Print Form | Clear Form

AFLAC Enrollment Form

Last Name	M.I.	First Name	Social Security #	Employee ID	D.O.B.	Gender

Home Address (Number, Street, Apt #)	City	State	Zip Code	Mail Station

Home Phone	Work Phone	Fax

Home E-mail	Work E-mail

Plan Selection			Payroll Deduction		Flex	Effective Dates	
Type	Plan/Level	Monthly	Post Tax	Pre Tax	Annual Value	Policy	Deduction
Accident							
Cancer							
Hospital							
Intensive Care							
Specified Health							
Life							
Total							

I authorize the above listed payroll and/or flex deductions listed above.

Signature: _____ **Date:** _____

Please Return Forms to: MEA Benefits Department: Fax 619-923-1700 | E-mail: Benefits@sdmea.org
Phone 619-677-3952 | P.O. Box 34547 San Diego, CA 92163-4547 | MS 74