REQUEST FOR GENDER IDENTITY CHANGE/REASSIGNMENT

Please use blue or black ink only and print legibly when completing this form in its entirety. Keep a copy of the supporting documentation and this completed form for your records. **Sign, date and mail the completed form to the address below or fax to 1.800.448.8922.**

American Family Life Assurance Company of Columbus
(herein referred to as 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

Name of Policyholder/Certificateholder _____ SSN _____
Last Name First Name MI Suffix

Policy/Certificate Number _____ Policy/Certificate Type _____ Date of Birth _____

Policyholder's/Certificateholder's E-Mail Address _____

❑ **GENDER IDENTITY CHANGE/REASSIGNMENT ONLY**

PLEASE NOTE: Changing the gender/sex from the gender/sex you selected at the time of application may impact the premium you will be charged for this policy/certificate.

Change the gender of: ☐ Insured ☐ Spouse

Gender requested: ☐ Male ☐ Female

Date of gender change (surgery) _____

Please provide one of the following:
☐ Court Order
☐ New/modified Birth Certificate
☐ Physician Letter

Policyholder's/Certificateholder's Signature _____ Date _____