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						
PLEASE MAKE THE FOLLOWING CHANGES	S TO MY POLICY						
□ ADDRESS CHANGE ONLY							
New Address of Policyholder							
City State ZIP	Apt.No. Telephone No						
Former Address of Policyholder							
City State	Apt.No.						
Oity State	ZIF						
TRANSFERS TO PAYROLL BILLING ONLY Transfer From Transfer To Employer Name	Transfer To						
Department No Employee No							
Amount Remitted \$ Months							
Billing Name	MI						
Effective Date of Transfer							
□ TRANSFERS TO DIRECT BILLING ONLY □ Bill at Home □ Bankdraft □ Credit Card Transfer From:							
Direct Billing Mode (select one) ☐ Quarterly ☐ Semian	nual 🔲 Annual						
Amount Remitted \$ Months							
Effective Date of Transfer							

Form H-L0046 Fax

Fax: 800-448-8922 or mail:

1

HL0046.12

AFLAC, Attn: PHS 1932 Wynnton Rd, Columbus GA 31999

	NAME CHANGE ONLY							
Name	Shown on Policy	/ Last Na	me	First Name	MI	 Title		
01			iiie	riistivaille	IVII	Title		
Change Name To						Title		
Reaso	n 🛭 Mar	riage	☐ Divorce		☐ Death	☐ Request		
Payroll	Billing Name							
D (1 -	(if policy is on payroll)							
Dratte	Draftee Name (if policy is on bankdraft)							
Effective Date of Change								
	DELETIONS (ONLY						
Person to be Deleted								
		Last Na	me	First Name	MI	Title		
Sex	□Male	□Female	Relationship	☐ Insured	☐ Spouse	☐ Child		
Reaso	n for Deletion	☐ Divorce	☐ Death	☐ Request				
Date of Divorce/Death/Request								
New Policy/Contract Holder's Full Name								
			Last Name	First Nam	ne	MI		
Sex								
Billing Name (only applicable if policy on payroll)								
			Last Na	me	First Name	MI		
New C	overage Desired	d 🗆 Individual	☐ One-Parent Family	☐ Two-Parent I	Family Named Ir	sured-Spouse Only		
□ BENEFICIARY CHANGE ONLY								
Change the Beneficiary From								
			Last Name	First Nam	ne	MI		
To the following Beneficiary's Name								
CC No								
						Age		
Contin	gent Beneficiary	's Name	Last name	First Nam	ne.	MI		
Effectiv	ve Date of Chan	ge						
Policyh	nolder's Signatur	e			Date			
Is this a Section 125 account? If yes, you must have the Plan Administrator's Signature.								
Section 125 Account Approval Date								
		11	(Section 125 Plan Administra	tor Signature)				