Name_____

Date of Birth _____State of Birth _____

Social Security _____-_____-_____ Annual Income _____ ***(Disability Only)***

Mailing Address _____

City _____State_____ Zip _____

Home Phone #_____ Cell Phone # _____

Date of Hire _____Job Title_____

Height _____ Weight_____ Driver's License _____ ***(Life Insurance Only)***

Email address: _____

Spouse Name _____ Date of Birth_____

Dependents: Under age 26

Name _____Date of Birth _____M / F

Name _____Date of Birth _____M / F

Name _____Date of Birth _____M / F

Name _____Date of Birth _____M / F

Name _____Date of Birth _____M / F

Beneficiary Name: _____Date of Birth _____M / F

Address _____State_____Zip_____

Phone# _____Relationship _____

Beneficiary Name: _____Date of Birth _____M / F

Address _____State_____Zip_____

Phone# _____Relationship _____

Short Term Disability:

Premium $ _____ For a Monthly Benefit Amount of $ _____

Term: _____ Other_____ Elimination Period _____

Accident Premium: (IND) $_____ (INS & S) $_____ (1PF) $_____ (2PF) $_____

Aflac Plus Rider: (IND) $_____ (INS&S)$ _____(1PF) $_____ (2PF) $_____

**Medical Concerns if any* _____

Hospital Premium: (IND) $_____ (INS+S) $_____ (1PF) $_____ (2PF) $_____

**Medical Concerns if any*_____

Cancer Premium: (IND) $_____ (INS&S) $_____(1PF) $ _____ (2PF) $ _____

Have you or anyone being covered under these policies been diagnosed with cancer? _____

Vision Premium: (IND) $_____ (INS&S) $_____(1PF) $ _____ (2PF) $ _____

Dental Premium: (IND) $_____ (INS&S) $_____(1PF) $ _____ (2PF) $ _____

Life Premium: _____ Term:____ ADB____ Whole:____ ADB____ Benefit Amount:_____

Pre-existing conditions refer to a condition, which took place 12 months prior to the effective date of coverage, and is not a payable claim. **Please initial** _____

By Law; there is a 30-day waiting period from the effective date of coverage on all policies listed except the accident and life plans. **Please initial** _____

I authorize _____to deduct $ _____, bi-weekly _____or weekly _____ from my paycheck for purchasing my Aflac supplemental insurance.

Printed Name _____

Signature _____ Date _____