



AFGE MEMBER INFORMATION FORM

_____ _____ **M** **F**
 First Name Last Name Gender

_____ _____ _____
 City State Zip

_____ _____ _____
 Occupation Date of Hire Salary

_____ _____ _____ _____
 Date of Birth Age Payroll ID or SSN AFGE Local #

_____ _____ **Y** **N**
 Email Address Cell Phone Number Tobacco User

FAMILY INFORMATION

_____ _____ **M** **F** _____ **Y** **N**
 Spouse First Name Spouse Last Name Gender Spouse DOB Tobacco User

_____ _____ **M** **F** _____
 Child #1 First Name Child #1 Last Name Gender Child #1 DOB

_____ _____ **M** **F** _____
 Child #2 First Name Child #2 Last Name Gender Child #2 DOB

_____ _____ **M** **F** _____
 Child #3 First Name Child #3 Last Name Gender Child #3 DOB

_____ _____ **M** **F** _____
 Child #4 First Name Child #4 Last Name Gender Child #4 DOB

_____ _____ **M** **F** _____
 Child #5 First Name Child #5 Last Name Gender Child #5 DOB

BENEFICIARY INFORMATION

_____ _____ _____ _____
 AFLAC Beneficiary Name Relationship TransAmerica Beneficiary Name Relationship

Questions? Please Contact:



Agent Use Only

AFLAC Accident
 Cl: Member
 Cl: Spouse
 Hospital (HI)
 Trans: Member
 Trans: Spouse
 Trans: Children



Representative:	Cell:
	Email:

Note: Rates & Statements are for 2019 Enrollment Only. Rates Subject to Change Prior to Enrollment

Accident - 24-Hr On & Off-the-Job Coverage	Individual Member 9.43 Bi-Weekly	Member & Spouse 14.13 Bi-Weekly	Member and Kids 16.37 Bi-Weekly	Family 21.07 Bi-Weekly
Plan includes \$50 Annual Wellness after 12-Months Active, per Covered Person • Pays a Max \$125 for initial X-Ray or Doctor Services for accidents, if treated within 72-Hours. Pays \$1,000 for 1st-24 Hour Day in Hospital, then \$200 a day, up to 365 days (\$400 per day, Intensive Care for up to 30-Days) • Major Fracture Injuries (Chip Fractures pays 25%): Hip/Thigh \$4,000, Vertebrae (except Processes) \$3,600, Leg \$2,400, Forearm/Hand/Wrist \$2,000, Foot/Ankle/Kneecap \$2,000, Shoulder Blade/Collar Bone \$1,600, Lower Jaw (mandible) \$1,600, Skull (simple) \$1,400, Upper Arm/Upper Jaw \$1,400, Facial Bones (except teeth) \$1,200, Vertebral Processes \$800, Coccyx/Rib/Finger/Toe \$320. Must provide proof of Treatment/ Services, a Doctor/Hospital Bill/Receipt. • Pays Accidental Death for Employee \$50,000, Spouse \$25,000, Dependents at \$5,000				

Hospital Indemnity	Individual Member 15.24 Bi-Weekly	Member & Spouse 29.94 Bi-Weekly	Member and Kids 25.24 Bi-Weekly	Family 39.95 Bi-Weekly
When due to a covered accidental injury or sickness: Plan includes Hospital Admission Benefit of \$1,000 per confinement, once per covered sickness or accident per calendar year. Excludes ER. See plan for details. • Outpatient Doctor's Office Visit – max of 6 visits per calendar year - \$25 each visit. Chiropractor Visit – max of 4 visits per calendar year - \$20 each visit. Major Diagnostic Exam – CT/CAT scan, MRI, EEG - \$150 payment. Hospital ER Visit – max of 5 visits per calendar year - \$100 per day. Inpatient Surgery and Anesthesia - \$500. Outpatient Surgery and Anesthesia - \$250.				

Group Critical Illness		NON-SMOKER RATES				SMOKER RATES			
		Age Band	Member Benefit	Member Premium	Max Spouse Benefit	Spouse Premium	Member Benefit	Member Premium	Max Spouse Benefit
Guaranteed Issue: Heart • Stroke • Cancer \$50 Wellness Annually per Adult Pays 100% of Benefit for Diagnosis of: <ul style="list-style-type: none"> • Heart Attack • Stroke • Cancer Internal or Invasive • Major Organ Transplant • Kidney Failure • Bone Marrow Transplant • Sudden Cardiac Arrest • Severe Burns • Paralysis • Coma • Loss of Speech • Sight • Hearing 	(18-29)	\$5,000	\$2.00	\$2,500	\$1.87	\$5,000	\$2.56	\$2,500	\$1.43
		\$10,000	\$3.30	\$5,000	\$1.87	\$10,000	\$4.42	\$5,000	\$2.43
		\$15,000	\$4.60	\$7,500	\$2.45	\$15,000	\$6.29	\$7,500	\$3.29
		\$20,000	\$5.90	\$10,000	\$3.04	\$20,000	\$8.15	\$10,000	\$4.16
		\$25,000	\$7.20	\$12,500	\$3.62	\$25,000	\$10.01	\$12,500	\$5.02
		\$30,000	\$8.50	\$15,000	\$4.20	\$30,000	\$11.87	\$15,000	\$5.89
	(30-39)	\$5,000	\$2.66	\$2,500	\$2.53	\$5,000	\$3.94	\$2,500	\$3.80
		\$10,000	\$4.62	\$5,000	\$2.53	\$10,000	\$7.17	\$5,000	\$3.80
		\$15,000	\$6.57	\$7,500	\$3.44	\$15,000	\$10.41	\$7,500	\$5.36
		\$20,000	\$8.53	\$10,000	\$4.35	\$20,000	\$13.65	\$10,000	\$6.91
		\$25,000	\$10.49	\$12,500	\$5.26	\$25,000	\$16.89	\$12,500	\$8.46
		\$30,000	\$12.45	\$15,000	\$6.18	\$30,000	\$20.12	\$15,000	\$10.01
	(40-49)	\$5,000	\$4.71	\$2,500	\$4.58	\$5,000	\$7.47	\$2,500	\$7.33
		\$10,000	\$8.72	\$5,000	\$4.58	\$10,000	\$14.23	\$5,000	\$7.33
		\$15,000	\$12.74	\$7,500	\$6.52	\$15,000	\$21.00	\$7,500	\$10.65
		\$20,000	\$16.75	\$10,000	\$8.46	\$20,000	\$27.76	\$10,000	\$13.97
		\$25,000	\$20.76	\$12,500	\$10.40	\$25,000	\$34.53	\$12,500	\$17.28
		\$30,000	\$24.77	\$15,000	\$12.34	\$30,000	\$41.29	\$15,000	\$20.60
(50-59)	\$5,000	\$7.96	\$2,500	\$7.82	\$5,000	\$13.18	\$2,500	\$13.05	
	\$10,000	\$15.21	\$5,000	\$7.82	\$10,000	\$25.67	\$5,000	\$13.05	
	\$15,000	\$22.47	\$7,500	\$11.39	\$15,000	\$38.15	\$7,500	\$19.23	
	\$20,000	\$29.73	\$10,000	\$14.95	\$20,000	\$50.64	\$10,000	\$25.40	
	\$25,000	\$36.98	\$12,500	\$18.51	\$25,000	\$63.12	\$12,500	\$31.58	
	\$30,000	\$44.24	\$15,000	\$22.07	\$30,000	\$75.61	\$15,000	\$37.75	
(60+)	\$5,000	\$14.00	\$2,500	\$13.87	\$5,000	\$23.49	\$2,500	\$23.36	
	\$10,000	\$27.37	\$5,000	\$13.87	\$10,000	\$46.28	\$5,000	\$23.36	
	\$15,000	\$40.61	\$7,500	\$20.46	\$15,000	\$69.07	\$7,500	\$34.69	
	\$20,000	\$53.91	\$10,000	\$27.04	\$20,000	\$91.86	\$10,000	\$46.02	
	\$25,000	\$67.22	\$12,500	\$33.63	\$25,000	\$114.65	\$12,500	\$57.35	
	\$30,000	\$80.52	\$15,000	\$40.21	\$30,000	\$137.45	\$15,000	\$68.67	
Pays 25% of Benefit Amount for: <ul style="list-style-type: none"> • Non-Invasive Cancer • Coronary Artery Bi-Pass Surgery • Pays \$250 for Skin Cancer (1X per year) 	(60+)	\$5,000	\$14.00	\$2,500	\$13.87	\$5,000	\$23.49	\$2,500	\$23.36
		\$10,000	\$27.37	\$5,000	\$13.87	\$10,000	\$46.28	\$5,000	\$23.36
		\$15,000	\$40.61	\$7,500	\$20.46	\$15,000	\$69.07	\$7,500	\$34.69
		\$20,000	\$53.91	\$10,000	\$27.04	\$20,000	\$91.86	\$10,000	\$46.02
		\$25,000	\$67.22	\$12,500	\$33.63	\$25,000	\$114.65	\$12,500	\$57.35
		\$30,000	\$80.52	\$15,000	\$40.21	\$30,000	\$137.45	\$15,000	\$68.67

Summary of Voluntary Benefits

Below is a confirmation of your election of the voluntary benefits offered.

AFLAC Coverage	Premium	
Accident Plan		
Critical Illness		
Hospital Insurance		
Subtotal		Allotment Total
Admin Fee		



AFLAC Bank Account # 870031070 Bank Routing 11400093

TransAmerica Coverage	Premium	
TransElite Life		
Admin Fee		Allotment Total



TransAmerica Bank Account #870031089 Bank Routing 11400093

If you choose to elect coverage, please read the followings

1. DEDUCTIONS

- I understand that the premium above will be deducted from my first pay check in _____.
- I understand if payroll deductions do not occur. It is my responsibility to pay these premiums directly to the above carrier otherwise my coverage may cancel _____ ** PLEASE INITIAL**

2. POLICY

- I understand that I should receive a welcome letter in the mail 6-8 weeks after the voluntary benefit enrollment period ends.
- I understand it is important to review the policy when I receive it.
- I understand that coverage is not effective until ___/___/___.

I hereby authorize Frates Benefit Administration to receive my payroll deduction into their Frost National Bank Premium Trust Account. I also authorize FBA to distribute the amount indicated to my FBA policy. I understand that for the convenience of payroll deduction, the administrative fee paid to FBA will be non-refundable.

Applicant Name: _____
Printed

Benefit Specialist _____
Printed

Applicant: _____
Signature

Benefit Specialist: _____
Signature

Date: ___/___/___



If you have any questions regarding your Benefit Election Protection prior to your first payroll deduction, Please call toll free (800)733-7236 ext. 1000 or 1002

MyPay Web Instruction

1. Go the web site <https://mypay.dfas.mil/mypay.aspx>
2. Sign in with your **Login ID** and **PIN Number**
3. Under **Pay Changes**, click on **Allotment**
4. Choose Add new Allotment
5. Enter **114000093** as the Bank Routing Code, **870031070** as the Account Number, click on **Savings** as the account type.
6. Enter the biweekly premium (whole dollar amounts only)
7. Verify the banking information is Frost Bank, San Antonio TX.
8. If the information is correct choose **Save**.
9. Please send a short email with your name and the facility your work at to kristenmiller@benefitarchitects.com or kpaz@benefitarchitects.com letting us know that your allotment has been input.

TRANSAMERICA® MyPay Web Instruction

1. Go the web site <https://mypay.dfas.mil/mypay.aspx>
2. Sign in with your **Login ID** and **PIN Number**
3. Under **Pay Changes**, click on **Allotment**
4. Choose Add new Allotment
5. Enter **114000093** as the Bank Routing Code, **870031089** as the Account Number, click on **Savings** as the account type.
6. Enter the biweekly premium (whole dollar amounts only)
7. Verify the banking information is Frost Bank, San Antonio TX.
8. If the information is correct choose **Save**.
9. Please send a short email with your name and the facility your work at to kristenmiller@benefitarchitects.com or kpaz@benefitarchitects.com letting us know that your allotment has been input.



If you have any questions regarding your payroll deduction amounts or the process to start or change your payroll deductions, please call (800)733-7236 and ask for Kristen at extension 1000 or Karla at extension 1002



Standard Form 1199A (EG)
 (Rev. August 2012)
 Prescribed by Treasury
 Department
 Treasury Dept. Cir. 1076

DIRECT DEPOSIT SIGN-UP FORM

DIRECTIONS

OMB No. 1510-0007

- To sign up for Direct Deposit, the payee is to read the back of this form and fill in the information requested in Sections 1 and 2. Then take or mail this form to the financial institution. The financial institution will verify the information in Sections 1 and 2, and will complete Section 3. The completed form will be returned to the Government agency identified below.
- A separate form must be completed for each type of payment to be sent by Direct Deposit.
- The claim number and type of payment are printed on Government checks. (See the sample check on the back of this form.) This information is also stated on beneficiary/annuitant award letters and other documents from the Government agency.
- Payees must keep the Government agency informed of any address changes in order to receive important information about benefits and to remain qualified for payments.

SECTION 1 (TO BE COMPLETED BY PAYEE)

A NAME OF PAYEE (<i>last, first, middle initial</i>)		D TYPE OF DEPOSITOR ACCOUNT <input type="checkbox"/> CHECKING <input checked="" type="checkbox"/> SAVINGS	
ADDRESS (<i>street, route, P.O. Box, APO/FPO</i>)		E DEPOSITOR ACCOUNT NUMBER	
CITY STATE ZIP CODE		0 8 7 0 0 3 1 0 7 0	
TELEPHONE NUMBER AREA CODE		F TYPE OF PAYMENT (<i>Check only one</i>)	
B NAME OF PERSON(S) ENTITLED TO PAYMENT		<input type="checkbox"/> Social Security <input type="checkbox"/> Fed. Salary/Mil. Civilian Pay <input type="checkbox"/> Supplemental Security Income <input type="checkbox"/> Mil. Active _____ <input type="checkbox"/> Railroad Retirement <input type="checkbox"/> Mil. Retire. _____ <input type="checkbox"/> Civil Service Retirement (OPM) <input type="checkbox"/> Mil. Survivor _____ <input type="checkbox"/> VA Compensation or Pension <input checked="" type="checkbox"/> Other <u>ALLOTMENT</u> <i>(specify)</i>	
C CLAIM OR PAYROLL ID NUMBER		G THIS BOX FOR ALLOTMENT OF PAYMENT ONLY (<i>if applicable</i>)	
Prefix Suffix		TYPE AMOUNT	
PAYEE/JOINT PAYEE CERTIFICATION		JOINT ACCOUNT HOLDERS' CERTIFICATION (<i>optional</i>)	
I certify that I am entitled to the payment identified above, and that I have read and understood the back of this form. In signing this form, I authorize my payment to be sent to the financial institution named below to be deposited to the designated account.		I certify that I have read and understood the back of this form, including the SPECIAL NOTICE TO JOINT ACCOUNT HOLDERS.	
SIGNATURE	DATE	SIGNATURE	DATE
SIGNATURE	DATE	SIGNATURE	DATE

SECTION 2 (TO BE COMPLETED BY PAYEE OR FINANCIAL INSTITUTION)

GOVERNMENT AGENCY NAME	GOVERNMENT AGENCY ADDRESS
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SECTION 3 (TO BE COMPLETED BY FINANCIAL INSTITUTION)

NAME AND ADDRESS OF FINANCIAL INSTITUTION		ROUTING NUMBER		CHECK DIGIT
FROST BANK PO BOX 1600 SAN ANTONIO, TX		1 1 4 0 0 0 0 9		3
DEPOSITOR ACCOUNT TITLE				
RMJP- AFLAC				
FINANCIAL INSTITUTION CERTIFICATION				
I confirm the identity of the above-named payee(s) and the account number and title. As representative of the above-named financial institution, I certify that the financial institution agrees to receive and deposit the payment identified above in accordance with 31 CFR Parts 240, 209, and 210.				
PRINT OR TYPE REPRESENTATIVE'S NAME	SIGNATURE OF REPRESENTATIVE	TELEPHONE NUMBER	DATE	
Karen Green	<i>Karen E. Green</i>	800-733-7236	9-8-2016	

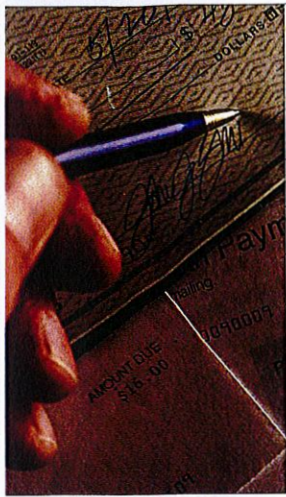
Financial institutions should refer to the GREEN BOOK for further instructions.

THE FINANCIAL INSTITUTION SHOULD MAIL THE COMPLETED FORM TO THE GOVERNMENT AGENCY IDENTIFIED ABOVE.

AFGE

The AFGE Difference

Don't sell yourself short. Representation in statutory appeals is **FREE** for AFGE MEMBERS. If you are not a member and you find yourself in need of an attorney, these cases can cost you thousands.



Non-Member REPRESENTATION BY PRIVATE ATTORNEYS	Issue	AFGE Member REPRESENTATION
\$1,500*	Letters of Reprimand	No Cost
\$5,000*	Suspension of 14 days or less	No Cost
\$10,000*	Suspension of 14 days or more	No Cost
\$12,000*	Termination/Removal	No Cost
\$10,000*	E.E.O.C.	No Cost
\$4,500*	Workers' Compensation	No Cost



*Minimum estimated cost to hire attorney at \$250.00/hr.

Under current and case law in the U.S. Court of Appeals for the District of Columbia, **federal unions have no duty to represent non-members in statutory appeal procedures.** In the leading case on this issue, the federal court found the union did not have a duty to represent an inspector fired by the Bureau of Alcohol, Tobacco and Firearms. The discharged employee was a member of a certified bargaining unit, but not a member of the labor organization.

Don't sell yourself short. Representation in statutory appeals is **FREE** for AFGE MEMBERS. If you are not a member and you find yourself in need of an attorney, these cases can cost you thousands.

Encouraged by the public's belief that federal employees cannot be fired, Congress has enacted legislation making it easier for managers to discharge government employees. Federal employees must decide whether to purchase representation/protection by joining the union or risk huge legal bills if you ever need representation.

AFGE membership can make a huge difference when it comes to representation. You work too hard to leave yourself unprotected. Join AFGE Today! Go to www.afge.org to find out more information.



Membership Makes the Difference. JOIN AFGE!





REQUEST FOR PAYROLL DEDUCTIONS FOR LABOR ORGANIZATION DUES

Section 5525 of title 5 United States Code (Allotments and Assignments of Pay) permits Federal agencies to collect this information. This completed form is used to request that labor organization dues be deducted from your pay and to notify your labor organization of the deduction. Completing this form is voluntary, but it may not be processed if all requested information is not provided.

This record may be disclosed outside your agency to: 1) the Department of the Treasury to make proper financial adjustments; 2) a Congressional office if you make an inquiry to that office related to this record; 3) a court or an appropriate Government agency if the Government is party to a legal suit;

4) an appropriate law enforcement agency if we become aware of a legal violation; 5) an organization which is a designated collection agent of a particular labor organization; and 6) other Federal agencies for management, statistical and other official functions (without your personal identification).

Executive Order 9397 allows Federal agencies to use the social security number (SSN) as an individual identifier to avoid confusion caused by employees with the same or similar names. Supplying your SSN is voluntary, but failure to provide it, when it is used as the employee identification number, may mean that payroll deductions cannot be processed.

Your agency shall provide an additional statement if it uses the information furnished on this form for purposes other than those mentioned above.

PLEASE PRINT IN BLOCK UPPERCASE LETTERING USING BLACK/BLUE INK.

1. Last Name First M.I.

2. Home Address Unit #

City State Zip code 3. Employee SSN - - 4. Date of Birth - MM/DD/YY / /

5. Home Phone Number 6. Personal Cell Phone Number (preferred) 7. Office Phone Number X Extension

8. Primary Personal Email (Not your government email address) Opt Out Email I would like to receive text messages from AFGE.

9. Name of Agency I give permission for AFGE to invite me to robocalls and tele-town halls via my personal cell phone.

Section A - Authorization by Employee

I hereby authorize the agency named above to deduct from my pay each pay period, or the first full pay period of each month, the amount certified below as the regular dues of the:

American Federation of Government Employees

C Council # (if applicable)

L Local #

and to remit such amount to that labor organization in accordance with its arrangements with my employing agency. I further authorize any change in the amount to be deducted which is certified by the below named labor organization as a uniform change in its dues structure.

I understand that this authorization, if for a biweekly deduction, will become effective the pay

period following its receipt in the payroll office of my employing agency. I further understand that Standard Form 1188, Cancellation of Payroll Deductions for Labor Organization Dues, is available from my employing agency, and that I may cancel this authorization by filing Standard Form 1188 or other written cancellation request with the payroll office of my employing agency.

Such cancellation will not be effective, however, until the first full pay period which begins on or after the next established cancellation date of the calendar year after the cancellation is received in the payroll office.

Contributions or gifts (including dues) to the labor organization shown at the left are not tax deductible as charitable contributions. However, they may be tax deductible under other provisions of the Internal Revenue Code.

Signature of Employee Date Signed MM/DD/YY Gender (Optional) F M Other

FOR COMPLETION BY AGENCY ONLY - The above named employee and labor organization meet the requirements for dues withholding. (Mark the appropriate box. If "YES" send this form to payroll. If "NO" return this form to the labor organization.)

Yes No

Section B - For Use by Labor Organization

Name of Labor Organization (Indicate Local)

AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES, AFL-CIO, LOCAL

I. D. Code:

I hereby certify that the regular dues of this organization for the above named member are currently established at \$ _____ per biweekly pay period.

Signature and Title of Authorized Official

Date signed MM/DD/YY

REBATE REQUEST FORM *

Fax to

Membership Type Full-time Part-time

New Member

I hereby certify that I have received a rebate from Local _____ in the amount of _____

Name _____ Signature _____ Date _____

Recruiter

I hereby certify that I have received recruiter bonus from Local _____ in the amount of _____

Recruiter Name _____ Signature _____ Date _____

Recruiter SSN _____ Local # _____

Current Address _____ City _____ State _____ Zip _____

Notes _____

*IRS Form 1099 or W-2 will be issued based on current income tax laws by the payer.

