



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
<input type="checkbox"/> Other _____	\$ _____	_____	\$ _____	_____
<input type="checkbox"/> Specified Disease (Cancer) _____	\$ _____	_____	\$ _____	_____
<input type="checkbox"/> Return of Premium Rider _____	\$ _____	_____	\$ _____	_____
<input type="checkbox"/> Dental _____	\$ _____	_____	\$ _____	_____
<input type="checkbox"/> Vision _____	\$ _____	_____	\$ _____	_____
<input type="checkbox"/> LTC _____	\$ _____	_____	\$ _____	_____
<input type="checkbox"/> Hospital Intensive Care _____	\$ _____	_____	\$ _____	_____
<input type="checkbox"/> Specified Health Event _____	\$ _____	_____	\$ _____	_____
<input type="checkbox"/> Hospital Confinement Indemnity _____	\$ _____	_____	\$ _____	_____
<input type="checkbox"/> Accident _____	\$ _____	_____	\$ _____	_____
<input type="checkbox"/> Disability Rider _____	\$ _____	_____	\$ _____	_____
<input type="checkbox"/> Short-Term Disability _____	\$ _____	_____	\$ _____	_____
<input type="checkbox"/> 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 Producer/Agent _____ Date _____

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