Account Name: _____

Tax ID: _____ Group No.: _____ Writing No.: _____

Payroll Account Acknowledgment

All applicable sections must be completed for processing.

INSTRUCTIONS

- ALL accounts must complete Section 8, Authorization and Signatures.
- Accounts establishing or modifying a Wingspan[SM] cafeteria plan must complete Section 5.
- Accounts with another carrier's cafeteria plan must complete Section 7.
- Broker Information must be completed in Sections 9 and 10.
- Fax the completed form to 1-866-AFL-NASA (1-866-235-6272).

1. GENERAL ACCOUNT INFORMATION

☐ **New Aflac Payroll Account**
☐ **Changes to an Existing Aflac Payroll Account** **Group Number:** _____
☐ **Split or Transferred Account** **Transferring From Account:** _____

Will new split account be affiliated with an existing Aflac account? ☐ Yes, Account: _____ ☐ No

Does this account have multiple locations, each requiring an invoice? ☐ Yes ☐ No

Are there any existing policies to place on this account? ☐ Yes ☐ No (If yes, list the policies on a separate page and send it with the completed Payroll Account Acknowledgment form to Aflac WWHQ.)

Name of Account:

Type of Business:	Tax ID No.:	SIC Internet Request No.:
Affiliate/Subsidiary of *(if applicable):*	Master Account No.:	

Mailing Address:

City:	State:	Zip:

Location Address: ☐ *Check if same as mailing address (P.O. Box is not acceptable).*

City:	State:	Zip:	Phone:	Fax *(if applicable):*

Total Employees: _____ Total Benefits-Eligible Employees: _____ Total Benefits-Eligible W-2 Employees: _____

Total benefits-eligible 1099 Workers: _____	Will benefits-eligible 1099 workers be applying for coverage? ☐ Yes ☐ No
Is this a leasing company or staffing agency? ☐ Yes ☐ No	If yes, will the temporary/leased employees be applying for coverage? ☐ Yes ☐ No

Account Website Address *(if applicable):*

Is there an established Aflac New York account? ☐ Yes ☐ No If yes, provide the name and group number:

Account Name: _____

Tax ID: _____ Group No.: _____ Writing No.: _____

Please consult with employer's payroll contact to ensure accurate completion of the next section.

What led your organization to begin offering Aflac products to your employees? *(Check all that apply.)*

☐ Employee/Member Request ☐ Benefit Package Improvement ☐ Benefit Advisor or Broker Recommendation

☐ Sales Associate/Agent ☐ Commercial Advertising ☐ Value of Aflac Products

☐ Other: _____

2. ENROLLMENT INFORMATION

Enrollment Period: What is the length of the enrollment period? _____ (Options are 30, 60, or 90 days.)

Will the enrollment period exceed 90 days? ☐ Yes ☐ No

If yes, has this been approved by Sales Support? ☐ Yes ☐ No

Enrollment Provider(s): ☐ Field ☐ Broker ☐ Enrollment Firm ☐ Unknown

(If Enrollment Firm is selected, please provide the Enrollment Firm Name and Writing No.)

Enrollment Firm Name: _____

Enrollment Firm Writing No (if applicable): _____

Enrollment Method(s): ☐ One-on-One ☐ SNG ☐ Paper ☐ One-on-One 3rd Party laptop ☐ Call Center ☐ Web

Enrollment Platform Name (if applicable): _____

3. BILLING INFORMATION

3a. BILLING CONTACT INFORMATION

NOTE: Aflac will contact the designated billing contact to review information.

All accounts with fewer than 1,000 employees will receive their invoice via Aflac's Wingspan℠ Online Services for Accounts system. With the Online Billing feature, you have the option of making payments and reconciling your account online. Once your account is established, you can submit your invoice and payment electronically from the bank account noted below. At that time, if you prefer, you may also choose to pay by mailing a check. Aflac will not debit your account until you have reconciled and submitted your invoice for payment. Any adjustments or requested changes you submit electronically will not be processed until payment is received and the transaction is complete.

Bank Routing No.:	Account No.:	Account Type: ☐ Checking ☐ Savings

Contact for Billing Inquiries: ☐ Mr. ☐ Ms.

Billing Contact Phone: Ext:	Fax *(if applicable):*
Best Time to Make Contact Call: ☐ a.m. ☐ p.m.	Billing Contact Email *(required):*

Will an associate, broker, or other third party be collecting and remitting Aflac premiums? ☐ Yes ☐ No
If yes, provide the name and contact information below.

Name:	Contact Phone:

Account Name: _____

Tax ID:_____ Group No.:_____ Writing No.: _____

3b. BILLING FREQUENCIES

Invoice Due Date: On what day of the month would you like your Aflac invoice to be due (o 1st or the o 15th)?

How often would you like to receive your invoice from Aflac?

☐ Monthly (Aflac will bill for the number of deductions made the previous month. For example: Deductions made January 1st through the 31st will be due in February.)

Note: Moded accounts (8-, 9-, or 10-month billings) cannot accommodate weekly or biweekly deductions.

☐ 8-Month (8 invoices) ☐ 9-Month (9 invoices) ☐ 10-Month (10 invoices)

For 8-, 9-, or 10-month billings, indicate months when no deductions will be made:

☐ Jan ☐ Feb ☐ Mar ☐ Apr ☐ May ☐ Jun ☐ Jul ☐ Aug ☐ Sep ☐ Oct ☐ Nov ☐ Dec

☐ Quarterly (4 invoices)

☐ Semiannual (2 invoices)

☐ Annual (1 invoice)

For quarterly, semiannual, and annual, initial premiums must be submitted with applications.

Account Name: _____

Tax ID:_____Group No.:_____Writing No.: _____

3c. BILLING FORMAT

☐ Check if account uses Social Security number for employee number.

In what order would you like your employees listed on your bill?
(If more than one is checked, please number your choices according to priority.)

☐ Alphabetic_____ ☐ Department No._____ ☐ Employee No. _____

EXAMPLE: To request a bill with employees listed alphabetically under their department numbers, you would mark:
☐ Alphabetic 2 ☐ Department No. 1 ☐ Employee No. _____

4. DEDUCTION INFORMATION

Employer Contributions: ***Does the employer pay any portion of this benefit?*** ☐ Yes ☐ No

If yes, please provide percent:_____% OR flat dollar amount: $_____
Percent or dollar amount must be a whole number, such as 50% or $10.

Based on the information provided in this section, Aflac will determine the number of deduction periods billed each month (when the account selects monthly billing).

If you choose a monthly billing frequency, indicate the number of payroll deductions made annually for insurance premiums.
☐ Check if premiums are deducted at different frequencies for different employees (i.e., some employees are deducted weekly while others are deducted biweekly), and indicate the different frequencies that exist for the account. An additional account(s) will be established using this information.

Initial Deduction: When will premium deductions begin?

Note: The date of the first deduction should be the date the payroll account physically obtains funds from the employees. It does not necessarily equal the pay date for the employees. The 52, 26, 24, and 12 deductions do not apply to 8-, 9-, or 10-month billing.

☐ **52 Deductions** – Date of first deduction:_____/_____/_____ Date of second deduction:_____/_____/_____

☐ **26 Deductions** – Date of first deduction:_____/_____/_____ Date of second deduction:_____/_____/_____

☐ **24 Deductions** – Date of first deduction:_____/_____/_____ Date of second deduction:_____/_____/_____

☐ **12 Deductions** – Date of first deduction:_____/_____/_____ Date of second deduction:_____/_____/_____

Does employer withhold deductions on weekends? ☐ Yes ☐ No

_____ **NOTE: By initialing this box, the employer understands that premium payments are due to Aflac by the due date listed on each invoice, and payments are considered past due 10 days after the invoice due date. Therefore, the employer will make every attempt to provide premium payments to Aflac by the due date on each invoice.**

Account Name: _____

Tax ID:_____Group No.:_____Writing No.: _____

5. INFORMATION CONCERNING TAX STATUS OF DISABILITY INSURANCE BENEFIT PAYMENTS

If disability coverage is funded by employer contributions, pre-tax employee contributions, or a combination of these two, then the disability benefits an employee receives upon becoming disabled will be includible in the employee's income and are fully taxable when paid. In addition, FICA taxes must be withheld and paid on all such benefits during the first six months after the disability begins. Where, as noted below, coverage is funded by employer contributions or employee pre-tax contributions, Aflac will notify the employer of the amount of disability benefits to be paid. Aflac will withhold the employee's portion of FICA taxes and will deposit such taxes with the government as required by the Internal Revenue Code. **The employer will be required to submit the employer's portion of applicable FICA and FUTA taxes, and report the benefit payments on its Form 941 and the employee's Form W-2.**

Employer authorizes disability coverage to be included as part of this agreement: ☐ Yes ☐ No

NOTE: At least one disability type must be marked if the question above is checked yes.

All the remaining questions in the section below must be answered if disability is being offered.

- **Authorized disability coverage types:** ☐ Accident/Disability ☐ Short-Term Disability ☐ Off-the-job
- **Authorized riders**: ☐ Off-the-job ☐ On-the-job ☐ Sickness ☐ Spouse

Will any portion of disability premiums be funded by employer contributions? ☐ Yes ☐ No

If yes, please provide percent:_____% OR flat dollar amount: $_____Per

Will any portion of disability premiums be funded by pre-tax employee contributions? ☐ Yes ☐ No

This employer is a government employer exempt from FICA or a portion of FICA. ☐ Yes ☐ No

Employees of this employer are eligible for RRTA (Railroad Retirement Tax). ☐ Yes ☐ No

NOTE: Disability caused by or under certain circumstances will not be covered. Refer to each policy to determine specific coverage, exclusions, and limitations.

6. WINGSPAN℠ CAFETERIA PLAN

Please consult with employer's cafeteria plan contact to ensure accurate completion of the next section.

☐ **New Wingspan℠ Cafeteria Plan**

☐ **Wingspan℠ Cafeteria Plan Change Request**

☐ **Requesting Additional Payroll Account Number for Existing Wingspan℠ Cafeteria Plan**

Plan/Company Name:	Tax ID:

Plan Type: ***What type of cafeteria plan will this be? (FSA = Flexible Spending Account)***

☐ Premium Only – no FSAs ☐ Self-Administered with FSAs (employer processes FSA claims)

Plan Year: What are the dates of this plan?

Plan Start Date:_____/_____/_____Plan End Date:_____/_____/_____

Plan Sponsor/Legal Representative: ***List the plan sponsor and legal representative for this cafeteria plan.***

Plan Sponsor/Principal Contact:	Email address:
Phone:	Fax:
Legal Representative's Name:	Title:

Account Name: _____

Tax ID: _____ Group No.: _____ Writing No.: _____

Is this a leasing company or professional employee organization (PEO)? ☐ Yes ☐ No

Business Type: ☐ Corporation ☐ Sub S Corporation ☐ Partnership ☐ Sole Proprietorship
☐ Other _____

Eligibility: Indicate eligibility criteria (e.g., eligibility dates, exceptions) for your cafeteria plan.

Employees will become eligible:
- ☐ Immediately upon the first day of employment.
- ☐ On the _____ day following commencement of employment.
- ☐ On the first day of the month following _____ days of employment.
- Other _____

All employees will be eligible under the plan except: _____

☐ **Authorization to Add Benefits Mid-Year (Complete if adding benefits to a Wingspan℠ cafeteria plan at mid-year.)**

Effective Start Date of Additional Benefits: _____/_____/_____

Cafeteria Plan Benefits: (To add, account must be qualified under Section 106 of the Internal Revenue Code.)

Check plans to add:

- ☐ Medical
- ☐ Short-Term Disability
- ☐ Dental
- ☐ Personal Sickness Indemnity
- ☐ Long-Term Disability
- ☐ Accident
- ☐ Group Term Life
- ☐ HSA (Section 223)
- ☐ Vision Care
- ☐ Cancer
- ☐ Specified Health Event
- ☐ Intensive Care
- ☐ Hospital Indemnity

Affiliated Companies: List the names and tax ID numbers of all affiliated companies adopting this plan.

Company Name:	**Tax Identification Number:**

7. SELF-ADMINISTERED FLEXIBLE SPENDING ACCOUNT INFORMATION

(not applicable to Premium-Only Plans)

FSA Type: ***Which types of FSAs will be included in this cafeteria plan? (Complete for self-administered plans.)***

☐ Section 105: Unreimbursed medical expense annual maximum per participant requested by employer: $ _____
- ☐ Check to include Grace Period option for this benefit.

☐ Section 129: Dependent child care annual maximum per participant cannot exceed $5,000 by law.
- ☐ Check to include Grace Period option for this benefit.

8. OTHER CARRIER'S (NOT WINGSPAN℠ CAFETERIA PLANS) CAFETERIA PLAN INFORMATION

Please consult with employer's cafeteria plan contact to ensure accurate completion of next section.

Current plan year dates required: ____/_____/_____ through _____/_____/_____

Renewal dates required: _____/_____/_____ through _____/_____/_____

☐ **Authorization to Add Benefits Mid-Year (Complete ONLY if adding benefits to a non-Wingspan℠ cafeteria plan at mid-year.)**

Effective Start Date of Additional Benefits: _____/_____/_____

Benefits (check new benefits to be added):

- ☐ Medical
- ☐ Short-Term Disability
- ☐ Dental
- ☐ Personal Sickness Indemnity
- ☐ Long-Term Disability
- ☐ Accident
- ☐ Group Term Life
- ☐ HSA (Section 223)
- ☐ Vision Care
- ☐ Cancer
- ☐ Specified Health Event
- ☐ Intensive Care
- ☐ Hospital Indemnity

Account Name: _____

Tax ID: _____ Group No.: _____ Writing No.: _____

9. AUTHORIZATION AND SIGNATURES – EMPLOYER

Aflac assures you that you will be reimbursed without question for premium you advance for any employee who terminates after the premium is remitted but before payroll deductions commence. Aflac also agrees to hold you harmless from any claims against you due to any disagreements between your employees and our company with respect to the coverage provided under our insurance policies issued to your employees, except where caused by misconduct or negligence committed by you or any of your employees or violations of your responsibilities under state or federal laws.

The employer agrees to provide Aflac (and its agents) with certain personally identifiable information (including but not limited to compensation, Social Security numbers, addresses, etc.) regarding its officers and employees for Aflac (and its agents) to use in the administration of employer's cafeteria (including health and dependent care FSA) plan, and Aflac products and services.

Aflac is authorized to offer this insurance program to our officers and employees. I understand that all applicants must qualify for coverage based on each product's underwriting requirements and that payments for such coverage will be deducted from wages and remitted by my organization to Aflac. An Aflac representative will be given the opportunity to meet with only verified W2 employees of your business or eligible 1099 contractors.

The paragraph below only applies if establishing a Wingspan℠ cafeteria plan:

The employer plans to establish/amend a flexible benefits plan in accordance with Section 125 of the Internal Revenue Code. The employer acknowledges that neither Aflac nor its agents are providing legal or tax advice, nor serving as the plan administrator or a plan fiduciary under the plan. The employer shall be the sole party responsible for establishment of the plan under applicable law. Aflac shall have no power or authority to waive, alter, breach, or modify any terms and conditions of the plan. The employer shall retain all responsibility and liability for the plan, except as may otherwise be specifically agreed to in writing by an officer of Aflac. The plan sponsor/administrator should consult its own tax advisor regarding the plan and any changes to the plan. The employer acknowledges receipt of the Summary of Plan Sponsor Responsibilities and agrees to fulfill its responsibilities as stated therein.

Authorizing Officer's Name/Title *(please print)*: ☐ **Mr.** ☐ **Ms.**

Authorizing Officer's Email Address:

Authorizing Officer's Signature: **Date:**

Account Name: _____

Tax ID: _____ Group No.: _____ Writing No.: _____

10. BROKER INDICATOR INFORMATION ONLY

(This section is used for tracking purposes only and does not cause business to pend. This section should contain the writing number of the brokerage firm or producer responsible.)

Broker's Company Name:

Servicing Broker's Name:

Servicing Broker's Writing Number:	**Employee ID No.:**

11. BROKER SECURITY/BLOCK

(This section is to be used only if the broker is going to be compensated via override/sit. code.)

Broker's Name:

Broker's Writing Number:	**Sit. Code:**	**Level:**

☐ **Check here if there is no broker involved in this account.**

12. ASSOCIATE/AGENT

I acknowledge that Aflac has the sole and absolute right to determine who shall solicit and service payroll deduction accounts, and Aflac may assign and/or reassign any account for servicing and designate who may solicit applications from persons in the account. I confirm that I am not an employee, officer, director, owner, or relative of any of the foregoing (or otherwise a party in interest as defined under ERISA). I acknowledge that, for Key Accounts as defined in the Key Account Management Procedures, the proper guidelines will be followed to provide the most efficient service to the account. I confirm that I will register any such account with Key Account Management, regardless of whether I use their assistance in the overall management and coordination of the enrollment. I understand that I am not authorized to collect premium from this account without specific written approval from Aflac.

Associate's/Agent's Signature: **Date:**

Associate's/Agent's Name

Writing Number:	**Sit. Code:**	**Geographical Code:**

Phone Number:	**Fax Number:**

Did you obtain the account through a competitive takeover? ☐ **Yes** ☐ **No**

If yes, list the competitor(s) involved: _____

Note: A competitive takeover is when an existing voluntary carrier is already working with the account and the decision-maker decides to switch to Aflac.

Account Name: _____

Tax ID: _____ Group No.: _____ Writing No.: _____

AFFILIATE NAME	TAX ID	AFFILIATE NAME	TAX ID

Account Name: _____

Tax ID:_____Group No.:_____Writing No.: _____

Group Short-Term Disability Insurance

Number of Eligible Employees at Company:	Participation Requirements (%):

(A minimum of 30% participation is required for all eligible employees.)

Guaranteed-Issue Only:

Benefit Amount	$
Elimination Period (Injury/Sickness)	
Benefit Period	

Simplified-Issue Only:

Benefit Amount	$
Elimination Period (Injury/Sickness)	
Benefit Period	

Group Short-Term Disability Approval Date:_____/_____/_____

Group Short-Term Disability Withdrawal Date: _____/

_____/ _____

Dental Requirements

Dental Plan Start Date:_____/_____/_____

Dental Plan Stop Date:_____/_____/ _____

Number of Eligible Employees for Dental at Company:	Participation Requirements:

Long-Term Care Requirements

Long-Term Care Plan Start Date:_____/_____/_____

Long-Term Care Plan Stop Date:_____/_____/ _____

Revised Personal Short-Term Disability

Exempt From Standard Salary Income Chart: _____

Accident/Disability Revised Income Replacement

Exempt From Standard Salary Income Chart: _____