STATE INSURANCE SPECIFIC CORRECTION/AMENDMENT/DELETION REQUEST FORM

This is a request for: _____ Correction _____ Amendment _____ Deletion

These rights do not extend to information that relates to a claim or to a civil or criminal proceeding.

This form is applicable to American Family Life Assurance Company of Columbus, American Family Life Assurance Company of New York, Continental American Life Insurance Company, and Tier One Life Insurance Company (collectively, "we," "our," or "Aflac").

You have the right to request Aflac to make corrections, amendments or deletions to the personal information we retain on your behalf if you believe something in that information is in error or needs to be changed. To ensure the security of information in our files, we may require positive identification before we process your request. We are not always able to fulfill your request (e.g., if the medical record was created by your doctor, he/she would be responsible for modifying your records), but each request will be carefully reviewed. You will be notified when your request has been approved or denied. Our response will be mailed to the current address we have on file.

Name:_____

SSN (last four digits):_____ Date of Birth:_____

Policy or Certificate Number(s):_____

Primary Policyholder's Name (if different from above): _____

Please provide as much detail as possible regarding the personal information we have about you that you are requesting be corrected, amended or deleted. In order to review the request, we must be able to locate the record at issue and the exact entries or reports you want changed or deleted.

_____

_____

_____

Please provide as much detail as possible regarding the purpose(s) for this request.

_____

_____

_____

_____ _____

Signature Date

_____ _____

Printed Name of Legal/Personal Representative
(If Signed by a Legal/Personal Representative)

Legal Relationship
(e.g., Legal Guardian, Power of Attorney)

Note: We will not process this request if the form has not been signed by you or your personal representative. If this document is being signed by a Legal/Personal Representative, please provide us with the court appointed documents granting this authority.

Select the company through which you have coverage.		**Mail To:**
	American Family Life Assurance Company of Columbus	Aflac Attn: Privacy Office 1932 Wynnton Road Columbus, GA 31999
	American Family Life Assurance Company of New York	
	Tier One Life Insurance Company	
	Continental American Life Insurance Company	Aflac Attn: Privacy Office PO Box 427 Columbia, SC 29202