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

Nonpayroll Insurance Program Acknowledgment

All applicable sections must be completed for processing.

INSTRUCTIONS

- **The Authorization and Signatures section must be completed for ALL accounts.**
- **If completed on paper, fax the completed form to 1.866.AFL.NASA (1.866.235.6272).**

1. GENERAL INFORMATION

A. ☐ Changes/Additions to an Existing Aflac Nonpayroll Account – Account Number: _____
B. ☐ New Aflac Nonpayroll Account
- ☐ Association
- ☐ Credit Union (ACH/Draft only)
- ☐ Labor Union
- ☐ Employer Account (Accounts that want a bill but do not qualify for payroll rates)
- ☐ Employee Direct Bill (*W-2 employees only*)

C. **Bill Form:** ☐ Invoice Account (List Bill)
- ☐ Paper Invoice ☐ Online Billing
- ☐ Aflac premium will be deducted from one of the following:
  - ☐ Credit Union Account ☐ Association or Union Dues
  - ☐ Wages ☐ Other: _____
- ☐ Direct Bill Policyholder
- ☐ ACH/Draft (Credit Union only): ACH Routing Number: _____
  - ☐ Checking ☐ Savings ☐ Both

D. Name of Employer/Organization: _____
Nature of Employer/Organization: _____ Tax ID No.: _____

E. Web Address of Employer/Organization (*if applicable*): _____

F. Industry Classification: ☐ A ☐ B ☐ C ☐ D ☐ E Internet Request No: _____

G. 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 No. Employees/Members: _____

American Family Life Assurance Company of Columbus
Worldwide Headquarters ● 1932 Wynnton Road ● Columbus, Georgia 31999
1.800.992.3522 ● aflac.com

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

1. GENERAL INFORMATION (Cont'd)

Is there an established New York nonpayroll account? ☐ Yes ☐ No

If yes, provide name and account number: Name: _____ Acct. No. _____

H. Is this a multi-location (MLA) account? ☐ Yes ☐ No

I. What led to your organization's making Aflac insurance policies available to employees/members? (*Check all that apply*.)

☐ Benefits advisor or broker recommendation ☐ Benefits package improvement
☐ Employee/member request ☐ Commercial advertising
☐ Sales associate/agent ☐ Value of Aflac products
☐ Other:_____

2. ENROLLMENT INFORMATION

A. **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*): _____

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

C. **Enrollment Platform Name** (if applicable): _____

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

3. ACCOUNT CONTACT INFORMATION

Contact Name: ☐ Mr. ☐ Ms. _____

Contact Phone: (_____) _____ Ext.: _____

Best Time to Call: _____ (a.m. or p.m.) Best Day to Call: _____

Fax (if applicable): (_____) _____

Contact Email: _____

NOTE: Aflac will contact the person listed above to review account information, if applicable.

4. PREMIUM PAYMENT AND BILLING INFORMATION (Complete only if requesting an invoice or electronic billing.)

A. **Initial deduction: When will premiums begin?**

Date of first premium payment: ____/____/____

B. **Invoice due date: Would you like your first Aflac invoice to be due on the 1st or the 15th of the month?**

☐ 1st ☐ 15th

C. **Billing frequency: How often would you like to receive your invoice from Aflac?**

☐ Monthly (12 invoices)
☐ Quarterly (4 invoices)
☐ Semiannually (2 invoices)
☐ Annually (1 invoice)

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

D. **Organization contributions: Does the organization pay any portion of the benefit?**

☐ Yes ☐ No If yes, please provide percent: _____% **OR** flat dollar amount: $_____

Aflac herein means American Family Life Assurance Company of Columbus.

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

5. **AUTHORIZATION AND SIGNATURES**

A. **The following applies only to Direct Bill Accounts with payroll rates**

Aflac agrees to hold Employer/Organization harmless from any claims against Employer/Organization due to any disagreements between your employees/members and our Company with respect to the coverage provided under our insurance policies issued to your employees/members except where caused by misconduct or negligence committed by Employer/Organization or violations of Employer/Organization's responsibilities under state or federal laws.

- The Employer/Organization authorizes and agrees to provide Aflac (and its agents) with certain information (including but not limited to employee/member census data, compensation, addresses, employment status, including information regarding any employees who are not working full time, etc.) about employees/members, when required, for Aflac (and its agents) to use in the one-on-one enrollment of Aflac products and services.
- The Employer/Organization authorizes and agrees to allow Aflac Associates to see all employees/members one-on-one at the worksite to offer products and take applications.
- Products will only be offered to active W-2 employees/members of Employer/Organization, subject to underwriting, and do not include retirees or 1099 workers. Employer/Organization will confirm that each employee/member is an active employee/member at the time of application.
- Aflac products are individually-issued policies and are individually underwritten. Some Aflac products may not be available.
- Either Employer/Organization or Aflac may terminate this agreement without cause or reason by giving 60 days' prior written notice. Employer/Organization is subject to periodic monitoring to ensure that all conditions have been met.
- Completed and signed applications must be received by Aflac and approved before a policy will be issued.
- Aflac policies issued to the employees/members of Employer/Organization will be paid on an after-tax basis by the employees/members through credit card or bank draft billing.

The undersigned agrees with the above statements and authorizes Aflac to offer this insurance program to our employees or members, as indicated above, in accordance with the above terms and conditions. I understand that all applicants must qualify for coverage based on the above product's underwriting requirements.

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

Authorizing Officer's Signature: _____Date: _____

B. **The following applies only to Association Accounts**

Please complete the following questions (**Not applicable for employer accounts**):

- Has the organization been in existence for at least two years? ☐ Yes ☐ No
  What was the charter date? _____
- Does the organization have a constitution and bylaws? ☐ Yes ☐ No
- Does the organization have at least 50 dues-paying members? ☐ Yes ☐ No

For accounts with fewer than three policies or for those accounts that answer no to any of the questions above, Online Billing or Direct Bill Policyholder must be chosen on Page 1.

The undersigned agrees with the above statements and authorizes Aflac to offer this insurance program to our employees or members, as indicated above, in accordance with the above terms and conditions. I understand that all applicants must qualify for coverage based on the above product's underwriting requirements.

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

Authorizing Officer's Signature: _____Date: _____

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

5. **AUTHORIZATION AND SIGNATURES (Cont'd)**

C. **The following applies only to Invoice or Electronic Billing Accounts**

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

- The Employer/Organization will deduct and remit to Aflac all premiums due, making adjustments for benefit and other changes.
- The Employer/Organization is not entitled to make any offset, recoupment, or any deduction whatsoever from Aflac premiums.
- Unassigned funds or funds that have no active policy must be promptly returned to the member.
- The Employer/Organization agrees to allow Aflac to audit its performance of the obligations imposed hereunder. Aflac's audit rights may include but not be limited to the authority to access, review, and copy billing records, deduction registers, bank, and other records that relate to Aflac's policies, or the deduction of all insurance premiums.
- The Employer/Organization is not entitled to charge for or collect from any member or Aflac policyholder any fees, expenses, or other compensation for deducting and remitting Aflac premiums.
- The Employer/Organization is solely responsible for ensuring its compliance with applicable state and federal laws, including applicable ERISA and third-party administrator laws, in connection with the Employer's/Organization's obligations hereunder and shall indemnify and hold Aflac harmless from any breach thereof.
- The Employer/Organization is authorized and 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 members, when required, for Aflac (and its agents) to use in the administration of Aflac products and services, and otherwise in accordance with Aflac's then-current privacy policy.
- If this coverage is provided through an Association, the Association represents that each individual for whom it deducts and remits premiums to Aflac will be an active member of the Association in accordance with its written charter and bylaws.

The undersigned agrees with the above statements and authorizes Aflac to offer this insurance program to our employees or members, as indicated above, in accordance with the above terms and conditions. I understand that all applicants must qualify for coverage based on the above product's underwriting requirements.

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

Authorizing Officer's Signature: _____Date: _____

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

5. **AUTHORIZATION AND SIGNATURES (Cont'd)**

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: _____

Broker's Name: _____

Broker's Writing Number: _____ Employee ID No.: _____

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

Servicing Broker's Name: _____

Servicing Broker's Writing Number: _____ Sit Code: _____ Level: _____

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

ASSOCIATE/AGENT

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

Associate's/Agent's Name: _____

Writing Number: _____ Sit. Code: _____ Geographical Code: _____

Phone Number: ( ) _____ Fax Number: ( ) _____

I acknowledge that Aflac has the sole and absolute right to determine who will solicit and service accounts, and that Aflac may assign and/or reassign any account for servicing and designate who may solicit applications from persons in the account. I understand that I am not authorized to collect premium from this account without specific written approval from Aflac.