

REQUEST FOR CHANGE
American Family Life Assurance Company of Columbus (Aflac)
ATTENTION: POLICYHOLDER SERVICES (PHS)
Worldwide Headquarters • 1932 Wynnton Road • Columbus, GA 31999
For information call toll-free 1.800.99.AFLAC (1.800.992.3522)
Toll-Free Fax: 1.800.448.8922

Pre-tax After-tax

Name of Policyholder _____ SSN _____
Last Name First Name MI

Policy Number _____ Policy Type _____ Date of Birth _____

Policyholder's E-Mail Address _____

Associate/Agent's Signature _____ Writing Number _____
Licensed Resident Associate/Agent

PLEASE MAKE THE FOLLOWING CHANGES TO MY POLICY.

ADDRESS CHANGE ONLY

New Address of Policyholder _____
Street Apt. No.

City _____ State _____ ZIP _____ Telephone No. _____

Former Address of Policyholder _____
Street Apt. No.

City _____ State _____ ZIP _____

NAME CHANGE ONLY

Name Shown on Policy _____
Last Name First Name MI Title

Change Name To _____
Last Name First Name MI Title

Reason Marriage Divorce Death Request

Billing Name _____
(If policy is on payroll/association)

Draftee/Cardholder Name _____
(If policy is on bank draft/credit card)

Effective Date of Change _____

TRANSFERS TO PAYROLL/UNION/ASSOCIATION BILLING ONLY

Transfer From _____
Account Name Account Number

Transfer To _____
Account Name Account Number

Department No. _____ Employee/Member No. _____

Amount Remitted \$ _____ Months _____

Billing Name _____
Last Name First Name MI

Effective Date of Transfer _____

TRANSFERS TO DIRECT BILLING ONLY

Bill at Home Bank Draft Credit Card

Transfer From _____ Effective Date of Transfer _____

Direct Billing Mode (select one) Monthly (Bank Draft/Credit Card Only) Quarterly Semiannual Annual

Amount Remitted \$ _____ Months _____

When would you like your premiums deducted? _____ (Please choose any day 1-28.)

I choose to pay by electronic draft.

Account Holder's Name _____

Account Holder's Address _____

City _____ State _____ ZIP _____

Transit/ABA Number _____

Account Number _____ Checking Savings

I choose to pay by credit or debit card (only Visa, MasterCard, and American Express are accepted).

Card Holder's Name _____

Card Holder's Address _____ City _____ State _____ ZIP _____

Card Number _____ Expiration Date _____

Confirmation

I authorize Aflac to initiate debit entries electronically to my account indicated above, and I authorize the depository institution named above to debit same to such account. This authorization remains effective and in full force until Aflac and the depository/institution receive written notification from me of its termination in such time and in such manner to afford Aflac and the depository/institution a reasonable opportunity to act on it.

Account Holder/Card Holder's Signature _____ Date _____
(If different from Policyholder/Applicant)

Policyholder's/Applicant's Signature _____ Date _____

DELETIONS ONLY

Person to be Deleted _____
Last Name First Name MI Title

Sex Male Female Relationship Insured Spouse Dependent

Address of person being deleted _____

Reason for Deletion Divorce Death Dependent attaining age Request

Date of Divorce/Death/Request _____

New Policy/Contract Holder's Full Name _____
Last Name First Name MI

Sex Male Female Birth Date of New Policy/Contract Holder _____

Billing Name (only applicable if policy on payroll/association) _____
Last Name First Name MI

New Coverage Desired Individual One-Parent Family Two-Parent Family Named Insured-Spouse Only

BENEFICIARY CHANGE ONLY

Change the Beneficiary From _____
Last Name First Name MI

To the following Beneficiary's Name _____
Last Name First Name MI

Beneficiary's Address _____

SSN _____ - _____ - _____ Relationship _____ Age _____

Contingent Beneficiary's Name _____
Last name First Name MI

Contingent Beneficiary's Address _____

Effective Date of Change _____

PLEASE NOTE: We do not recommend that you name a minor child as your beneficiary. If you name a minor child as your beneficiary, any benefits due your minor beneficiary will not be payable until a guardian for the financial estate of the minor is appointed by the court or such beneficiary reaches the age of majority as defined by your state. If there is no beneficiary, Aflac will pay any applicable benefit to your estate.

PRIMARY BENEFICIARY

FULL NAME (Last, First, MI)	RELATIONSHIP	CITY/STATE	DATE OF BIRTH	% OF PROCEEDS

CONTINGENT BENEFICIARY

FULL NAME (Last, First, MI)	RELATIONSHIP	CITY/STATE	DATE OF BIRTH	% OF PROCEEDS

ACCIDENT/DISABILITY DOWNGRADES ONLY

(a) – Decrease the monthly benefit amount under the policy from \$ _____ to \$ _____

(b) – Increase the policy elimination period from _____ days to _____ days.

(c) – Decrease the maximum benefit period under the policy from _____ to _____

(d) – Delete optional benefit rider titled _____

OCCUPATION CLASS CHANGE ONLY

Please note that all occupation class changes are subject to review and approval.

Class A B C D E

Type of Business _____

Job Duties _____

Job Title _____

CANCER RIDER DOWNGRADES ONLY

- (a) – Decrease the benefit amount under the Initial Diagnosis Benefit Rider from \$_____ to \$_____
- (b) – Decrease the benefit amount under the Cancer Screening and Annual Care Benefit Rider from \$_____ to \$_____
- (c) – Delete optional benefit rider titled _____

DENTAL DOWNGRADES ONLY

- Delete optional benefit rider titled _____

Policyholder's Signature _____

Date _____