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 _____
Last Name *First Name* *MI*

Policy Number _____

Policy Type _____

Date of Birth _____

Person to be Deleted _____
Last Name *First Name* *MI* *Title*

Sex □ Male □ Female

Relationship □ Insured □ Spouse □ Child

Reason for Deletion □ Divorce □ Death □ Request

Date of Divorce/Death/Request _____

New Policy/Contract Holder's Full Name _____
Last Name *First Name* *MI*

Sex □ Male □ Female

Birth Date of New Policy/Contract Holder _____

Billing Name (only applicable if policy on payroll) _____
Last Name *First Name* *MI*

New Coverage Desired
□ Individual □ One-Parent Family □ Two-Parent Family □ 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 _____ Date _____
(Section 125 Plan Administrator Signature)