



ENROLLMENT OR TERMINATION FORM FOR AFLAC SUPPLEMENTAL BENEFITS

Available Programs: Accident covers you in the event of any accident. Sickness covers you in the event of sickness of any kind. Cancer covers you if diagnosed with internal cancer, Personal Recovery Plan covers you for specified events such as heart attack or stroke.

Section 1. To be completed if enrolling in AFLAC

Employee Name _____

Please give us your contact information so an AFLAC representative can speak with you about your AFLAC options and pre-tax benefits:

Best time to reach you during the day: _____ a.m. _____ p.m.

Best way to reach you during the day: Home Phone: _____

Work Phone: _____

Cell Phone: _____

Hospital/Facility Name _____

Work City & State _____

Employment Start Date _____ Employee Status: Full Time Part Time

Section 2. To be completed if terminating AFLAC through Advantage RN

Employee Name _____

Please give us your contact information so an AFLAC representative can call you to set up direct billing or arrange for another method of payment if you wish to retain your AFLAC benefits.

Home Phone _____ Cell Phone _____

Separation Date _____ AFLAC Deduction Amount _____ Employee Status: Full Time Part Time

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