

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	t Name	First Name	MI
Policy Number		· · · · · · · · · · · · · · · · · · ·	
Policy Type			
Date of Birth			
Name Shown on Policy			
Last Name	First Name	MI	Title
Change Name to	First Name	MI	
	□ Divorce		
Reason (check one) Warnage	□ Divoice	□ Death	□ Nequest
Payroll Billing Name			
, 0	(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 Date			

Form H-L0046 HL0046.12A