Name: _____ Phone Number: _____

Email: _____

Aflac policies are created to help you and your families with out of pocket costs and closing the gap in health care bills. You have the option to carry dependents on any of the policies except Short Term Disability. Please elect one or more of the following.

Benefits Package

_____ Accident: Pays policy holder for any injury on or off the job. 24/7 Coverage. Annual Wellness benefit $60.00.

_____ Cancer: Pays the policyholder if diagnosed with cancer. Wellness Benefit of $75.00.

_____ Short Term Disability: This policy is your paycheck protection. If you miss work due to an accident or illness, this policy will ensure 60 percent of your salary and includes maternity leave.

_____ Critical Illness: Pays the policyholder in the event of heart attack, stroke, 3rd degree burn or coma.

_____ Hospital Indemnity: Pays policy holder for initial stay and continued days in the hospital.

_____ Dental: Principal Plan: Benefits for cleaning, x rays, and, includes orthodontic. In and out of network options.

_____ Vision: Principal Vision: Benefits for eye exams, glasses and contacts.

_____ Life: Employer Paid $25K in Life Insurance.

_____ Voluntary Life: Additional life insurance options.

_____ AllyHealth: Employer paid tele-doc benefit.

Beneficiary Information

(Beneficiary must be at least 18 years old)

Name: _____

Date of Birth: _____

Relationship to you: _____

Phone Number: _____

Address: _____

If you have more than one, please write that down below. You have the ability to split 50/50

Name: _____

Date of Birth: _____

Relationship to you: _____

Phone Number: _____

Address: _____