

REQUEST FOR CHANGE
American Family Life Assurance Company of Columbus (AFLAC),
Worldwide Headquarters: Columbus, GA 31999
For information call toll-free 1-800-99-AFLAC (1-800-992-3522)

Pre-tax After-tax

Name of Policyholder _____			SS No. _____
Last Name	First Name	MI	
Policy Number _____	Policy Type _____	Date of Birth _____	

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

PLEASE MAKE THE FOLLOWING CHANGES TO MY POLICY

<input type="checkbox"/> 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 _____	

<input type="checkbox"/> TRANSFERS TO PAYROLL BILLING ONLY	
Transfer From _____	
Transfer To _____	Transfer To _____
Employer Name	Account Number
Department No. _____	Employee No. _____
Amount Remitted \$ _____	Months _____
Billing Name _____	MI _____
Last Name	First Name
Effective Date of Transfer _____	

<input type="checkbox"/> TRANSFERS TO DIRECT BILLING ONLY	
<input type="checkbox"/> Bill at Home <input type="checkbox"/> Bankdraft <input type="checkbox"/> Credit Card	
Transfer From: _____	
Direct Billing Mode (select one) <input type="checkbox"/> Quarterly <input type="checkbox"/> Semiannual <input type="checkbox"/> Annual	
Amount Remitted \$ _____	Months _____
Effective Date of Transfer _____	

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

Payroll Billing Name _____
(if policy is on payroll)

Draftee Name _____
(if policy is on bankdraft)

Effective Date of Change _____

DELETIONS ONLY

Person to be Deleted _____
Last Name First Name MI Title

Sex Male Female Relationship Insured Spouse Child

Reason for Deletion Divorce Death 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) _____
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

SS No. _____ - _____ - _____ Relationship _____ Age _____

Contingent Beneficiary's Name _____
Last name First Name MI

Effective Date of Change _____

Policyholder's Signature _____ Date _____

Is this a Section 125 account? If yes, you must have the Plan Administrator's Signature.

Section 125 Account Approval _____ Date _____

(Section 125 Plan Administrator Signature)