Aflac.

PREMIUM DEDUCTION AUTHORIZATION/WAIVER OF PARTICIPATION

Employee's name_____
Last First MI

SSN/Emp. ID_____

Employee DOB_____ Phone_____

Employee Email_____

Employee Address_____

I hereby authorize my 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 qualifying life event, such as a change in family status, as permitted by my employer. Also, pre-tax contributions reduce my compensation for Social Security tax purposes; therefore, my Social Security benefits could be decreased. Further, paying for coverage on a pre-tax basis may cause insurance claim payments under health and medical coverage to be subject to federal and state taxes if claim payments (combining the total from all health and medical policies/plans) are in excess of medical expenses.

Signature of Applicant_____ Date_____

WAIVER OF PARTICIPATION

(if Not Applying, Sign Here)

I understand that these policies are offered through my employer by payroll deduction and I am waiving my participation based on one of the following:

☐ I am NOT currently participating in the offerings by my employer, including products offered by Aflac, and waive my opportunity to participate at this time.

☐ I currently have these products (i.e. through Aflac) and have decided not to upgrade to any newer policies at this time.

I certify that the features and benefits of Aflac's guaranteed-renewable insurance policies and other products offered to me by my employer have been explained to me completely.

EMPLOYEE'S SIGNATURE_____ DATE_____

Employer Tax ID No. _____

Dept. No. _____

Location _____

Date of first deduction _____ Effective Date of Coverage_____

Plan Year_____ to_____

Deduction Mode ☐ Weekly ☐ Biweekly ☐ Semimonthly ☐ Monthly

	OLD		NEW	
	AFTER-TAX	PRE-TAX	AFTER-TAX	PRE-TAX
☐ Medical_____	$_____	$_____	$_____	$_____
☐ Cancer/Specified Disease_____	$_____	$_____	$_____	$_____
☐ Return of Premium Rider_____	$_____	$_____	$_____	$_____
☐ Dental_____	$_____	$_____	$_____	$_____
☐ Vision_____	$_____	$_____	$_____	$_____
☐ Hospital Intensive Care_____	$_____	$_____	$_____	$_____
☐ Specific Health Event/Critical Illness_____	$_____	$_____	$_____	$_____
☐ 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.

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