Aflac. PREMIUM DEDUCTION AUTHORIZATION/WAIVER OF PARTICIPATION

Employee's name WADE (Last) JEFF (First) (MI)

SSN/Emp. ID XXX XX 5738

I hereby authorize my employer: 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 my earnings.

In addition, I understand that any pre-tax elections cannot be changed or revoked prior to the next plan anniversary date, unless due to a change in family status and permitted by my employer.

Signature of Applicant ELECTRONICALLY SIGNED BY JEFFERY A WADE Date 2022-10-15

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.

EMPLOYEE'S SIGNATURE _____ DATE _____

Dept. No. _____

Location _____

Date of first deduction 2022-11-04

Deduction Mode ☑ Weekly ☐ Biweekly ☐ Semimonthly ☐ Monthly

	OLD AFTER-TAX	OLD PRE-TAX	NEW AFTER-TAX	NEW PRE-TAX
☐ Other	$		$	
☑ Cancer/Specified-Disease	$		$ 15.75	
☐ Return of Premium Rider	$		$	
☐ Dental	$		$	
☐ Vision	$		$	
☐ Hospital Intensive Care	$		$	
☐ Specified Health Event	$		$	
☑ Hospital Confinement Indemnity	$		$ 20.67	
☑ Accident	$		$ 9.42	
☐ Disability Rider	$		$	
☐ Short-Term Disability	$		$	
☐ Life				
Employee	$		$	
Dependent	$		$	
TOTAL	$		$ 45.84	

The amount of deduction and frequency thereof shall be determined by my employer and based on a plan that will comply with the payment checked above.

Payroll Account

Insurance Agent/Producer	Date	Insurance Agent/Producer's Writing No.	Insurance Agent/Producer's Phone No.
KEITH O'TOOLE	2022-10-15	AHW51	3074137774

M0083B1 Aflac herein means American Family Life Assurance Company of Columbus • Worldwide Headquarters • Columbus, GA 31999

Aflac. PREMIUM DEDUCTION AUTHORIZATION/WAIVER OF PARTICIPATION

Employee's name WADE (Last) HALEY (First) (MI)

SSN/Emp. ID XXX XX 3368

I hereby authorize my employer: 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 my earnings.

In addition, I understand that any pre-tax elections cannot be changed or revoked prior to the next plan anniversary date, unless due to a change in family status and permitted by my employer.

Signature of Applicant ELECTRONICALLY SIGNED BY HALEY WADE Date 2022-10-15

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.

EMPLOYEE'S SIGNATURE _____ DATE _____

Dept. No. _____

Location _____

Date of first deduction 2022-11-04

Deduction Mode ☑ Weekly ☐ Biweekly ☐ Semimonthly ☐ Monthly

	OLD AFTER-TAX	OLD PRE-TAX	NEW AFTER-TAX	NEW PRE-TAX
☐ Other	$		$	
☑ Cancer/Specified-Disease	$		$ 8.04	
☐ Return of Premium Rider	$		$	
☐ Dental	$		$	
☐ Vision	$		$	
☐ Hospital Intensive Care	$		$	
☐ Specified Health Event	$		$	
☑ Hospital Confinement Indemnity	$		$ 8.67	
☑ Accident	$		$ 7.20	
☐ Disability Rider	$		$	
☐ Short-Term Disability	$		$	
☐ Life				
Employee	$		$	
Dependent	$		$	
TOTAL	$		$ 23.91	

The amount of deduction and frequency thereof shall be determined by my employer and based on a plan that will comply with the payment checked above.

Payroll Account

Insurance Agent/Producer	Date	Insurance Agent/Producer's Writing No.	Insurance Agent/Producer's Phone No.
KEITH O'TOOLE	2022-10-15	AHW51	3074137774

M0083B1 Aflac herein means American Family Life Assurance Company of Columbus • Worldwide Headquarters • Columbus, GA 31999

Aflac. PREMIUM DEDUCTION AUTHORIZATION/WAIVER OF PARTICIPATION

Employee's name COUCH (Last) ROBERT (First) (MI)

SSN/Emp. ID XXX XX 8611

I hereby authorize my employer: 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 my earnings.

In addition, I understand that any pre-tax elections cannot be changed or revoked prior to the next plan anniversary date, unless due to a change in family status and permitted by my employer.

Signature of Applicant ELECTRONICALLY SIGNED BY ROBERT COUCH Date 2022-10-26

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.

EMPLOYEE'S SIGNATURE _____ DATE _____

Dept. No. _____

Location _____

Date of first deduction 2022-11-04

Deduction Mode ☑ Weekly ☐ Biweekly ☐ Semimonthly ☐ Monthly

	OLD AFTER-TAX	OLD PRE-TAX	NEW AFTER-TAX	NEW PRE-TAX
☐ Other	$		$	
☑ Cancer/Specified-Disease	$		$	8.88
☐ Return of Premium Rider	$		$	
☐ Dental	$		$	
☐ Vision	$		$	
☐ Hospital Intensive Care	$		$	
☐ Specified Health Event	$		$	
☑ Hospital Confinement Indemnity	$		$	8.76
☑ Accident	$		$	13.56
☐ Disability Rider	$		$	
☑ Short-Term Disability	$		$	3.75
☐ Life				
Employee	$		$	
Dependent	$		$	
TOTAL	$		$	3.75 31.20

The amount of deduction and frequency thereof shall be determined by my employer and based on a plan that will comply with the payment checked above.

Payroll Account

Insurance Agent/Producer	Date	Insurance Agent/Producer's Writing No.	Insurance Agent/Producer's Phone No.
EMILY TAGG	2022-10-26	AKHQ3	4256145267

M0083B1 Aflac herein means American Family Life Assurance Company of Columbus • Worldwide Headquarters • Columbus, GA 31999

Aflac. PREMIUM DEDUCTION AUTHORIZATION/WAIVER OF PARTICIPATION

Employee's name THOMPSON (Last) WILLIAM (First) (MI)

SSN/Emp. ID XXX XX 6247

I hereby authorize my employer: 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 my earnings.

In addition, I understand that any pre-tax elections cannot be changed or revoked prior to the next plan anniversary date, unless due to a change in family status and permitted by my employer.

Signature of Applicant ELECTRONICALLY SIGNED BY WILLIAM L THOMPSON Date 2022-10-15

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.

EMPLOYEE'S SIGNATURE _____ DATE _____

Dept. No. _____

Location _____

Date of first deduction 2022-11-04

Deduction Mode ☑ Weekly ☐ Biweekly ☐ Semimonthly ☐ Monthly

	OLD AFTER-TAX	OLD PRE-TAX	NEW AFTER-TAX	NEW PRE-TAX
☐ Other	$		$	
☑ Cancer/Specified-Disease	$		$ 15.84	
☐ Return of Premium Rider	$		$	
☐ Dental	$		$	
☐ Vision	$		$	
☐ Hospital Intensive Care	$		$	
☐ Specified Health Event	$		$	
☐ Hospital Confinement Indemnity	$		$	
☑ Accident	$		$ 13.14	
☐ Disability Rider	$		$	
☐ Short-Term Disability	$		$	
☐ Life				
Employee	$		$	
Dependent	$		$	
TOTAL	$		$ 28.98	

The amount of deduction and frequency thereof shall be determined by my employer and based on a plan that will comply with the payment checked above.

Payroll Account

Insurance Agent/Producer	Date	Insurance Agent/Producer's Writing No.	Insurance Agent/Producer's Phone No.
KEITH O'TOOLE	2022-10-15	AHW51	3074137774

M0083B1 Aflac herein means American Family Life Assurance Company of Columbus • Worldwide Headquarters • Columbus, GA 31999