Provider Election Agreement

The fully executed Provider Election Agreement along with a copy of your W-9 should be returned via facsimile to:

Aflac
Attn: Aflac EFT
Facsimile: 855-697-1860

This Provider Election Agreement should be used by Providers electing to utilize the "Banking Service," an enrollment and claims payments tool offered by J.P. Morgan Chase Bank, N.A. (the "Bank"), that automates the processing and reconcilement of payments, including the receipts and delivery of 835s and Explanation of Benefits (EOBs) from Aflac and to its Providers registered with the Bank. By submitting this completed Provider Election Agreement to Aflac, the Provider named herein is authorizing Aflac to share information with, and process payments through, the Bank and Healthcare Link Service, as more fully explained herein. **Separate registration with the Bank is required to obtain and utilize the Banking Service. Banking information should not be submitted to Aflac.**

Please complete ALL fields and print clearly.

PART I: REASON FOR SUBMISSION

Reason for Submission:

☐ New Electronic Funds Transfer (EFT) Enrollment

☐ New EFT and Electronic Remittance Advice (ERA) Enrollment

☐ New ERA Enrollment

** Note – any changes or cancellations to EFT Enrollment will be made through the Banking Services. Please visit their website at https://healthcarelink.jpmorgan.com/hcp/app for more information.

PART II: PROVIDER INFORMATION

Provider Name as shown on Box 1 of attached W-9 Form

Provider Address

Provider City	Provider State	Provider Zip Code

Provider Tax Identification Number	Health Plan Identifier (HPID) or Other Entity Identifier (OEID)

*National Provider Identifier (NPI)	Type 1 NPI — Health care providers who are individuals, including physicians and dentists. Type 2 NPI — Health care providers who are organizations, including physician groups, hospitals, nursing homes, and the corporation formed when an individual incorporates him/herself.

*A separate Provider Election Agreement must be completed for each National Provider Identifier (NPI).

PART III: PROVIDER CONTACT INFORMATION

Provider Contact (Name)	Title

Telephone Number	E-mail Address

PART IV: AUTHORIZATION

By completing and submitting this Provider Election Agreement to Aflac, the Provider named herein acknowledges, agrees and authorizes the following:

1. Aflac may transmit any information contained herein to the Bank as may be necessary for the Provider to obtain and utilize from the Bank its Banking Service.

2. Provider is requesting from Aflac an Authorization Code that will enable Provider to complete the enrollment process at the Bank's website: https://healthcarelink.jpmorgan.com/hcp/registration. The Bank may require the disclosure of additional information from the Provider, including deposit account information, in order to complete the enrollment process.

3. Aflac may communicate with the Bank, and provide information to or receive information from the Bank, on any and all matters related to the provision by the Bank of the service to the Provider, including but not limited to: (a) for the Bank to process electronic fund transfers from Aflac demand deposit accounts (DDAs) to Provider, in accordance with electronic data interchange (EDI) instructions submitted by Provider and Aflac; and (b) to enable Aflac to furnish Provider, through the Banking Service, all relevant payment and claims information in a format that complies with the standard mandated by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

4. This Provider Election Agreement, and the authorizations contained herein, is effective as of the Date of Submission, below, and is to remain in full force and effect until Aflac has received written notification from Provider of its termination in such time and such manner as to afford Aflac a reasonable opportunity to act on it. The notification required herein is separate from and in addition to any notification that the Bank may require from the Provider to terminate the Banking Service.

5. If any information set forth herein changes, Provider must submit to Aflac an updated Provider Election Agreement. By signing below, I hereby agree that I have read and agree to the terms and conditions stated above. Furthermore, I certify that the information provided herein is true and correct, and that I have been duly authorized and to enter into this agreement on behalf of the Provider.

Name of Person Submitting Enrollment (Print)	Telephone Number
Title of Person Submitting Enrollment	E-mail Address
Signature of Person Submitting Enrollment	Date of Submission

PRIVACY ACT ADVISORY STATEMENT

Sections 1842, 1862(b) and 1874 of title XVIII of the Social Security Act authorize the collection of this information. The purpose of collecting this information is to authorize electronic funds transfers.

Per 42 CFR 424.510(e)(1), providers are required to receive electronic funds transfer (EFT) at the time of enrollment, revalidation, or submission of an enrollment change request.

You should be aware that P.L. 100-503, the Computer Matching and Privacy Protection Act of 1988, permits the government, under certain circumstances, to verify the information you provide by way of computer matches.