REQUEST FOR LIFE POLICY CHANGE/BENEFICIARY CHANGE
Application to American Family Life Assurance Company of Columbus (Aflac)
Worldwide Headquarters: Columbus, Georgia 31999

INSTRUCTIONS:
1. Complete a separate request for each policy.
2. Please print or type all information except signatures.
3. If you request change 15B, return the policy with this form.

NOTE: If applicable, the term "insured" also means "annuitant," and the term "policy" also means "contract."

REQUIRED SIGNATURES:
1. Owner must sign ALL requests.
2. If policy is collaterally assigned, assignee must sign if Request #4, 7 or 15 is made.
3. If beneficiary was designated without right of revocation, beneficiary must sign if Request #7, 12 or 15 is made.
4. If owner resides in a community property state, the spouse of the owner must sign if Request #7, 12 or 15 is made.
5. If owner is a partnership, each partner must sign if Request #7, 12 or 15 is made.
6. If owner is a corporation, only an authorized officer other than the insured may sign. A resolution of authorization by the corporation board of directors must be attached to this form if Request #7, 12 or 15 is made.
7. Additional Required Signature(s) in #16 apply to any and all requests within this form.
8. Owner must complete income tax withholding notice and election if Requests #13 and 14 are made.

Name of company_____

MULTIPURPOSE POLICY SERVICE FORM
Use this form to change address, premium mode, billing mode, name, beneficiary or owner; deletion; request duplicate policy; surrender the policy; exercise the nonforfeiture option; or effect release of interest.

Insured_____ Policy number_____

Owner_____ Telephone # of owner(____)_____

Mailing address of owner_____
Number and street City State ZIP code

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1. ☐ ADDRESS CHANGE (owner only). The mailing address of owner indicated above is a change of address.

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2. ☐ ADDRESS CHANGE (other than owner)

For: ☐ Insured ☐ Assignee ☐ Billing address ☐ Other (Specify)_____

New Address_____
Number and street City State ZIP code

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3. ☐ MODE OF PREMIUM PAYMENT CHANGE
Change Mode to:
☐Annual ☐Quarterly ☐Pre-authorized check (attach completed
☐Semiannual ☐Monthly authorization form and voided check) ☐Other

NOTE: One of the premium due dates of the new mode must be a policy anniversary date.

4. ☐ DUPLICATE POLICY

I hereby declare that the above policy was lost or destroyed under the following circumstances:

_____

I request Aflac to issue a duplicate of the above policy numbered the same as the original. I agree that upon issuance of the duplicate policy, the original policy will be null and void and that if the original is found, I will promptly return it to Aflac. I agree to hold Aflac harmless from any claim or expense under the original policy.

5. ☐ NAME CHANGE OR CORRECTION

Change the name of: ☐Insured ☐Owner ☐Other (specify)_____

From_____ To_____

Reason: ☐Marriage ☐Divorce ☐Court order
☐Other (specify)_____

NOTES:

1. For all name changes other than by marriage, attach a certified copy of the legal document (such as court order, adoption papers). The change cannot be processed without such proof.

2. If the name is that of a corporation, submit certified resolution of the board of directors changing its name and a copy of the document indicating that the change is officially recorded with state of incorporation.

6. ☐ DELETIONS ONLY

Person to be Deleted _____
Last Name First Name MI Title

Sex ❑ Male ❑ Female Relationship ❑ Insured ❑ Spouse ❑ Child

Address of person being deleted _____

Reason for Deletion: ❑ Divorce ❑ Death ❑ Dependent attaining age ❑ Request

Date of Divorce/Death/Request _____

7. ☐ OWNERSHIP CHANGE - ABSOLUTE ASSIGNMENT

For the value received, I hereby give all benefits, rights and privileges incident to ownership of the above policy to:

New Owner_____ Social Security #_____

Mailing address_____
Number and street City State ZIP code

All future correspondence and notices unless otherwise specified will be sent to the mailing address indicated above.

CAUTION: This change of ownership does not change the existing beneficiary designation.

8. ☐ TRANSFERS TO PAYROLL OR UNION BILLING ONLY

Transfer From _____

Transfer To _____ Transfer To _____
Employer Name Account Number

Department No. _____ Employee No. _____

Amount Remitted $_____ Months _____

Billing Name _____
Last Name First Name MI

Requested Effective Date of Transfer _____

9. ☐ TRANSFERS TO DIRECT BILLING ONLY

❑ Bill at Home ❑ Bankdraft ❑ Credit Card

Transfer From _____

Direct Billing Mode (select one): ❑ Monthly **(Bankdraft/Credit Card Only)** ❑ Quarterly
❑ Semiannual ❑ Annual

Amount Remitted $_____ Months _____

Requested Effective Date of Transfer _____

10. ☐ RELEASE OF INTEREST

a. By: ☐Collateral assignee ☐Beneficiary ☐Other (specify)_____
For the value received, I hereby release all rights, title and interest in the above policy.

b. ☐ Spouse/Former spouse in community property state

I, (print full name)_____, spouse/former spouse of the owner of the above policy, hereby release all right, title and interest that I may have in this policy now or in the future, by virtue of the community property laws of the state of_____.

_____ _____
Signature of assignee, beneficiary, spouse/former spouse, other Date

11. ☐ OTHER. Indicate here any change not listed on this form, EXCEPT addition of riders, reinstatement, increase in death benefit, change in plan, exchange or reissue.

SAMPLE BENEFICIARY DESIGNATIONS

Two or more to share equally	Specify names of beneficiaries, their relationship to insured, and dates of birth. State "Equally or to the survivor."
Estate of the insured	State "Executors or Administrators of the Insured" or "The Estate of the Insured."
Unnamed children (per capita)	State "Children born of the marriage of John Doe and Jane Doe, equally or to the survivor."
Adopted children (per capita)	State "Children born of the marriage of, or legally adopted by, John Doe and Jane Doe, equally or to the survivor."
Unnamed children (per stirpes)	State "Children born of the marriage of John Doe and Jane Doe, per stirpes."
Trustee	State "Trustee(s) of_____ Trust under trust agreement dated _____.
Partnership	Example: Smith and Smith, a partnership, 123 Main Street, Chicago, IL
Sole proprietorship	Example: John Doe, D/B/A The Sandwich Shop, 123 Main Street, Chicago, IL

12. ☐ BENEFICIARY CHANGE

I hereby revoke all previous beneficiary designations and settlement options for the above policy. The beneficiary designation shall be as shown below. The rights of the beneficiary will be subject to the rights of any assignee of record.

PLEASE NOTE: We do not recommend that you name a minor child as your beneficiary. If you name a minor child as your beneficiary, any benefits due your minor beneficiary will not be payable until a guardian for the financial estate of the minor is appointed by the court or such beneficiary reaches the age of majority as defined by your state. If there is no beneficiary, Aflac will pay any applicable benefit to your estate.

PRIMARY BENEFICIARY

FULL NAME (Last, First, MI)	RELATIONSHIP	CITY/STATE	DATE OF BIRTH	% OF PROCEEDS

CONTINGENT BENEFICIARY

FULL NAME (Last, First, MI)	RELATIONSHIP	CITY/STATE	DATE OF BIRTH	% OF PROCEEDS

Unless otherwise provided, the proceeds of the policy are to be paid in one sum. Unless otherwise provided, if two or more beneficiaries are named in a class (primary or contingent), all members of the class who survive the insured will SHARE equally in any payment(s) due.

13. ☐ POLICY LOAN

I understand that Aflac will make this loan with this policy, whose number is shown above, as the sole security for the loan. I also understand that the death benefit payable will be reduced by the amount of all outstanding loans. I agree to take this loan subject to all the applicable terms and conditions in my policy.

☐$_____cash or full amount, if less.

☐Maximum amount available ☐Minimum deposit - amount enclosed_____

☐Loan to pay premium(s) (indicate premium due date)_____

☐Special requests_____

14. ☐ DIVIDEND OR COUPON CHANGE (Income tax withholding notice and election must be completed.)
The owner authorizes a change of dividend/coupon election to the following:

☐To be paid in cash ☐To pay premium(s) (specify premium due date)_____

☐To purchase paid-up additions ☐To be used to reduce policy loan indebtedness

☐To accumulate with interest☐To be applied as follows_____

15. ☐ NONFORFEITURE OPTION REQUEST (Income tax withholding notice and election must be completed.)

a. Effective on the date premiums are paid, I request that the above policy continue as:
   ☐ Reduced paid-up insurance
   ☐ Extended term insurance, if available; otherwise, reduced paid-up insurance.
b. ☐ I am returning the policy; I request full cash surrender.

INCOME TAX WITHHOLDING NOTICE AND ELECTION: In 1982, Congress passed the Tax Equity and Fiscal Responsibility Act (TEFRA). This law requires that a tax of 10% be withheld from the taxable portion of certain life insurance payments you receive unless you decide not to have tax withheld. Withholding applies only to the taxable portion of the payment you receive and not to the entire payment. The taxable portion that is subject to withholding is, in general, equal to the excess of the amount you receive over the total net amount that is considered to be your cost basis for such amount. In many instances, when a life insurance policy is surrendered for its cash value, there is no such excess.

Elect "withholding" or "no withholding" by checking the appropriate box below. Please complete this section of this form by signing it and filling in your Social Security number. If you do not make a choice, we will withhold 10% for federal income taxes from any taxable portion of your payment.

Even if you decide not to have federal income tax withheld, you are still liable for payment of federal income tax on the taxable portion of this payment. You may be subject to tax penalties under the Estimated Tax Payment Rules if your payments of estimated tax withholding, if any, are not sufficient.

PLEASE (✓) ONE BLOCK

☐ I have read the above notice and elect to have no income tax withheld.
☐ I have read the above notice and elect to have income tax withheld.

Social Security number*_____
*If not completed properly, we may be required to withhold 20% from any taxable portion of your payment.

16. ☐ **BY MY SIGNATURE BELOW, I ACKNOWLEDGE THAT** I understand that this request is subject to the provisions and conditions of the above policy and that Aflac may request additional information or impose additional requirements. I agree that my signature shall apply to each request that has been checked on this form and further agree that no request will become effective that is not checked. I certify that the above policy is not pledged or assigned to any other person or corporation, except where stated in the request, and that no proceedings in bankruptcy are pending.

Signed at _____ Date _____
City and state

_____ _____
Owner's signature New owner's signature, if applicable

_____ _____
Owner's City State ZIP code Additional required signature, if any

(applies to any item in this form where required)

FOR COMPANY USE ONLY

The above request(s) for change is acknowledged and has been completed by Aflac. This acknowledgment applies only to the policy specified in this form. Presentation of the policy for completion of this change has been waived, except in Request #14b.

Date completed _____ By _____
Name (Print or type) Title

Company _____ Signature _____

Address _____