Additional Diagnosis separation period outlined in the brochure, if applicable.

SPECIFIED DISEASE RIDER	Percentage of Face Amount
TIER II SPECIFIED DISEASE BENEFIT	
HUMAN CORONAVIRUS	10% if confined to a hospital for 4-9 days 25% if confined to a hospital for 10 or more days 40% if confined to an intensive care unit

We will pay the benefit shown if an insured is diagnosed with one of the Tier II Specified Diseases listed, and such diagnosis results in either a period of hospital confinement or hospital intensive care unit confinement as a direct result of the Tier II Specified Disease. Furthermore, the date of diagnosis must be while the rider is in force. In addition, the insured must be receiving treatment for the Tier II Specified Disease for the minimum number of days shown. Only the highest eligible benefit amount will be payable under these benefits. In the event a lower benefit amount was previously paid under these benefits for any period of hospital confinement and that confinement is extended or the insured is moved to an intensive care unit triggering a higher payment, the difference between the previous paid benefit amount and the new benefit amount will be provided. For any subsequent Tier II Specified Disease to be covered, the date of diagnosis of the subsequent Tier II Specified Disease must satisfy the Additional Diagnosis separation period outlined in the brochure, if applicable.

OCCUPATIONAL DISEASE RIDER	Percentage of Face Amount
OCCUPATIONAL HIV	100%
OCCUPATIONAL HEPATITIS	10%

The benefit is payable for the initial positive diagnosis of the listed disease(s) if the diagnosis results from an occupational-specific covered injury. The date of diagnosis must be while the rider is in force. One benefit is payable per each covered disease. After a benefit is paid for each covered disease, rider coverage will terminate.

LIMITATIONS AND EXCLUSIONS

Benefit percentages will be paid based on the face amount in effect on the critical illness date of diagnosis.

Riders become effective when the rider is issued. If it is issued after the certificate, the rider will have a later effective date.

All limitations and exclusions that apply to the critical illness plan also apply to the riders unless amended by the riders.

ATTAINED AGE PREMIUMS

If your plan includes attained age rates, that means your plan is age-banded and your rates may increase on the policy anniversary date.

EXCLUSIONS

We will not pay for loss due to any of the following:

- Self-Inflicted Injuries – injuring or attempting to injure oneself intentionally or taking action that causes oneself to become injured;
- Suicide – committing or attempting to commit suicide, while sane or insane;
- Illegal Acts – participating or attempting to participate in an illegal activity, or working at an illegal job;
- Participation in aggressive conflict of any kind, including:
  - War (declared or undeclared) or military conflicts; War does not include acts of terrorism.
  - Insurrection or riot
  - Civil commotion or civil state of belligerence
- Illegal substance abuse which includes the following: – Abuse of legally-obtained prescription medication – Illegal use of non-prescription drugs;

Diagnosis must be made and treatment must be received in the United States or its territories.

All benefits under the plan, including benefits for diagnoses, treatment, confinement and covered tests, are payable only while coverage is in force.

TERMS YOU NEED TO KNOW

Benign Brain Tumor must be caused by Multiple Endocrine Neoplasia, Neurofibromatosis, or Von Hippel-Lindau Syndrome.

The Bone Marrow Transplant (Stem Cell Transplant) benefit is not payable if the transplant results from a covered critical illness for which a benefit has been paid under this plan.

The following are not considered internal or invasive cancers:

- Pre-malignant tumors or polyps
- Carcinomas in Situ
- Any superficial, non-invasive skin cancers including basal cell and squamous cell carcinoma of the skin
- Melanoma in Situ
- Melanoma that is diagnosed as
  - Clark's Level I or II,
  - Breslow depth less than 0.77mm, or
  - Stage 1A melanomas under TNM Staging
- Metastatic Cancer

A Non-Invasive Cancer is:

- Internal Carcinoma in Situ
- Myelodysplastic Syndrome - RA (refractory anemia)
- Myelodysplastic Syndrome - RARS (refractory anemia with ring sideroblasts)
- Myeloproliferative Blood Disorder

Premalignant conditions or conditions with malignant potential, other than those specifically named above, are not considered non-invasive cancer.

Skin cancers are not payable under the Cancer (internal or invasive) Benefit or the Non-Invasive Cancer Benefit. The following are considered skin cancers:

- Basal cell carcinoma
- Squamous cell carcinoma of the skin
- Melanoma in Situ
- Melanoma that is diagnosed as
  - Clark's Level I or II,
  - Breslow depth less than 0.77mm, or
  - Stage 1A melanomas under TNM Staging

Coma means a state of continuous, profound

unconsciousness, lasting at least seven consecutive days, and characterized by the absence of:

- Spontaneous eye movements,
- Response to painful stimuli, and
- Vocalization.

Coma does not include a medically-induced coma. To be considered a critical illness, the coma must be caused solely by or be solely attributed to one of the following diseases:

- Brain Aneurysm
- Diabetes
- Encephalitis
- Epilepsy
- Hyperglycemia
- Hypoglycemia
- Meningitis

Critical Illness is a disease or a sickness as defined in the plan that first manifests while your coverage is in force.

Date of Diagnosis is defined as follows:

- Benign Brain Tumor: The date a doctor determines a benign brain tumor is present based on examination of tissue (biopsy or surgical excision) or specific neuroradiological examination.
- Cancer: The day tissue specimens, blood samples, or titer(s) are taken (diagnosis of cancer and/or carcinoma in situ is based on such specimens).
- Non-Invasive Cancer: The day tissue specimens, blood samples, or titer(s) are taken (diagnosis of cancer and/or carcinoma in situ is based on such specimens).
- Skin Cancer: The date the skin biopsy samples are taken for microscopic examination.
- Bone Marrow Transplant (Stem Cell Transplant): The date the surgery occurs.
- Coma: The first day of the period for which a doctor confirms a coma that is due to one of the underlying diseases and that has lasted for at least seven consecutive days.
- Coronary Artery Bypass Surgery: The date the surgery occurs.
- Heart Attack (Myocardial Infarction): The date the infarction (death) of a portion of the heart muscle occurs. This is based on the criteria listed under the heart attack (myocardial Infarction) definition.
- Kidney Failure (End-Stage Renal Failure): The date a doctor recommends that an insured begin renal dialysis.
- Loss of Hearing: The date the loss due to one of the underlying diseases is objectively determined by a Doctor to be total and irreversible.
- Loss of Sight: The date the loss due to one of the underlying diseases is objectively determined by a Doctor to be total and irreversible.
- Loss of Speech: The date the loss due to one of the underlying diseases is objectively determined by a Doctor to be total and irreversible.
- Major Organ Transplant: The date the surgery occurs.
- Metastatic Cancer: The date a doctor determines cancer has metastasized to other parts of the body from the original site.
- Paralysis: The date a doctor diagnoses an insured with paralysis due to one of the underlying diseases as specified in this plan, where such diagnosis is based on clinical and/or laboratory findings as supported by the insured's medical records.
- Severe Burn: The date the burn takes place.
- Stroke: The date the stroke occurs (based on documented neurological deficits and neuroimaging studies).
- Sudden Cardiac Arrest: The date the pumping action of the heart fails (based on the sudden cardiac arrest definition).
- Type I Diabetes: The date a doctor diagnoses an insured as having type I diabetes based on clinical and/or laboratory findings as supported by medical records.

Spouse is your legal wife or husband, including a legally-recognized same-sex spouse, or a person of either gender who is in a legally recognized and registered domestic partnership, civil union, reciprocal beneficiary relationship, or similar relationship with you, who is listed on your application. Read your certificate carefully for details.

Dependent children are your or your spouse's natural children, step-children, foster children, children subject to

legal guardianship, legally adopted children, or children placed for adoption, who are younger than age 26. Newborn children are automatically covered from the moment of birth. Read your certificate carefully for details.

A doctor does not include you or any of your family members. For the purposes of this definition, family member includes your spouse as well as the following members of your immediate family:

- Son
- Daughter
- Mother
- Father
- Sister
- Brother

This includes step-family members and family-members-in-law.

Employee is a person who meets eligibility requirements and who is covered under the plan. The employee is the primary insured under the plan.

Heart Attack (Myocardial Infarction) does not include:

- Any other disease or injury involving the cardiovascular system.
- Cardiac Arrest not caused by a Heart Attack (Myocardial Infarction).

Diagnosis of a Heart Attack (Myocardial Infarction) must include the following:

- New and serial electrocardiographic (ECG) findings consistent with heart attack (myocardial infarction), and
- Elevation of cardiac enzymes above generally accepted laboratory levels of normal. (In the case of creatine physphokinase (CPK) a CPK-MB measurement must be used.) Confirmatory imaging studies, such as thallium scans, MUGA scans, or stress echocardiograms may also be used.

Kidney Failure (End-Stage Renal Failure) is covered only under the following conditions:

- A doctor advises that regular renal dialysis, hemo-dialysis, or peritoneal dialysis (at least weekly) is necessary to treat the kidney failure (end-stage renal failure); or
- The kidney failure (end-stage renal failure) results in kidney transplantation.

Loss of Hearing means the total and irreversible loss of hearing in both ears. Loss of hearing does not include hearing loss that can be corrected by the use of a hearing aid or device. To be considered a critical illness, loss of hearing must be caused solely by or be solely attributed to one of the following diseases:

- Alport syndrome
- Autoimmune inner ear disease
- Chicken pox
- Diabetes
- Goldenhar syndrome
- Meniere's disease
- Meningitis
- Mumps

Loss of Sight means the total and irreversible loss of all sight in both eyes. To be considered a critical illness, loss of sight must be caused solely by or be solely attributed to one of the following diseases:

- Retinal disease
- Optic nerve disease
- Hypoxia

Loss of Speech means the total and permanent loss of the ability to speak. To be considered a critical illness, loss of speech must be caused solely by or be solely attributable to one of the following diseases:

- Alzheimer's disease
- Arteriovenous malformation

Maintenance Drug Therapy is meant to decrease the risk of cancer recurrence; it is not meant to treat a cancer that is still present.

A Major Organ Transplant benefit is not payable if the major organ transplant results from a covered critical illness for which a benefit has been paid.

Paralysis or Paralyzed means the permanent, total, and irreversible loss of muscle function to the whole of at least

two limbs. To be considered a critical illness, paralysis must be caused solely by or be solely attributed to one or more of the following diseases:

- Amyotrophic lateral sclerosis
- Cerebral palsy
- Parkinson's disease,
- Poliomyelitis

The diagnosis of paralysis must be supported by neurological evidence.

Severe Burn or Severely Burned means a burn resulting from fire, heat, caustics, electricity, or radiation. The burn must:

- Be a full-thickness or third-degree burn, as determined by a doctor. A Full-Thickness Burn or Third-Degree Burn is the destruction of the skin through the entire thickness or depth of the dermis (or possibly into underlying tissues). This results in loss of fluid and sometimes shock.
- Cause cosmetic disfigurement to the body's surface area of at least 35 square inches.
- Be caused solely by or be solely attributed to a covered accident.

Stroke does not include:

- Transient Ischemic Attacks (TIAs)
- Head injury
- Chronic cerebrovascular insufficiency
- Reversible ischemic neurological deficits unless brain tissue damage is confirmed by neurological imaging

Sudden Cardiac Arrest is not a heart attack (myocardial infarction). A sudden cardiac arrest benefit is not payable if the sudden cardiac arrest is caused by or contributed to by a heart attack (myocardial infarction).

Treatment does not include maintenance drug therapy or routine follow-up visits to verify whether cancer or carcinoma in situ has returned.

Type I Diabetes excludes gestational diabetes and prediabetes.

PROGRESSIVE DISEASES RIDER

Date of Diagnosis is defined for each specified critical illness as follows:

- Amyotrophic Lateral Sclerosis (ALS or Lou Gehrig's Disease): The date a doctor diagnoses an insured as having ALS and where such diagnosis is supported by medical records.
- Sustained Multiple Sclerosis: The date a doctor diagnoses an Insured as having Multiple Sclerosis and where such diagnosis is supported by medical records.
- Advanced Alzheimer's Disease: The date a doctor diagnoses the insured as incapacitated due to Alzheimer's disease.
- Advanced Parkinson's Disease: The date a doctor diagnoses the insured as incapacitated due to Parkinson's disease.
- Chronic Obstructive Pulmonary Disease (COPD): The date a doctor diagnoses an insured as having COPD based on clinical and/or laboratory findings as supported by medical records.
- Crohn's Disease: The date a doctor diagnoses an insured as having Crohn's Disease based on clinical and/or laboratory findings as supported by medical records.

SPECIFIED DISEASES RIDER

Date of diagnosis is defined for each specified disease as follows:

- Adrenal Hypofunction (Addison's Disease): The date a doctor diagnoses an insured as having Adrenal Hypofunction and where such diagnosis is supported by medical records.
- Cerebrospinal Meningitis: The date a doctor diagnoses an insured as having Cerebrospinal Meningitis and where such diagnosis is supported by medical records.
- Diphtheria: The date a doctor diagnoses an insured as having Diphtheria based on clinical and/or laboratory findings as supported by medical records.
- Encephalitis: The date a doctor diagnoses an insured as having Encephalitis and where such diagnosis is supported by medical records.

- Huntington's Chorea: The date a doctor diagnoses an insured as having Huntington's Chorea based on clinical findings as supported by medical records.
- Legionnaire's Disease: The date a doctor diagnoses an insured as having Legionnaire's Disease by finding Legionella bacteria in a clinical specimen taken from the insured.
- Lyme Disease: The date a doctor diagnoses an insured as having Lyme Disease and where such diagnosis is supported by medical records.
- Malaria: The date a doctor diagnoses an insured as having Malaria and where such diagnosis is supported by medical records.
- Muscular Dystrophy: The date a doctor diagnoses an insured as having Muscular Dystrophy and where such diagnosis is supported by medical records.
- Myasthenia Gravis: The date a doctor diagnoses an insured as having Myasthenia Gravis and where such diagnosis is supported by medical records.
- Necrotizing Fasciitis: The date a doctor diagnoses an insured as having Necrotizing Fasciitis and where such diagnosis is supported by medical records.
- Osteomyelitis: The date a doctor diagnoses an insured as having Osteomyelitis and where such diagnosis is supported by medical records.
- Poliomyelitis: The date a doctor diagnoses an insured as having Poliomyelitis and where such diagnosis is supported by medical records.
- Rabies: The date a doctor diagnoses an insured as having Rabies and where such diagnosis is supported by medical records.
- Sickle Cell Anemia: The date a doctor diagnoses an insured as having Sickle Cell Anemia and where such diagnosis is supported by medical records.
- Systemic Lupus: The date a doctor diagnoses an insured as having Systemic Lupus and where such diagnosis is supported by medical records.
- Systemic Sclerosis (Scleroderma): The date a doctor diagnoses an insured as having Systemic Sclerosis and where such diagnosis is supported by medical records.
- Tetanus: The date a doctor diagnoses an insured as having Tetanus by finding Clostridium tetani bacteria in a clinical specimen taken from the insured.
- Tuberculosis: The date a doctor diagnoses an insured as having Tuberculosis by finding Mycobacterium tuberculosis bacteria in a clinical specimen taken from the insured.
- Human Coronavirus: The date a doctor diagnoses an insured as having Human Coronavirus based on laboratory findings as supported by viral testing or a blood test.

Adrenal Hypofunction does not include secondary and tertiary adrenal insufficiency.

The term Hospital Intensive Care Unit specifically excludes any type of facility not meeting the definition of Hospital Intensive Care Unit as defined in the plan, including private monitored rooms, surgical recovery rooms, observation units, and the following step-down units:

- A progressive care unit,
- A sub-acute intensive care unit, or
- An intermediate care unit.

The term Hospital specifically excludes any facility not meeting the definition of Hospital as defined in the plan:

- A nursing home,
- An extended-care facility,
- A skilled nursing facility,
- A rest home or home for the aged,
- A rehabilitation facility,
- A facility for the treatment of alcoholism or drug addiction, or
- An assisted living facility.

Human Coronavirus does not include the following Human Coronaviruses: 229E, NL63, OC43, and HKU1.

OCCUPATIONAL DISEASE RIDER

We will not pay an Occupational Disease Benefit if the insured:

- Becomes HIV Positive or Hepatitis Positive as a result of a transmission other than an occupational-specific covered injury,

- Tested HIV Positive or Hepatitis Positive prior to the occupational-specific covered injury, unless the insured previously tested positive on a screening test and subsequently tested negative for that disease prior to the date of the occupational-specific covered injury, or
- Becomes HIV positive or Hepatitis positive as a result of intravenous drug use or sexual transmission.

Date of Diagnosis is defined as follows:

- Occupational HIV: The date a Doctor determines you are HIV Positive as supported by the ELISA test, Western Blot test, or another test approved by the Food and Drug Administration (FDA).
- Occupational Hepatitis: The date a Doctor determines you are Hepatitis Positive as supported by a Hepatitis B surface antigen test (HSbAg), a nucleic acid test (NAT) or PCR test for HCV RNA, or another test approved by the FDA.

Hepatitis Positive means the presence of Hepatitis B or Hepatitis C antibodies or antigens in the Insured's blood indicating Hepatitis infection, with the exception of an insured who previously received an immunization for Hepatitis B in the last 10 years. This must be evidenced by: a positive Hepatitis B surface antigen (HSbAg) test for Hepatitis B or a positive HCV RNA test for Hepatitis C; or another test approved by the FDA.

HIV Positive means the presence of HIV antibodies in the insured's blood. This must be evidenced by: a positive screening test, such as enzyme-linked immunosorbent assay (ELISA); or a positive supplement test, such as the Western Blot.

Occupational-Specific Covered Injury means that while you are actively at work, you are accidentally exposed to another person's blood or other bodily fluids that are contaminated with Human Immunodeficiency Virus (HIV) and/or Hepatitis virus through: cutaneous exposure through abraded skin, percutaneous exposure, or mucocutaneous exposure.

Applicable to both HIV and Hepatitis tests: all such tests must be approved by the Food and Drug Administration (FDA), and the interpretation of positive results must be in keeping with the manufacturer's specifications. In order to receive an Occupational Disease Benefit for an Occupational-Specific Covered Injury: • You must have two tests which meet the following criteria: –Within 5 days of the Occupational-Specific Covered Injury, you must have a preliminary screening test at an authorized laboratory other than the laboratory of your Employer appropriate for the disease to which you were exposed and the result of such test must show that HIV and/or Hepatitis is not present and that you do not have prior immunity to the Hepatitis virus to which you were exposed. We must receive notification of the negative results as soon as reasonably possible. –You must test HIV Positive and/or Hepatitis Positive within 26 weeks of the date of that Occupational-Specific Covered Injury. • You must file an incident report (notice of exposure) with your Employer within 72 hours of the positive test result. This report must: –Be on a form acceptable to the Company, –Describe the nature of the exposure to HIV and/or Hepatitis, and –Be sent to the Company as soon as reasonably possible after the Occupational-Specific Covered Injury.

YOU MAY CONTINUE YOUR COVERAGE

Your coverage may be continued with certain stipulations. See certificate for details.

TERMINATION OF COVERAGE

Your insurance may terminate when the plan is terminated; the 31st day after the premium due date if the premium has not been paid; or the date you no longer belong to an eligible class. If your coverage terminates, we will provide benefits for valid claims that arose while your coverage was in force. See certificate for details.

NOTICES

If this coverage will replace any existing individual policy, please be aware that it may be in your best interest to maintain your individual guaranteed-renewable policy.

Notice to Consumer: The coverages provided by Continental American Insurance Company (CAIC) represent supplemental benefits only. They do not constitute comprehensive health insurance coverage and do not satisfy the requirement of minimum essential coverage under the Affordable Care Act. CAIC coverage is not intended to replace or be issued in lieu of major medical coverage. It is designed to supplement a major medical program.

If you are a resident of New Mexico, you may not be eligible for this coverage. Please contact your employer for more information.



aflacgroupinsurance.com | 1.800.433.3036

Continental American Insurance Company (CAIC), a proud member of the Aflac family of insurers, is a wholly owned subsidiary of Aflac Incorporated and underwrites group coverage. CAIC is not licensed to solicit business in New York, Guam, Puerto Rico or the Virgin Islands.

Continental American Insurance Company • Columbia, South Carolina

The certificate to which this sales material pertains may be written only in English; the certificate prevails if interpretation of this material varies.

This brochure is a brief description of coverage and is not a contract. Read your certificate carefully for exact terms and conditions. You're welcome to request a full copy of the plan certificate through your employer or by reaching out to our Customer Service Center.

This brochure is subject to the terms, conditions, and limitations of Policy Series C22000.

AGD22FL GP-55381.PLAN-352728B 08/08/2025 12 EXP 09/27