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

❑ **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 _____

❑ **TRANSFERS TO PAYROLL BILLING ONLY**

Transfer From _____

Transfer To _____ Transfer To _____
Employer Name Account Number

Department No. _____ Employee No. _____

Amount Remitted $ _____ Months _____

Billing Name _____
Last Name First 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 ❑ Semiannual ❑ Annual

Amount Remitted $ _____ Months _____

Effective Date of Transfer _____

Fax: 800-448-8922 or mail:
AFLAC, Attn: PHS
1932 Wynnton Rd,
Columbus GA 31999

❑ **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)