

AFLAC Voluntary Benefits Enrollment

General Information

Employer Lake Superior State University				Effective Date 1/1/2027	
Name (Last,First,Middle)				Gender ☒ M ☐ F	
Social Security Number	Birthdate	Hire Date	☐ 24 Pay Deductions		
Address		City	State	Zip	
Phone Number	Email Address		Job Title	Hours Worked Per Week	
☐ New Enrollment ☐ Change In Enrollment		If due to a family status change, enter date			
(REQUIRED) Primary Beneficiary SSN / Full Name / Relationship					

Benefits Elections

Product	Plan	Person(s) to be Covered		Deduction
Critical Illness	☐ \$10,000	☐ Employee Only ☐ Employee + Child(ren)	☐ Employee + Spouse ☐ Employee + Family	\$ _____
	☐ \$20,000			
	☐ \$30,000			
	☐ Waive			
Off the Job Accident	☐ Enroll	☐ Employee Only ☐ Employee + Child(ren)	☐ Employee + Spouse ☐ Employee + Family	\$ _____
	☐ Waive			
Hospital Indemnity	☐ Enroll	☐ Employee Only ☐ Employee + Child(ren)	☐ Employee + Spouse ☐ Employee + Family	\$ _____
	☐ Waive			

Dependent Information

If you are electing coverage for a spouse and/or child(ren) please provide the information below:

Name (Last,First,Middle):	Relationship:	Sex:	Date of Birth:
	Spouse	☐ M ☐ F	
		☐ M ☐ F	
		☐ M ☐ F	
		☐ M ☐ F	
		☐ M ☐ F	
		☐ M ☐ F	

Eligible Dependents = Legal spouses, and dependent children up to the age 26.

Declaration and Signature

ACKNOWLEDGEMENT FOR ELECTIONS: I acknowledge that my elections cannot be changed once the plan year has begun unless there is a change in family status. A change in family status includes: marriage, divorce, legal separation or annulment, death of a spouse or dependent, birth or adoption of a child, placement for adoption, the termination or commencement of employment of the employee, spouse or dependent, the switching from part-time to full-time employment status or the reverse by you or your spouse or the taking of an unpaid leave of absence by you or your spouse. I understand that the benefit options elected above will remain in force unless my family status changes and I notify my HR department within 30 days of the event.

ACCEPTANCE/AUTHORIZATION/ACKNOWLEDGEMENT: I understand that if I have made any material false statement, misrepresentation or omission on this form that I may lose coverage under this plan. I hereby authorize my employer to payroll deduct premiums based upon my elections above.



SIGN HERE

Signature

Print Name

Date