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
(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

❑ **Pre-tax** ❑ **After-tax**

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 _____

❑ **DELETIONS ONLY**

Person to be Deleted _____
Last Name First Name MI Suffix

Gender ❑ Male ❑ Female Relationship ❑ Insured ❑ Spouse ❑ Dependent

Address of person being deleted _____

Reason for Deletion ❑ Divorce/Annulment/Dissolution of Domestic Partnership*
❑ Death ❑ Dependent attaining age ❑ Request

Date of Divorce*/Death/Request or Date of birth of dependent attaining age _____

New Policyholder's/Certificateholder's Full Name _____
Last Name First Name MI Suffix

Gender ❑ Male ❑ Female Birth Date of Policyholder's/Certificateholder's _____

Billing Name (only applicable if policy/certificate on payroll/association) _____
Last Name First Name MI Suffix

New Coverage Desired ❑ Individual ❑ One-Parent Family ❑ Two-Parent Family ❑ Named Insured-Spouse Only

***Please attach a copy of the divorce decree, court order verifying annulment, or order dissolving the domestic partnership. Failure to attach documentation may prevent Aflac from processing the deletion and/or issuing a refund of premium.**

Policyholder's/Certificateholder's Signature _____ Date _____