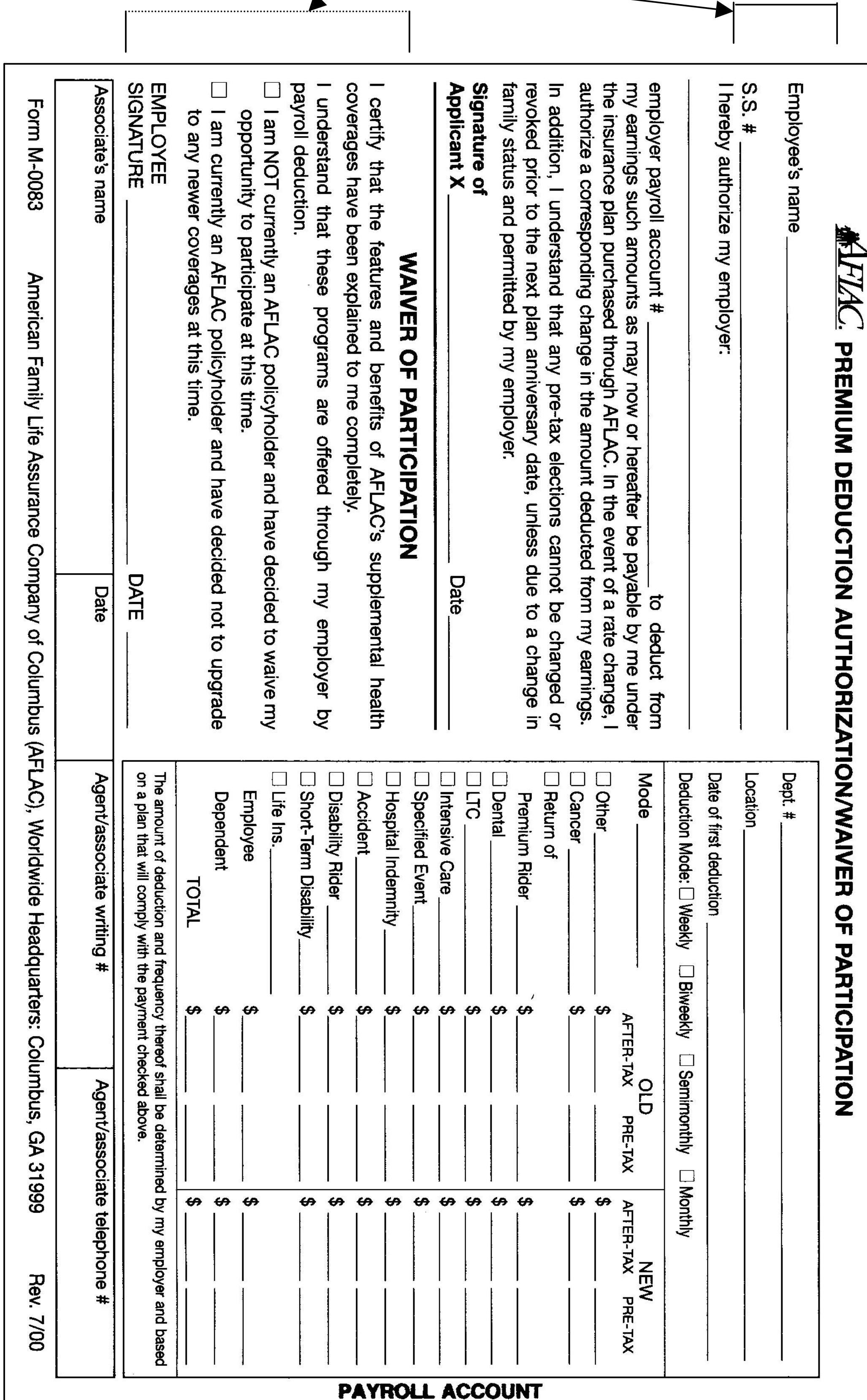
Form to Decline AFLAC Supplemental Insurance

- Use this web form only if you **don't want** to buy AFLAC supplemental insurance.
- If you **do want** AFLAC, call the office to get the version of this form that makes multiple copies.
- To decline AFLAC, fill in these 2 areas, then mail to the office.



AFLAC. **PREMIUM DEDUCTION AUTHORIZATION/WAIVER OF PARTICIPATION**

Employee's name ______________________

S.S. # ______________________

I hereby authorize my employer:

____

employer payroll account # ____________ 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. # ______________________

Location ______________________

Date of first deduction ______________________

Deduction Mode: ☐ Weekly ☐ Biweekly ☐ Semimonthly ☐ Monthly

Mode ________	OLD AFTER-TAX	OLD PRE-TAX	NEW AFTER-TAX	NEW PRE-TAX
☐ Other ________	$ ____	____	$ ____	____
☐ Cancer ________	$ ____	____	$ ____	____
☐ Return of Premium Rider ________	$ ____	____	$ ____	____
☐ Dental ________	$ ____	____	$ ____	____
☐ LTC ________	$ ____	____	$ ____	____
☐ Intensive Care ________	$ ____	____	$ ____	____
☐ Specified Event ________	$ ____	____	$ ____	____
☐ Hospital Indemnity ________	$ ____	____	$ ____	____
☐ Accident ________	$ ____	____	$ ____	____
☐ Disability Rider ________	$ ____	____	$ ____	____
☐ Short-Term Disability ________	$ ____	____	$ ____	____
☐ Life Ins. ________				
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

Associate's name	Date	Agent/associate writing #	Agent/associate telephone #

Form M-0083 American Family Life Assurance Company of Columbus (AFLAC), Worldwide Headquarters: Columbus, GA 31999 Rev. 7/00