

**REQUEST FOR CHANGE**  
**American Family Life Assurance Company of Columbus (AFLAC),**  
**Worldwide Headquarters: Columbus, GA 31999**  
For information call toll-free 1-800-99-AFLAC (1-800-992-3522)

Pre-tax     After-tax

Name of Policyholder \_\_\_\_\_ SS No. \_\_\_\_\_  
Policy Number \_\_\_\_\_ Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_  
Policy Type \_\_\_\_\_ Date of Birth \_\_\_\_\_

Associate/Agent's Signature \_\_\_\_\_ Writing Number \_\_\_\_\_  
Licensed Resident Associate/Agent

**PLEASE MAKE THE FOLLOWING CHANGES TO MY POLICY**

**ADDRESS CHANGE ONLY**

New Address of Policyholder \_\_\_\_\_ Street \_\_\_\_\_ Apt.No. \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_ Telephone No. \_\_\_\_\_  
Former Address of Policyholder \_\_\_\_\_ Street \_\_\_\_\_ Apt.No. \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

**TRANSFERS TO PAYROLL BILLING ONLY**

Transfer From \_\_\_\_\_  
Transfer To \_\_\_\_\_ Employer Name \_\_\_\_\_ Transfer To \_\_\_\_\_ Account Number \_\_\_\_\_  
Department No. \_\_\_\_\_ Employee No. \_\_\_\_\_  
Amount Remitted \$ \_\_\_\_\_ Months \_\_\_\_\_  
Billing Name \_\_\_\_\_ Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_  
Effective Date of Transfer \_\_\_\_\_

**TRANSFERS TO DIRECT BILLING ONLY**

Bill at Home     Bankdraft     Credit Card  
Transfer From: \_\_\_\_\_  
Direct Billing Mode (select one)     Quarterly     Semiannual     Annual  
Amount Remitted \$ \_\_\_\_\_ Months \_\_\_\_\_  
Effective Date of Transfer \_\_\_\_\_

