5099722841

Dental

## AFLAC INTEREST FORM

You MUST see the Aflac Agent to participate. This form will not enroll you!

Name:	The second secon
Address:	
City, Zip Code:	Code:
Phone #:	
DOB:	
□ Yes, I	$\square$ Yes, I am interested in the Aflac benefits and I
want moi	want more information.
□ No, I a	$\square$ No, I am not interested at this time *
*I understand representative	*I understand that I need to sign a waiver from the Aflac epresentative.
Ple inte	Please check the programs you are interested in learning more about.
	Accident
	Cancer
	Hospital
	Disability
	Life
	Dental

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Address:	
City, Zip Code:	Code:
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DOB:	
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