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 (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 _____
Last Name *First Name* *MI*

Policy Number _____

Policy Type _____

Date of Birth _____

Name Shown on Policy _____
Last Name *First Name* *MI* *Title*

Change Name to _____
Last Name *First Name* *MI* *Title*

Reason (check one) □ Marriage □ Divorce □ Death □ Request

Payroll Billing Name _____
(if policy is on payroll)

Draftee Name _____
(if policy is on payroll)

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)