



REQUEST FOR DELETION

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 (Aflac)
Attn: Policy Service Department
1932 Wynnton Road
Columbus, GA 31999-7000
For information call toll-free 1-800-99-AFLAC (1-800-992-3522)

Name of Policyholder _____ <i>Last Name</i> <i>First Name</i> <i>MI</i>
Policy Number _____
Policy Type _____
Date of Birth _____

Person to be Deleted _____ <i>Last Name</i> <i>First Name</i> <i>MI</i> <i>Title</i>
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
Relationship <input type="checkbox"/> Insured <input type="checkbox"/> Spouse <input type="checkbox"/> Child
Reason for Deletion <input type="checkbox"/> Divorce <input type="checkbox"/> Death <input type="checkbox"/> Request
Date of Divorce/Death/Request _____
New Policy/Contract Holder's Full Name _____ <i>Last Name</i> <i>First Name</i> <i>MI</i>
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
Birth Date of New Policy/Contract Holder _____
Billing Name (only applicable if policy on payroll) _____ <i>Last Name</i> <i>First Name</i> <i>MI</i>
New Coverage Desired <input type="checkbox"/> Individual <input type="checkbox"/> One-Parent Family <input type="checkbox"/> Two-Parent Family <input type="checkbox"/> Named Insured-Spouse Only

Policyholder's Signature _____	Date _____
Is this a Section 125 account? If yes, you must have the Plan Administrator's Signature.	
Section 125 Account Approval _____ <i>(Section 125 Plan Administrator Signature)</i>	Date _____