Client Information

Aflac Enroll Now

Name: _____ Date of Birth: ____/____/____
First Middle Last

Social Security #: ____-____-____ State of Birth: _____

Spouse's Name: _____ Birthdate: ____/____/____

Children Under Age 26: Yes _____ No _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: [ ] _____ Email: _____

Job Title: _____

Date of Hire: _____

For Short Term Disability

Annual Income: $_____ **(only needed for disability options)**

Drivers License Number: _____ State of Issue: _____

Please Check the boxes below of the Plans that interest you.
Please Speak with the Representative about the coverages for Individual and Family.
These are Voluntary Benefit Plans. No Obligation to participate.

Plan	Individual	Single Parent	Husband/Wife	Family
Cancer				
Accident				
Disability		XXXXXXXXXXXXXX	XXXXXXXXXXXXXX	XXXXXXXXXXXXXXX
Hospital				
Dental				
Vision				
Life		XXXXXXXXXXXXXX	XXXXXXXXXXXXXX	XXXXXXXXXXXXXXX