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 _____