REQUEST FOR BENEFICIARY 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 ______________________________

Change the Beneficiary From ______________________________
Last Name *First Name* *MI*

To the Following Beneficiary's Name ______________________________
Last Name *First Name* *MI*

SS No. ________ - ________ - ________

Relationship ______________________________

Age ______________

Contingent Beneficiary's Name ______________________________
Last Name *First Name* *MI*

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)