Aflac PREMIUM DEDUCTION AUTHORIZATION/WAIVER OF PARTICIPATION

Employee's name _____
Last First MI

SSN/Emp. ID _____

I hereby authorize my employer:

_____ ,

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.

Signature of Applicant _____ Date _____

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 _____ DATE _____

Dept. No. _____

Location _____

Date of first deduction _____

Deduction Mode ☐ Weekly ☐ Biweekly ☐ Semimonthly ☐ Monthly

	OLD		NEW	
	AFTER-TAX	PRE-TAX	AFTER-TAX	PRE-TAX
☐ Other _____	$_____	_____	$ _____	_____
☐ Cancer/Specified-Disease _____	$_____	_____	$ _____	_____
☐ Return of Premium Rider _____	$_____	_____	$ _____	_____
☐ Dental _____	$_____	_____	$ _____	_____
☐ Vision _____	$_____	_____	$ _____	_____
☐ Hospital Intensive Care _____	$_____	_____	$ _____	_____
☐ Specified Health Event _____	$_____	_____	$ _____	_____
☐ Hospital Confinement Indemnity _____	$_____	_____	$ _____	_____
☐ Accident _____	$_____	_____	$ _____	_____
☐ Disability Rider _____	$_____	_____	$ _____	_____
☐ Short-Term Disability _____	$_____	_____	$ _____	_____
☐ Life _____				
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.

Payroll Account

Insurance Agent/Producer	Date	Insurance Agent/Producer's Writing No.	Insurance Agent/Producer's Phone No.

Aflac PREMIUM DEDUCTION AUTHORIZATION/WAIVER OF PARTICIPATION

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Last First MI

SSN/Emp. ID _____

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Signature of Applicant _____ Date _____

WAIVER OF PARTICIPATION

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☐ I am currently an Aflac policyholder and have decided not to upgrade to any newer policies at this time.

EMPLOYEE'S SIGNATURE _____ DATE _____

Dept. No. _____

Location _____

Date of first deduction _____

Deduction Mode ☐ Weekly ☐ Biweekly ☐ Semimonthly ☐ Monthly

	OLD		NEW	
	AFTER-TAX	PRE-TAX	AFTER-TAX	PRE-TAX
☐ Other _____	$_____	_____	$ _____	_____
☐ Cancer/Specified-Disease _____	$_____	_____	$ _____	_____
☐ Return of Premium Rider _____	$_____	_____	$ _____	_____
☐ Dental _____	$_____	_____	$ _____	_____
☐ Vision _____	$_____	_____	$ _____	_____
☐ Hospital Intensive Care _____	$_____	_____	$ _____	_____
☐ Specified Health Event _____	$_____	_____	$ _____	_____
☐ Hospital Confinement Indemnity _____	$_____	_____	$ _____	_____
☐ Accident _____	$_____	_____	$ _____	_____
☐ Disability Rider _____	$_____	_____	$ _____	_____
☐ Short-Term Disability _____	$_____	_____	$ _____	_____
☐ Life _____				
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.

Policyholder

Insurance Agent/Producer	Date	Insurance Agent/Producer's Writing No.	Insurance Agent/Producer's Phone No.

Aflac PREMIUM DEDUCTION AUTHORIZATION/WAIVER OF PARTICIPATION

Employee's name _____
Last First MI

SSN/Emp. ID _____

I hereby authorize my employer:

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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.

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Signature of Applicant _____ Date _____

WAIVER OF PARTICIPATION

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☐ I am currently an Aflac policyholder and have decided not to upgrade to any newer policies at this time.

EMPLOYEE'S SIGNATURE _____ DATE _____

Dept. No. _____

Location _____

Date of first deduction _____

Deduction Mode ☐ Weekly ☐ Biweekly ☐ Semimonthly ☐ Monthly

	OLD		NEW	
	AFTER-TAX	PRE-TAX	AFTER-TAX	PRE-TAX
☐ Other _____	$_____	_____	$ _____	_____
☐ Cancer/Specified-Disease _____	$_____	_____	$ _____	_____
☐ Return of Premium Rider _____	$_____	_____	$ _____	_____
☐ Dental _____	$_____	_____	$ _____	_____
☐ Vision _____	$_____	_____	$ _____	_____
☐ Hospital Intensive Care _____	$_____	_____	$ _____	_____
☐ Specified Health Event _____	$_____	_____	$ _____	_____
☐ Hospital Confinement Indemnity _____	$_____	_____	$ _____	_____
☐ Accident _____	$_____	_____	$ _____	_____
☐ Disability Rider _____	$_____	_____	$ _____	_____
☐ Short-Term Disability _____	$_____	_____	$ _____	_____
☐ Life _____				
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.

Associate

Insurance Agent/Producer	Date	Insurance Agent/Producer's Writing No.	Insurance Agent/Producer's Phone No.