#### Affac P

### PREMIUM DEDUCTION AUTHORIZATION/WAIVER OF PARTICIPATION

Employee's name		Dept. No.				
	MI					
SSN/Emp. ID I hereby authorize my employer:		Location  Date of first deduction				
		Deduction Mode				
employer Payroll Account No	be payable by me he event of a rate unt deducted from not be changed or due to a change in	Other Cancer/Specified-Disease Return of Premium Rider Dental Vision Hospital Intensive Care Specified Health	OLD AFTER-TA \$  \$  \$  \$  \$  \$  \$  \$  \$  \$  \$  \$  \$	AX PRE-TAX	NEW AFTER-TAX PRE-TAX \$ \$ \$ \$ \$ \$ \$ \$	
	anteed-renewable ely. my employer by decided to waive ed not to upgrade	Event	\$\$ \$\$ \$\$ \$\$ sse payment chec	hall be determine ked above.		
Insurance Agent/Producer	Date	Insurance Agent/Producer's W	/riting No.	Insurance Agen	t/Producer's Phone No.	

# Policyholder

### Affac. Premium deduction authorization/waiver of participation

Employee's name		Dept. No.			
Last First	MI	Location			
SSN/Emp. ID					
I hereby authorize my employer:	Date of first deduction  Deduction Mode ☐ Weekly ☐ Biweekly ☐ Semimonthly ☐ Monthly				
	· · · · · · · · · · · · · · · · · · ·	Deduction wode - Weekly - E			
employer Payroll Account Nomy earnings such amounts as may now or hereafter bunder the insurance plan purchased through Aflac. In the change, I authorize a corresponding change in the amount my earnings.  In addition, I understand that any pre-tax elections can revoked prior to the next plan anniversary date, unless of family status and permitted by my employer.  Signature of Applicant	ne payable by me the event of a rate and deducted from the changed or the due to a change in	Other Cancer/Specified- Disease Return of Premium Rider Dental Vision Hospital Intensive Care Specified Health Event	\$\$ \$\$ \$\$ \$\$	FAX PRE-TAX	\$ \$ \$ \$
WAIVER OF PARTICIPATION  I certify that the features and benefits of Aflac's guaranteed-renewable insurance policies have been explained to me completely.  I understand that these policies are offered through my employer by payroll deduction.  ☐ I am NOT currently an Aflac policyholder and have decided to waive my opportunity to participate at this time.  ☐ I am currently an Aflac policyholder and have decided not to upgrade to any newer policies at this time.		☐ Hospital Confinement Indemnity Accident	\$ \$		\$
		Disability Rider	_ \$		\$
		☐ Short-Term Disability	_		
		Employee Dependent			
		TOTAL	\$		\$
EMPLOYEE'S SIGNATURE	DATE	The amount of deduction and freq on a plan that will comply with the			ed by my employer and based
Insurance Agent/Producer	Date	Insurance Agent/Producer's W	/riting No.	Insurance Ager	nt/Producer's Phone No.

## Affac. PREMIUM DEDUCTION AUTHORIZATION/WAIVER OF PARTICIPATION

Employee's name		Dept. No.				
Last First	MI					_
SSN/Emp. ID		Location  Date of first deduction				
I hereby authorize my employer:	Deduction Mode ☐ Weekly ☐ Biweekly ☐ Semimonthly ☐ Monthly					
employer Payroll Account No, to deduct from my earnings such amounts as may now or hereafter be payable by me under the insurance plan purchased through Aflac. In the event of a rate change, I authorize a corresponding change in the amount deducted from my earnings.  In addition, I understand that any pre-tax elections cannot be changed or revoked prior to the next plan anniversary date, unless due to a change in family status and permitted by my employer.		☐ Other Cancer/Specified-	OLD AFTER-1	ΓΑΧ PRE-TAX	NEW AFTER-TAX PRE-TAX \$	x _
		Disease				_
		Premium Rider  Dental  Vision	\$ \$ \$		\$ \$	_
Signature of Applicant	Date	☐ Hospital Intensive Care ☐ Specified Health Event	_ \$ _ \$		\$ \$	_
WAIVER OF PARTICIPATION  I certify that the features and benefits of Aflac's guaranteed-renewable insurance policies have been explained to me completely.  I understand that these policies are offered through my employer by payroll deduction.  I am NOT currently an Aflac policyholder and have decided to waive my opportunity to participate at this time.  I am currently an Aflac policyholder and have decided not to upgrade to any newer policies at this time.  EMPLOYEE'S SIGNATURE		☐ Hospital Confinement Indemnity	_ \$		\$	_
		☐ Disability Rider	_ \$		\$	_
		☐ Short-Term Disability	_		\$	_
		Employee Dependent			\$ \$	_
		TOTAL	\$		\$	-
		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.				
Insurance Agent/Producer	Date	Insurance Agent/Producer's W	riting No.	Insurance Ager	nt/Producer's Phone No.	