Aflac
Interest Sheet

Employee Name: _____ Birthdate: _____/_____/_____

Address: _____ City: _____ Zip: _____

SSN: _____ Phone: _____

State of Birth: _____ Job Title: _____ Tobacco User: Yes / No

Email: _____ Driver's License #: _____

☐ Check Box if **NOT** interested in any Aflac Policies

If interested in **Short Term Disability**: Annual Salary: _____

If interested in **Life Insurance**: Height: _____ ft. _____ in. Weight: _____

DEPENDENT INFORMATION:

Spouse Name: _____ Phone: _____ Birthdate: _____/____/____

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

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

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

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

AFLAC POLICY	COVERAGE TYPE (CIRCLE BELOW) E=Employee ES=Employee & Spouse EC=Employee & child(ren) F=Family				PRE-TAX	POST-TAX
Accident	E	ES	EC	F		
Plus Rider	E	ES	EC	F		
Cancer (Children Free)	E	ES	EC	F		
Short-Term Disability	Employee Only	---	---	---		
Vision	E	ES	EC	F		
Dental	E	ES	EC	F		
Whole Life	E	ES	EC	F		
Term Life	E	ES	EC	F		
Juvenile Life	E	ES	EC	F		
Hospital Choice	E	ES	EC	F		
				TOTAL		

BENEFICIARY INFORMATION FOR ACCIDENT POLICY / LIFE INSURANCE POLICY:

Name: _____ Birthdate: _____

Address: _____ City: _____ Zip: _____

Phone: _____ Relation: _____ Percentage: _____

EMPLOYEE'S SIGNATURE: _____ DATE: _____