

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)

Name of Policyholder _____ SS# _____
Policy Number _____ Date of Birth _____

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.#)

City _____ State _____ ZIP _____ Telephone #: _____

Former Address of Policyholder _____
(Street) (Apt.#)

City _____ State _____ ZIP _____

TRANSFERS ONLY

Transfer from: _____

To: _____
(If payroll, enter Employer or Account Name and Number. If direct, enter "Direct" and select a billing mode below.)

Direct Billing Mode (select one): Monthly Quarterly Semi-Annual Annual

Amount remitted: \$ _____ Months: _____

Payroll Billing Name: _____

Effective date of transfer: _____

NAME CHANGE ONLY

Name shown on policy: _____

Change name to: _____

Reason: _____
(marriage/divorce/death/other)

Effective date of change: _____

DELETIONS ONLY

Person to be deleted: _____ Relationship: _____

Effective date of deletion: _____ Reason: _____
(divorce/death/other)

New policy/contract holder's full name: _____

Birth date of new policy/contract holder: _____

Type of coverage now desired: Individual One-Parent Family
 Two-Parent Family Named Insured-Spouse Only

BENEFICIARY CHANGE ONLY

Change the beneficiary from: _____ to the following:

Beneficiary's Name _____

SS# ____ - ____ - ____ Relationship: _____ Age: _____

Contingent Beneficiary's Name _____
Last name First 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)