Aflac Group Payroll Account Setup

INSTRUCTIONS

- Complete this form for all new Aflac Group payroll accounts. *(Use the R0138 for re-enrollments)*
- All fields are required unless otherwise noted, please complete prior to submission to the market office.
- Submit completed forms to your **market office** for approval and submission to Aflac Group.
- For additional details regarding Aflac Group Account Setup, please refer Field Force Services>Selling Aflac > Aflac Group page.
- When applicable, all broker information must be completed

Today's Date: _____

1. GENERAL ACCOUNT INFORMATION (Please select only the category and sub-category that apply):

❑ **New Aflac Group Payroll Account**

❑ **Existing Aflac Group Account Changes or G0138 Changes (Not for Re-Enrollments, please complete all fields that are being updated)** Revised Date _____

Name of Account: _____ Market Operation _____

Type of Business: _____ Tax ID No.: _____

Situs State (situs/headquarters/domicile state): _____ Number of Eligible Employees: _____

Mailing Address: _____

City: _____ State: _____ ZIP: _____

Number of Enrollment States: _____ If multi-location account, list states: _____

_____

*Does this account employ residents of Massachusetts? ❑ Yes ❑ No

OSA Name: _____ OSA Writing Number: _____

Is the MLA department at WWHQ being utilized? ❑ Yes ❑ No

If Yes, Contact Name: _____

Broker Involved - ☐ No ☐ Yes (If yes, section 2 is <u>required</u>, please complete all information.)

2. BROKER INFORMATION

❑ Broker is acting as a non-commissioned consultant

Brokerage Company Name: _____ Writing #: _____

Broker's Name (Producer name if applicable): _____

3. ENROLLMENT INFORMATION

<u>Employee Eligibility:</u> Hours per week: _____ Length of employment: _____ (in days)

For multiple eligibility classes, please describe in Special Instructions.

<u>Enrollment Method(s):</u> A) *Licensed Agent Solicited*: ☐ Paper ☐ Third-Party Laptop ☐ Call Center

B) *Not Agent-Solicited*: ☐ Web Self-Enroll ☐ HR/Group Meetings

NOTE: *Third-Party Laptop, Call Center, and Web enrollment methods may result in commission reduction. Refer to the electronic enrollment guidelines on Field Force Services for additional requirements. All vendors must be approved prior to submission of G0138.*

Enrollment Data: ❑ Paper ❑ Electronic File

Employee ID Type *(check only one):* ❑ SSN ❑ Unique EID (applies to both enrollment forms and invoices)

Enrollment Dates: Start: _____ End: _____

Enrollment forms cannot be solicited more than 90 days prior to the coverage/billing effective date. Enrollment forms taken outside the dates specified above will be automatically declined unless they are new hires as noted below.

Coverage/Billing Effective Date: _____

Submission Date (Date enrollment forms will be received by Aflac Group): _____/_____/_____

- *Submit Paper Enrollment within 5 calendar days after enrollment end*
- *Submit Electronic Enrollment within 10 calendar days after enrollment end*

*Proof of Coverage will be mailed to the insured.

Newly Eligible Employees enroll throughout the year? ❑ Yes ❑ No

Enrollment Frequency: ❑ Monthly ❑ Quarterly ❑ Semiannually ❑ Other: _____

Notice to Account of newly eligible employee's deductions?: ❑ Invoice ❑ Electronic data transfer file

Enrollment Method: ❑ Same as for Open Enrollment ❑ Other Method (describe): _____

Enrollment Contacts (Agents must use @us.aflac.com email address)

OSA/Field Contact Name: _____ **State Operation:** _____

Address: _____

City: _____ State: _____ ZIP Code: _____

OSA Contact Title: _____ Contact Email Address: _____

Telephone: _____ Fax: _____ OSA Writing Number: _____

Is the OSA the main contact for any enrollment/account questions? ❑ Yes ❑ No

If no, please indicate the Main Point of Contact below:

Main Point of Contact Name *(not person at the account):*_____**State Operation:** _____

Main Contact Address: _____

City: _____ State: _____ ZIP Code: _____

Main Contact Title: _____ Contact Email Address: _____

Telephone: _____ Fax: _____

(❑ OSA ❑ Main Point of Contact ❑ Both)

For the contact indicated above they would like to be copied on:

❑ Billing correspondence with account ❑ Admin set up/confirmation ❑ Any other correspondence with the account

❑ Correspondence to insureds *[we cannot copy anyone on correspondence that contains health information.]*

❑ Other: _____

Broker Firm/Consultant (from Section 2): Brokerage Name: _____

Broker Address: _____

City: _____ State: _____ ZIP Code: _____

Contact Name: _____

Contact Title: _____ Contact Email Address: _____

Contact Phone: _____ Contact Fax: _____

Enrollment Platform/Software Vendor (if applicable): _____

Address: _____

City: _____ State: _____ ZIP Code: _____

Contact Name: _____ Contact Email Address: _____

Phone: _____ Fax: _____

Enrollment Firm Name (i.e. Licensed soliciting agent enrollers, if applicable):

_____

Enrollment Firm Address:_____

City: _____ State: _____ ZIP Code: _____

Contact Name: _____ Contact Email Address: _____

Contact Phone: _____ Contact Fax: _____

4. GROUP PRODUCTS BEING SOLD

Does the Group currently have Health Advocate services through a relationship other than through Aflac (i.e., through a broker or directly with Health Advocate)? ❑ Yes ❑ No

Please check the box for each group product and the options you will be offering during this enrollment:

❑ **Critical Illness (Series 21000)**

- ❑ Tobacco-Distinct Rates ❑ Uni-Tobacco Rates
- ❑ Include Additional Benefits (loss of sight, speech, hearing, coma, burns, paralysis)
- ❑ Health Screening Benefit
- ❑ Without Cancer
- ❑ Optional Benefits Rider (BTAP)
- ❑ Heart Rider
- ❑ Occupational HIV Rider (healthcare cases only)
- ❑ Building Benefit Rider
- ❑ Progressive Diseases Rider (ALS and MS)
- ❑ Cancer Survivor Benefit Rider

❑ **Group Accident (Series 70000)**

Select only one: ❑ Non-Occupational ❑ 24-Hour

Initial Accident Treatment Category/Base Plan: ❑ High ❑ Mid ❑ Low

Hospitalization Category: ❑ High ❑ Mid ❑ Low ❑ None

After Care Category: ❑ High ❑ Mid ❑ Low ❑ None

Life Changing Events Category: ❑ High ❑ Mid ❑ Low ❑ None

Additional Riders:

- ❑ Wellness: ❑ High ❑ Mid ❑ Low
- ❑ Accidental Death ❑ Organized Athletic Activity ❑ Sickness ❑ Catastrophic Accident
- ❑ Gunshot Wound - Select Only One: ❑ $1,000 ❑ $5,000

❑ **Group Hospital Indemnity (Series 80000)**

❑ HSA Compatible Plan Needed

Hospitalization Category: ❑ High ❑ Mid ❑ Low

Building Benefit: ❑ Yes ❑ No

Health Screening Benefit *(only available on HSA Compatible plan OR if Treatment Category is NONE)*: ❑ Yes ❑ No

Treatment Category: ❑ High ❑ Mid ❑ Low ❑ None

Surgery and Anesthesia Category:

❑ Inpatient and Outpatient ❑ Outpatient Only ❑ None

❑ High ❑ Mid ❑ Low

❑ **Dental (Series 1100)**

Select Only One: ❑ Basic Plan ❑ Standard ❑ Premier

❑ **Group Whole Life (Series 60000)**

Select Only One: ❑ Face Purchase ❑ Premium Purchase

❑ **Term Life (Series 9100)** – *only two selections per payroll account*

❑ 5-Year ❑ 10-Year ❑ 15-Year ❑ 20-Year ❑ 30-Year

❑ **Group Term Life (Series 91000)**

Please use Supplemental Form and attach Sold Proposal.

❑ **Short Term Disability (Series 50000)**

Select Only One: ❑ 24-Hour Benefit ❑ Non-Occupational

Select Only One: Benefit Period: ❑ 3-Month ❑ 6-Month ❑ 12-Month

Select Only One: Elimination Period: ❑ 0/7 ❑ 7/7 ❑ 0/14 ❑ 14/14

❑ 30/30 *(only available on 6 or 12 month benefit period)*

❑ 90/90 *(only available on 12 month benefit period)*

Riders: ❑ Pre-Existing Condition Benefit ❑ Mental Illness Limited Benefit

❑ Alcoholism/Drug Addiction Limited Benefit ❑ Continuity of Coverage

4a. PRE-TAX PLANS (Please complete if applicable)

Which products and plans will be pre-tax? ❑ None ❑ Critical Illness ❑ Accident ❑ Hospital Indemnity ❑ Dental ❑ Short-Term Disability

When does the plan year begin for the Aflac Group products? _____

When does the traditional plan year begin? _____

Will the account require pre-tax documentation (premium only plan document) from Aflac Group? ❑ Yes ❑ No

5. EXISTING AFLAC INDIVIDUAL ACCOUNTS

NOTE: Please complete this section only if your account has in-force Aflac or Aflac New York Individual products. *By offering a group product that is similar to (like) the in-force individual product, you acknowledge that you have advised the payroll account of the potential difference between the two products.*

Aflac Individual and/or Aflac New York Account Number: _____

Will individual products continue to be offered with the Aflac Group products? ❑ Yes ❑ No

If yes, which individual products will be offered during this enrollment? ❑ Cancer ❑ Accident ❑ Hospital ❑ Critical Illness ❑ Life ❑ Disability

Which individual products will be replaced by group products during this enrollment?

❑ Cancer ❑ Accident ❑ Hospital ❑ Critical Illness ❑ Life ❑ Disability

Please indicate the reason for offering group products:

- Low penetration on existing products: ❑ Yes ❑ No
- Multi-location/state account: ❑ Yes ❑ No
- To add a new line of business: ❑ Yes ❑ No
- Competitive situation: ❑ Yes ❑ No

If yes, list the name of the competitor: _____

NOTE: Please consult with the employer's payroll contact to ensure accurate completion of the next section.

6. AFLAC GROUP BILLING ADMINISTRATION

Please indicate which Contact would like access to online billing for this account: ❑ OSA ❑ Main Contact

Please select the preferred billing option:

☑ Electronic Billing (Invoice sent via email)
❑ Hard Copy Billing (Invoice sent via mail)
❑ Self-Billing (No Invoice. Group provides detailed list of deductions)
❑ Paylogix on-line Billing -- *Allow 6-8 weeks for setup. Billing will default to Electronic Billing until setup is complete.

6a. PAYROLL ACCOUNT CONTACT INFORMATION

NOTE: Aflac Group will contact the designated Account Billing Contact to review the information via email or telephone.

Account Contact for Billing: ☑ Mr. ❑ Ms. Tennyson Lum Jr.
Billing Contact Phone: (808) 792-5212 Ext. _____ Fax *(if applicable)*: (808) 792-5252
Billing Contact Email ***(required)***: tlumjr@piopac.com
Address: 1132 Bishop St. Suite 2101
City: Honolulu State: HI ZIP Code: 96813

Reserve Account Contact for Billing: ❑ Mr. ☑ Ms. Gabriella Bright
Billing Contact Phone: (808) 792-5214 Ext. _____ Fax *(if applicable)*: (808) 792-5252
Billing Contact Email ***(required)***: gabe@pioneerpacific.com
Address: 1132 Bishop St. Suite 2101
City: Honolulu State: HI ZIP Code: 96813

Please designate a point of contact at the account for cancellations, premium changes due to underwriting, and stop/change deduction notices, and complete that person's information below:

Cancellations Contact: ☑ Mr. ❑ Ms. Tennyson Lum Jr.
Contact Phone: (808) 792-5212 Ext. _____ Fax *(if applicable)*: (808) 792-5252
Contact Email ***(required)***: tlumjr@piopac.com
Address: 1132 Bishop St. Suite 2101
City: Honolulu State: HI ZIP Code: 96813

****Aflac Group requires the insured to contact us within 31 days of leaving employment to port coverage.****

6b. DEDUCTIONS

Deductions start by: ❑ Elections ❑ Elections (Self-Bill with payment detail)

❑ Deduction file after application processing is complete. Due to account: _____/_____/_____.

The deduction file due date must be at least 15 business days after enrollment forms are submitted.

Payroll Frequency Information:

❑ Check if premiums are employer-paid

❑ Check if premiums are deducted at different frequencies for different employees (i.e. some employees are deducted weekly while others are deducted bi-weekly). If this is the case, please complete all that apply below:

List the dates of the first and second deduction for each deduction frequency.

Deduction Frequency	First Deduction Date *(Must begin during the same month as CED)*	Second Deduction Date
Weekly (52 Annually)		
Bi-Weekly (26 Annually)		
Semi-Monthly (24 Annually)		
Monthly (12 Annually)		
Other (Describe):		

If "Other", please provide dates that payroll deductions will not be made:

_____

6c. BILLING INFORMATION

Bill Frequency: Deductions must start in the first pay period of the month of the coverage/billing effective date.

❑ Monthly (paid monthly or semi-monthly) ❑ Monthly 4-4-5 (paid weekly) ❑ 26 Week (paid every 4 weeks, 13 invoices)

❑ Monthly 2-2-3 (paid bi-weekly) ❑ Other: _____

How deductions will be handled for employees who may miss work/deductions:

❑ Insured pays account ❑ Insured pays Aflac Group (CAIC) ❑ Account fronts premium

Note: Aflac Group does not bill for missed deductions.

How refunds should be handled? Aflac Group does not allow credits.

❑ Issue to the employee (post tax plans only) ❑ Issue to the account ❑ Mail to the account and make payable to the employee

■ **A Third Party Administrator (TPA) will be used for billing purposes.** *(Must become contracted with Aflac Group.)*

TPA Name: PIOPAC Fidelity TPA Contact: Tennyson Lum Jr.

TPA Address: 1132 Bishop St. Suite 2101

City: Honolulu State: HI ZIP Code: 96813

TPA Contact Title: Vice President of Operations Contact Email Address: tlumjr@piopac.com

Phone: 808-792-5212 Fax: 808-792-5252

❑ Check if invoice should be subtotaled by department or location. Only one payment will be accepted for the account.

List locations or departments: _____

_____

_____

_____

Refer to multi-invoice guidelines if requesting separate invoices (only available to accounts with 1,000 or more eligible employees). If requirements are met:

❑ Check if multiple invoices are needed and complete the multi-invoice information below. One payment per invoice.

Multi-Invoice Information

Department/Location Name	Department/Location Contact Name	Department/Location Contact Mailing Address	Department/Location Contact Email Address

SPECIAL INSTRUCTIONS

Please include any additional special instructions as applicable:

7. ASSOCIATE/AGENT AUTHORIZATION AND SIGNATURE(S)

I acknowledge that I, as Broker or Securing Associate, am wholly responsible for servicing and maintaining my account(s) with Continental American Insurance Company (Aflac Group), and I will take all reasonable and expected efforts to do so properly. I further acknowledge that Continental American Insurance Company (Aflac Group) may assume the performance of any or all of my duties and responsibilities as Broker if Continental American Insurance Company (Aflac Group) provides notice that I have failed to properly service and maintain such account(s) and if I fail to cure said deficiencies within 10 days of such notice. I confirm that I am not an employee, officer, director, owner, or relative of any of the foregoing (or otherwise a "party in interest" as defined under ERISA). I understand that I am not authorized to collect premium from this account without specific written approval from Continental American Insurance Company (Aflac Group). I understand as the OSA for this account that I may be entitled to a split of commissions on all business written on this account (Master Application).

Associate's/Agent's Signature: _____ **Date:** _____

Associate's/Agent's Name: _____

Writing Number: _____ **Market Op:** _____

Phone Number: (_____)_____ **Fax Number: (_____)**_____

Please indicate the Aflac Group commission structure code to be used for this enrollment in the field below. Missing commission or assignment information will cause a delay in account setup and processing. Please contact your Market Office or Account Implementation Coordinator (AIC) to submit the necessary assignment documentation for this enrollment.

Commission Structure: ☐ **Standard** ☐ **Custom**

Commission Structure Code: _____

If requesting a new custom commission structure, please contact AVCustomCaseRequest@aflac.com. Please note, new custom commission requests are only eligible for accounts over 2500 employees.

8. SALES MANAGEMENT APPROVAL

Please review, approve, and submit to GroupRequests@aflac.com

Title of Approver: ❑ Market Director (Market Op _____) ❑ Market Coordinator ❑ Market Trainer

Signature of Approver: _____

Printed Name of Approver: _____

Date: _____