REQUEST FOR NAME CHANGE

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 _____

❑ **NAME CHANGE ONLY**

Name Shown on Policy/Certificate _____
Last Name First Name MI Suffix

Change Name To _____
Last Name First Name MI Suffix

Reason ❑ Marriage ❑ Divorce ❑ Death ❑ Request

Billing Name _____
(If policy/certificate is on payroll/association)

Draftee/Cardholder Name _____
(If policy/certificate is on bank draft/credit card)

Effective Date of Change _____

Policyholder's/Certificateholder's Signature _____ Date _____