EMPLOYEE BENEFITS ELECTION FORM

Name: Last _____ First _____ Middle _____ DOB _____/_____/_____

Spouse: Last _____ First _____ Middle ____ DOB _____/_____/_____

Add Dependents (Circle One) Yes / N o **If Pre Tax** SS#_____

Gender: Male / Female Date of Hire: _____

Address _____ State _____ Zip _____

Phone Number ( ) _____ Email Address _____

Beneficiary (more than 1, write on back of this page) Name _____ Relationship _____ Cell# _____

_____I am interested in (**CIRCLE OPTION BELOW)** **_____** I am not interested in coverage at this time

Lincoln Financial Group		After Tax Bi-Weekly ***26 DEDUCTIONS***
Short Term Disability	Individual	

AFLAC *Group*					Pre-Tax Semi-Monthly ***24 DEDUCTIONS***	After-Tax Semi-Monthly ***24 DEDUCTIONS***
Accident	Individual	Ind. & Spouse	1 Parent Family	2 Parent Family		
Hospital Indemnity	Individual	Ind. & Spouse	1 Parent Family	2 Parent Family		
Critical Illness	Individual	Ind. & Spouse	1 Parent Family	2 Parent Family		
Whole Life	Individual	Ind. & Spouse	1 Parent Family	2 Parent Family		

AFLAC *Traditional*					Pre-Tax Semi-Monthly ***24 DEDUCTIONS***	After-Tax Semi-Monthly ***24 DEDUCTIONS***
Cancer	Individual	Ind. & Spouse	1 Parent Family	2 Parent Family		
	Individual	Ind. & Spouse	1 Parent Family	2 Parent Family		
	Individual	Ind. & Spouse	1 Parent Family	2 Parent Family		

*** This is NOT an application for coverage. An application for coverage from the desired carrier must be completed and submitted to the company.** This form may be used to verify and provide deduction authorization**.**

Signature _____ Date _____