Become a Dental or Vision Provider

Thank you for your interest in becoming an Aflac Provider. Please know this is not a commitment to join but to contact your office to discuss network participation.
Please complete the form below and email it to our Network Management Department.

Dental or Vision (circle one)

Provider First Name _____ **Provider Last Name** _____

Practice Name_____

Address _____

City_____ **State** _____ **Zip Code**_____

Phone Number_____

Email Address _____

Office Contact Person _____

Upon receipt of your request, a network recruiter will reach out to you and your office to email you the requested recruitment packet, including the fee schedule. If you should have any questions, please email networkrecruitment@aflac.com and your request will be followed up with by our network recruitment team.

Thank you for your interest in joining the Aflac Network.