

**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 \_\_\_\_\_