Affac. PREMIUM DEDUCTION AUTHORIZATION/WAIVER OF PARTICIPATION

Employee's name WADE JEFF					
Last First	MI	Dept. No.			
SSN/Emp. ID XXX XX 5738		Location			
hereby authorize my employer:	Date of first deduction 2022-11-04				
WADE S HAULING		Deduction Mode ≤ Weekly	_ Biweekly _ S	emmonthly _ N	fonthly
my earnings such amounts as may now or hereafter under the insurance plan purchased through Aflac. In the change, I authorize a corresponding change in the amount earnings.	the event of a rate unt deducted from	☐ Return of	ss		NEW AFTER-TAX PRE-TAX S
In addition, I understand that any pre-tax elections can revoked prior to the next plan anniversary date, unless a family status and permitted by my employer.	Premium Rider Dental Vision Hospital Intensive	S		\$ \$ \$	
Signature of ELECTRONICALLY SIGNED BY JEFFERY A WADE Applicant	Care Specified Health Event	\$	_	\$	
WAIVER OF PARTICIPATION I certify that the features and benefits of Aflac's guaranteed-renewable insurance policies have been explained to me completely. I understand that these policies are offered through my employer by payroll deduction. I am NOT currently an Aflac policyholder and have decided to waive my opportunity to participate at this time. I am currently an Aflac policyholder and have decided not to upgrade to any newer policies at this time.		 ✓ Hospital Confinement Indemnity ✓ Accident 	\$		\$ 20.67
		☐ Disability Rider	\$		\$ 9.42
		☐ Short-Term Disability			\$
		Employee Dependent			\$
		TOTAL			\$ 45.84
EMPLOYEE'S SIGNATURE DATE		The amount of deduction and frequency thereof shall be determined by my employer and base on a plan that will comply with the payment checked above.			d by my employer and based
Insurance Agent/Producer KEITH O'TOOLE	Date 2022-10-15	Insurance Agent/Producer's Writing No. Insurance Agent/Producer's Phon AHW51 3074137774			AND THE RESERVE OF THE PARTY OF

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Afrac.	PREMIUM	DEDUCTION	AUTHORIZATION/WAIVER	OF	PARTICIPATIO
mirac.	PREMIUM	DEDUCTION	AUTHORIZATION/WAIVER	OF	PARTICIPAT

Employee's name WADE HALE	1				
Last First	M	Dept. No.			
SSN/Emp. ID XXX XX 3368		Location			
hereby authorize my employer:	Date of first deduction 2022-11-04				
WADE S HAULING		Deduction Mode	BiweeklyS	emimonthly _ N	Nonthly
my earnings such amounts as may now or hereafter under the insurance plan purchased through Aflac. In change, I authorize a corresponding change in the among earnings. In addition, I understand that any pre-tax elections can revoked prior to the next plan anniversary date, unless family status and permitted by my employer.	the event of a rate bunt deducted from anot be changed or due to a change in	☐ Other ☐ Cancer/Specified- Disease ☐ Return of Premium Rider ☐ Dental ☐ Vision ☐ Hospital Intensive	\$\$\$	AX PRE-TAX	\$
Signature of ELECTRONICALLY SIGNED BY HALEY WADE Applicant	Care Specified Health	S		\$	
WAIVER OF PARTICIPATION I certify that the features and benefits of Aflac's guaranteed-renewable insurance policies have been explained to me completely. I understand that these policies are offered through my employer by payroll deduction.		 ✓ Hospital Confinement Indemnity ✓ Accident 	\$\$		\$ 8.67 \$ 7.20
		☐ Disability Rider	\$		\$
		☐ Short-Term Disability			\$
I am NOT currently an Aflac policyholder and have decided to waive my opportunity to participate at this time. I am currently an Aflac policyholder and have decided not to upgrade to any newer policies at this time.		Employee	\$		\$
		Dependent	5		\$
		TOTAL			\$ 23.91
EMPLOYEE'S SIGNATURE DATE		The amount of deduction and frequency thereof shall be determined by my employer and basion a plan that will comply with the payment checked above.			d by my employer and based
Insurance Agent/Producer	Date	Insurance Agent/Producer's V	Writing No.	Insurance Agen	Producer's Phone No.
KEITH O'TOOLE	2022-10-15	The second secon			

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Affac. PREMIUM DEDUCTION AUTHORIZATION/WAIVER OF PARTICIPATION

Employee's name COUCH ROBE	RT					
Last First	MI	Dept. No.				
SSN/Emp. ID XXX XX 8611		Location				
hereby authorize my employer:	Date of first deduction 2022-11-04 Deduction Mode ≠ Weekly = Briveskly = Semimonthly = Monthly					
WADE S HAULING ,						
employer Payroll Account No. P0Y60 . to deduct from my earnings such amounts as may now or hereafter be payable by me under the insurance plan purchased through Aflac. In the event of a rate change, I authorize a corresponding change in the amount deducted from		☐ Other ☐ Cancer/Specified-	\$	X PRE-TAX	\$	(PRE-TAX
my earnings. In addition, I understand that any pre-tax elections can	Return of Premium Rider	\$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$		5	8.88	
revoked prior to the next plan anniversary date, unless family status and permitted by my employer.	☐ Dental ☐ Vision			\$		
Signature of ELECTRONICALLY SIGNED BY ROBERT COUCH Applicant	☐ Specified Health					
WAIVER OF PARTICIPATION I certify that the features and benefits of Aflac's guaranteed-renewable insurance policies have been explained to me completely. I understand that these policies are offered through my employer by payroll deduction. I am NOT currently an Aflac policyholder and have decided to waive my opportunity to participate at this time. I am currently an Aflac policyholder and have decided not to upgrade to any newer policies at this time.		Event Hospital Confinement Indemnity Accident	\$\$		\$	8.76 13.56
		☐ Disability Rider	\$		\$	
		☑ Short-Term Disability ☐			\$ 3.75	
		Employee Dependent			\$ \$	-
		TOTAL	\$		\$ 3.75	31.20
EMPLOYEE'S SIGNATURE DATE		The amount of deduction and frequency thereof shall be determined by my employer and bai on a plan that will comply with the payment checked above.				erand based
Insurance Agent/Producer	Date	Insurance Agent/Producer's	Writing No. In	surance Agent	/Producer's P	hone No
EMILY TAGG	2022-10-26				risitorio.	

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Affac. PREMIUM DEDUCTION AUTHORIZATION/WAIVER OF PARTICIPATION

Employee's name THOMPSON WILLIA	MA				
Last First	M	Dept. No.			
SSN/Emp. ID XXX XX 6247		Location			
hereby authorize my employer:	Date of first deduction 2022-11-04				
WADE S HAULING		Deduction Mode 👱 Weekly		ily Monthly	
employer Payroll Account No. P0Y60 my earnings such amounts as may now or hereafter under the insurance plan purchased through Aflac. In change, I authorize a corresponding change in the amo my earnings.	the event of a rate	☐ Other ☐ Cancer/Specified- Disease ☐ Return of	\$\$	NEW AFTER-TAX PRE-TAX \$ \$ 15.84	
In addition, I understand that any pre-tax elections can revoked prior to the next plan anniversary date, unless family status and permitted by my employer.	☐ Return of Premium Rider ☐ Dental ☐ Vision ☐ Hospital Intensive	\$ \$ \$	\$ \$ \$		
Signature of ELECTRONICALLY SIGNED BY WILLIAM L THOMPSON Applicant	Date 2022-10-15	Care Specified Health	\$\$		
WAIVER OF PARTICIPATION I certify that the features and benefits of Aflac's guaranteed-renewable insurance policies have been explained to me completely.		☐ Hospital Confinement Indemnity ☐ Accident	\$\$	\$ 13.14	
		Disability Rider	\$		
I understand that these policies are offered through payroll deduction.		☐ Short-Term Disability ☐☐		\\$	
 I am NOT currently an Aflac policyholder and have decided to waive my opportunity to participate at this time. I am currently an Aflac policyholder and have decided not to upgrade to any newer policies at this time. 		Employee Dependent	\$ \$		
		TOTAL	\$	\$ 28.98	
EMPLOYEE'S SIGNATURE DATE		The amount of deduction and frequency thereof shall be determined by my employer and bas on a plan that will comply with the payment checked above.			
Insurance Agent/Producer	Date	Insurance Agent/Producer's	Writing No. Insurance	e Agent/Producer's Phone No.	
KEITH O'TOOLE	2022-10-15	and the same of th		3074137774	

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