Supplemental Benefits Interest Form

Must enroll 30 days from first day of work

Diane Crisafi 404-259-7646
dianecrisafi@houze.org

Or email this form to: cobbenrollment@houze.org
(Note: Completing this form doesn't enroll benefits)

Name		Employee ID	Hire Date
Department		Shift Time	Effective Date
Cell Phone	Best Tim to Call	Personal Email Address	
Work Phone	Work Email Address		

I AM INTERESTED IN INFORMATION ON:

☐	**Short Term Disability**	Aflac	Income Protection
☐	**Cancer Insurance**	Aflac	Family Coverage Available
☐	**Accident Insurance**	Aflac	Family Coverage Available
☐	**Hospital Indemnity**	Aflac	Family Coverage Available
☐	**Critical Care Protection**	Aflac	Family Coverage Available