



AFLAC BENEFITS INTEREST SURVEY

Name: _____ DOB: _____ Sex: _____
LAST FIRST M MONTH/DAY/YEAR

Email: _____ Job Desc. _____ Children Yes No

Address: _____ City: _____ State: _____ Zip Code: _____
Cell Home
Phone# Phone# Fax#

Spouse's Name: _____ DOB: _____ Sex: _____
LAST FIRST M MONTH/DAY/YEAR

Beneficiary: _____ Relationship: _____ DOB: _____ City/State: _____

Personal Accident Indemnity Advantage () EMPLOYEE () EMPLOYEE + SPOUSE
(Our #1 plan to help with expenses after any Accident) () EMPLOYEE + CHILDREN () EMPLOYEE + FAMILY

Cancer Maximum Difference Plan () EMPLOYEE () EMPLOYEE + SPOUSE
(Helps with the financial catastrophe of a Cancer diagnosis) () EMPLOYEE + CHILDREN () EMPLOYEE + FAMILY

\$30,000 Lump Sum Critical Illness Plan () EMPLOYEE () EMPLOYEE + SPOUSE
Heart - Stroke-Coma-Transplant Etc. () EMPLOYEE + CHILDREN () EMPLOYEE + FAMILY

Hospital Protection Plan () EMPLOYEE () EMPLOYEE + SPOUSE
() EMPLOYEE + CHILDREN () EMPLOYEE + FAMILY

Short Term Disability Advantage Salary: _____ (EMPLOYEE ONLY) 3 mo / 6 mo / 12 mo / 24 mo

Aflac Life Tobacco Use? _____ () EMPLOYEE () EMP + SPOUSE () EMP + CHILDREN () EMP + FAMILY

If interested in any of the plans listed above email Interest Survey to carol.boyd@redriversystems.com or fax to 214-446-3301

After receiving Aflac Benefits Interest Survey Mickey Shuler, our Aflac Agent, will contact you to discuss your plan choices/pricing prior to completion of an insurance application. Additional forms will be required to confirm Pre-Tax and After-Tax selections.