DENTAL ENROLLMENT FORM

Complete only if applying for new Aflac Dental coverage:

Name _____, _____, ____
Last First Initial

Address _____ City _____ ZIP _____

Home phone (_____)_____ Job title/duties _____

SSN# _____ Date of Birth _____ Sex _____

If spouse is to be covered on any Aflac plan(s), please give spouse's name and date of birth.

Spouse's Name _____, _____, ____
Last First Initial

Spouse's date of birth _____ Spouse's SSN# _____

Will dependent child(ren) be covered on any Aflac plan(s)? YES _____ NO _____

Name – Last, First, MI	Date of Birth	Sex	SSN	Check If:
		❑ M ❑ F		❑ Handicapped Child
		❑ M ❑ F		❑ Handicapped Child
		❑ M ❑ F		❑ Handicapped Child
		❑ M ❑ F		❑ Handicapped Child
		❑ M ❑ F		❑ Handicapped Child
		❑ M ❑ F		❑ Handicapped Child
		❑ M ❑ F		❑ Handicapped Child
		❑ M ❑ F		❑ Handicapped Child