**OSOI**

## Consolidated AFLAC Supplemental Benefits Enrollment Form

**Employee Name:**_____

**Employee SSN:**_____ **Employee Date of Birth:** _____

**Employee Gender:**_____ **Employee Date of hire:** _____

## Dependent Information

| Name | DOB | Gender | SSN |
|---|---|---|---|
| Spouse: _____ | ___/___/___ | ☐ M ☐ F | _____-_____-_____ |
| Child: _____ | ___/___/___ | ☐ M ☐ F | _____-_____-_____ |
| Child: _____ | ___/___/___ | ☐ M ☐ F | _____-_____-_____ |
| Child: _____ | ___/___/___ | ☐ M ☐ F | _____-_____-_____ |
| Child: _____ | ___/___/___ | ☐ M ☐ F | _____-_____-_____ |
| Child: _____ | ___/___/___ | ☐ M ☐ F | _____-_____-_____ |
| Child: _____ | ___/___/___ | ☐ M ☐ F | _____-_____-_____ |

## Benefit Selection

**Short Term Disability: What Elimination Period?** _____ **What Monthly Benefit?** _____
**What Benefit Period?** _____
**Cancer Protection** ☐ **Employee Only** ☐ **Employee Spouse** ☐ **Employee Child/ren** ☐ **Family**
**Which Plan Level?** _____
**Accident Protection** ☐ **Employee Only** ☐ **Employee Spouse** ☐ **Employee Child/ren** ☐ **Family**
**Which Plan Level?** _____
**Critical Illness Protection** ☐ **Employee Only** ☐ **Employee Spouse** ☐ **Employee Child/ren** ☐ **Family**
**Which Plan Level?** _____

**I choose to Waive Supplemental Coverage**……. _____
Initial

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**Signature:** _____ **Date:** _____/_____/_____