REQUEST FOR BENEFICIARY 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 1-888-694-1265.

American Family Life Assurance Company of New York (Aflac New York)
Attn: Client Services Department
22 Corporate Woods Boulevard Suite 2 • Albany NY 12211
For information call toll-free 1.800.366.3436

Name of Policyholder _____
Last Name *First Name* *MI*

Policy Number _____

Policy Type _____

Date of Birth _____

Change the Beneficiary From _____
Last Name *First Name* *MI*

To the following Beneficiary's Name _____
Last Name *First Name* *MI*

_____
Beneficiary's Address

Relationship _____ Age _____

Contingent Beneficiary's Name _____
Last Name *First Name* *MI*

_____
Contingent Beneficiary's Address

Effective Date of Change _____

Policyholder's Signature _____ Date _____