Aflac Representative
Garett Keller
Garettkeller13@gmail.com
270-993-7738

KENTUCKY WESLEYAN COLLEGE 1858

ACCIDENT COVERAGE (Level 3)

- Accident emergency treatment	$120 for treatment within 72 hours	**Monthly Rates**
- Accident follow-up treatment	$35 per visit (max 6 visits per acc)	Single $21.97
- X-Ray	$25 per accident at ER or hospital	Husband & Wife $31.20
- Lump sum	$35-$12,500 per injury	One parent family $36.92
- Appliance benefit	$25-300 walking boot, knee scooter, crutches, cane, wheelchair	Family $47.84
- Accident hospitalization	$1,000-$2,000 initial confinement ($250 additional per day)	
- Intensive care unit confinement	$400 per day. Up to 15 days	
- Major diagnostic exam	$200 per calendar year	
- Physical therapy	$35 per treatment	
- Rehabilitation unit	$150 per day	
- Ambulance	$200/ground, $1,500/air	
- Wellness	$60 per calendar year	
- Transportation and lodging	$600 per round trip/ $125 per night lodging	
- Accidental Death Life Insurance	$40,000 - $150,000	Additional benefits in booklet

CANCER COVERAGE

- Initial diagnosis benefit	$4,000; child $8,000	Skin Cancer surgery	$35-400 no max
- Cancer wellness	$75 per person	Additional surgical option	$200 per day
- Bone marrow donor screening	$40	Hospital confinement	$200-400 per day
- Injected chemotherapy	$600 per week	Extended-Care facility	$100 per day, Limit 30 days
- Hormonal oral chemo	$250 per month	Home Health care	$100 per day, Limit 30 days
- Radiation therapy	$350 per week	Hospice care	$1,000 1st day $50 per day after
- Experimental treatment	$350 per week	Nursing services	$100 per day, No max
- Immunotherapy	$350	Surgical Prosthesis	$2,000; Lifetime max $4,000
- Antinausea benefit	$100/ month	Reconstructive surgery	$220-2,000
- Bone marrow transplantation	$7,000 / $750 to donor		
- Surgical/Anesthesia	$100 - 3,400 no max on # of operations		

Children covered at no cost

	HIGH	LOW	50% of benefits
Single	$33.50	$16.59	
Husband & Wife	$57.64	$26.35	monthly rates

SHORT TERM DISABILITY

Elimination Period Accident/Sickness - 7/14 DAYS

Annual Income		$9,000	$12,000	$12,000	$16,000	$18,000	$20,000	$22,000	$24,000	$26,000	$28,000
Benefit Period	Age	$500	$600	$700	$800	$900	$1,000	$1,100	$1,200	$1,300	$1,400
3 MONTHS	18-49	$9.10	$10.92	$12.74	$14.56	$16.38	$18.20	$20.02	$21.84	$23.66	$25.48
	50-64	$9.75	$11.70	$13.65	$15.60	$17.55	$19.50	$21.45	$23.40	$25.35	$27.30
	65-74	$11.70	$14.04	$16.38	$18.72	$21.06	$23.40	$25.74	$28.08	$30.42	$32.76
6 MONTHS	18-49	$10.40	$12.48	$14.56	$16.64	$18.72	$20.80	$22.88	$24.96	$27.04	$29.12
	50-64	$12.35	$14.82	$17.29	$19.76	$22.23	$24.70	$27.17	$29.64	$32.11	$34.58
	65-74	$15.60	$18.72	$21.84	$24.96	$28.08	$31.20	$34.32	$37.44	$40.56	$43.68

LUMP SUM CRITICAL ILLNESS

- Defined as Heart Attack, Stroke, End-stage Renal Failure, Paralysis, Major Human Organ Transplant, or Coma
- First Occurrence - $10,000 lump sum
- Reoccurrence Benefit - $5,000 per reoccurrence
- Coronary Artery Bypass Graft - $3,000 once/person
- Additional benefits available in $5,000 increments up to $30,000

Age:	18-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-70	
Individual rate	$4.42	$4.94	$6.50	$8.84	$11.44	$13.91	$16.25	$18.46	$21.71	$21.71	monthly rates
Husband & wife:	$7.15	$8.06	$10.53	$13.91	$17.42	$21.19	$25.48	$29.90	$36.79	$36.79	

If you are a smoker your rate is slightly increased.

Employee Information form

Employer: Kentucky Wesleyan

Name:	Gender:	DOB:	
Address:	City	State:	ZIP:
Job Title:	Social:	Phone:	

NAME of dependents	DOB	GENDER
Beneficiary -		

Tier Options	Accident		Tier Options	Cancer		Disability		Illness	
Employee Only	$21.97	☐	Single	HIGH $33.50	☐	$ BENEFIT AMOUNT	☐	$ BENEFIT AMOUNT	☐
Employee & Spouse	$31.20	☐		LOW $16.59	☐				
One Parent Family	$36.92	☐	Husband & Wife	HIGH $57.64	☐	$ WEEKLY RATE	☐	$ WEEKLY RATE	
Two Parent Family	$47.84	☐		LOW $26.35	☐				

Cancer qualifying questions	
Has anyone to be covered ever been diagnosed with or treated for Cancer or an Associated Cancerous Condition of any type or form, **other than Nonmelanoma Skin Cancer?**	☐ yes ☐ no
Has anyone to be covered had Nonmelanoma Skin Cancer that was diagnosed or last treated **within the last five years**?	☐ yes ☐ no

☐ ELECT COVERAGE: I understand the benefits I have elected fall under a Cafeteria 125 plan & changes cannot be made until open enrollment unless there is a qualifying event (marriage, divorce, birth, adoption, loss of coverage). The amount of deduction and frequency thereof shall be determined by my employer and based on a plan that will comply with the payment checked above. I hereby authorized my employer to deduct from my earnings such amounts as may now or hereafter be payable to me under the insurance plan purchased through Aflac. In the event of a rate change, I authorized a corresponding change in the amount deducted from my earnings. All information furnished in this application is true, correct, and complete to the best of my knowledge.

☐ DECLINE COVERAGE: I decline all Aflac coverage for myself and my dependents.

EMPLOYEE SIGNATURE: _____ **DATE:** _____