PREMIUM DEDUCTION AUTHORIZATION/WAIVER OF PARTICIPATION

Employee's name _____

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 X _____ Date _____

WAIVER OF PARTICIPATION

I certify that the features and benefits of Aflac's supplemental health coverages have been explained to me completely.

I understand that these programs 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 coverages at this time.

EMPLOYEE SIGNATURE _____ DATE _____

Dept. No. _____

Location _____

Date of first deduction _____

Deduction Mode: ☐ Weekly ☐ Biweekly ☐ Semimonthly ☐ Monthly

Mode _____	OLD		NEW	
	AFTER-TAX	PRE-TAX	AFTER-TAX	PRE-TAX
☐ Other _____	$ _____	_____	$ _____	_____
☐ Specified Disease (Cancer) _____	$ _____	_____	$ _____	_____
☐ Return of Premium Rider _____	$ _____	_____	$ _____	_____
☐ Dental _____	$ _____	_____	$ _____	_____
☐ Vision _____	$ _____	_____	$ _____	_____
☐ LTC _____	$ _____	_____	$ _____	_____
☐ 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 Producer/Agent	Date	Insurance Producer/Agent's Writing No.	Insurance Producer/Agent's Phone No.