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, the Authorization and Signatures section.
- Accounts establishing or modifying a Flex One® cafeteria plan or offering an Aflac Now Card℠ must complete Sections 5 & 6.
- Accounts with another carrier's cafeteria plan must complete Section 7.
- Broker Information must be completed in Section 9
- Fax 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:** _____

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, submit a list of the policies on a separate page with the Payroll Account Acknowledgment to Aflac WWHQ.)

Name of Account: _____

Type of Business: _____Tax ID No.: _____

Industry Classification (Contact SIC Team for correct classification.): ☐A ☐B ☐C ☐D ☐E 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 No. of Employees: _____

Total No. of W2 Employees: _____Total No. of 1099 Workers: _____ Will 1099 workers be applying for coverage? ☐Yes ☐No

If 1099 workers are applying for coverage, submit an exception request for payroll rates to WWHQ on Form ***IN-02-05*** *prior to writing the business.*

Account Web Site Address *(if applicable)*: _____

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 *so, has this been approved by Sales Support?* ☐Yes ☐No

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

If yes, provide name and group number: _____

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 ☐ Aflac Products Are a Good Value ☐ Other: _____

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

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

2. BILLING INFORMATION

2a. 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 Online Billing system. As an Online Billing account, 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 when due 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)*: ( ) _____

Billing Contact E-Mail *(required)*: _____

2b. BILLING FREQUENCIES

Invoice Due Date: On what day of the month would you like your Aflac invoice to be due (1st or the 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.
Example: Deductions made January 1st through the 31st will be due in February.)

☐ 8-Month *(8 invoices)*
☐ 9-Month *(9 invoices)*
☐10-Month *(10 invoices)*
For 8-, 9- or 10-month, indicate months when no deductions will be made:
☐Jan ☐Feb ☐Mar ☐Apr ☐May ☐Jun ☐Jul ☐Aug ☐Sep ☐Oct ☐Nov ☐Dec

☐ Quarterly *(4 invoices)*
☐ Semiannually *(2 invoices)*
☐ Annually *(1 invoice)*
For Quarterly, Semiannually, and Annually, initial premiums must be submitted with applications.

2c. 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___ ☒ Dept. No. ____1____ ☐ Employee No. _____

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

3. 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 monthly billing frequency, indicate the number of payroll deductions made annually for insurance premiums: 52 ☐ 26 ☐ 24 ☐ 12☐.

☐ 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 on separate M-0138 applications.

Initial Deduction: *When will premium deductions begin?*

Date of first deduction: _____/_____/_____ Date of second deduction: _____/_____/_____

The date of the first deduction should reflect the date the payroll account physically obtains funds from the employees. It does not necessarily equal the pay date for the employees.

4. 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. 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 paid, from which the employee's portion of FICA taxes is withheld 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: $ _____
Percent or dollar amount must be a whole number, such as "50%" or "$10."

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 exempt from 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.

Account Name: _____

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

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

5. FLEX ONE® CAFETERIA PLAN:

☐**New Flex One Plan** ☐**Flex One Plan Change Request**

☐**Requesting Additional Payroll Account Number for Existing Flex One**

Plan/Company Name: _____ **Tax ID:** _____

Plan Type: ***What type of Flex One Plan will this be? (Flexible Spending Account = FSA)***
☐Premium Only – no FSAs ☐Self-Administered – has FSAs; employer processes FSA claims ☐Full – has FSAs; Flex One 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: _____E-mail address: _____

Phone: **( )** _____ Fax: **( )** _____

Legal Representative's Name/Title: _____

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: _____

Cafeteria Plan Benefits: *(**To add**, account must be qualified under Section 106 of the Internal Revenue Code.)*
Check plans to add:
☐ Medical ☐ Long-Term Disability ☐ Vision Care ☐ Intensive Care ☐ Short-Term Disability ☐ Accident
☐ Cancer ☐ Hospital Indemnity ☐ Dental ☐ Group Term Life ☐ Specified Health Event ☐ Personal Sickness Indemnity
☐ HSA (Section 223)

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

Company Name	*Tax Identification Number*

6. FLEXIBLE SPENDING ACCOUNT (FSA) INFORMATION (*not applicable to Premium-Only Plans)*

FSA Type: ***Which types of FSAs will be included in this cafeteria plan? (Complete for both self-administered and full plans.)***
☐ Section 105: Unreimbursed medical expense annual maximum per participant requested by employer: $ _____
☐ Select to include Grace Period option for this benefit.
☐ Section 129: Dependent child care annual maximum per participant cannot exceed $5,000 by law.
☐ Select to include Grace Period option for this benefit.

Medical Plan Copay Information: (Complete this section *only* if participating in unreimbursed medical.)
This information may be used to assist in adjudicating employee unreimbursed medical claim requests. Please select all copay amounts below that apply to your company's medical benefit plan(s).
Doctor/Office Visit Copays:
☐$5 ☐$10 ☐$15 ☐$20 ☐$25 ☐$30 ☐$35 ☐$40 ☐$45 ☐Other $___.__ ☐Other $___.__
Pharmacy/Rx Copays:
☐$5 ☐$10 ☐$15 ☐$20 ☐$25 ☐$30 ☐$35 ☐$40 ☐$45 ☐Other $___.__ ☐Other $___.__

Complete account type only if Full Plan is selected in Section 5.
Account Type: ***If you selected Flex One to process your FSA claims, you must establish an account from which Flex One will draw funds for claim payments. No banking option is required for self-administered plans.***
☐ **Local Zero Balance Account:** You establish a local bank account against which Flex One is authorized to write checks for the sole purpose of paying participant claims. With this option, reimbursements can be issued **within 2–3 business days.**
☐ ***Aflac Now Card℠ (Check to include FSA payment card feature).***
☐ **ACH Debit:** You authorize Flex One to initiate funds transfers from a specified bank account for the sole purpose of paying participant claims. With this option, reimbursements can be issued **within 5–7 business days.** The Aflac Now card is not available with this option.
☐ **Self-Pay:** Upon notification by Flex One, you issue reimbursement checks to participants. Reimbursements are issued according to **your** time frame because you are responsible for disbursement. Direct Deposit is not available through Flex One with this payment option. The Aflac Now card is not available with this option.
*Please note that the time frame for the issuance of reimbursements is subject to the processing schedule chosen by the employer and the **employer's response time** for funding payment amounts.

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

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

7. OTHER CARRIER'S (not FLEX ONE®) CAFETERIA PLAN INFORMATION

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

If short plan year, renewal dates required: _____ / _____ / _____ through _____ / _____ / _____

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

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

Benefits (check new benefits to be added):

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

8. 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.

☐ **Check if Establishing Flex One Account:** 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 Signature: _____ **Date:** _____

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

9. BROKER INFORMATION

Broker's Company Name: _____

Broker's Name (Producer name if applicable): _____

Corporate Writing Number: _____

Employee ID # (This field is only applicable if a broker relationship manager or non-commissioned representative (i.e. Consultant) is assigned to this account): _____

Broker Writing Number: _____ **Sit Code:** _____ **Level:** _____

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

10. 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 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.

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 percent 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:_____