SERVICE REQUEST FORM

Certificate Number	Insured	Certificateholder (if other than insured)
Address		Phone Number

1. Change of Beneficiary (Note: The witness must be someone other than the beneficiary.)

Please change the beneficiary under the above certificate as follows:

Primary Beneficiary			Relationship to Insured
Date of Birth	Social Security Number	Telephone Number	Email Address
Address			
Contingent Beneficiary			Relationship to Insured
Date of Birth	Social Security Number	Telephone Number	Email Address
Address			

2. Change of Name (Please attach official documentation of the name change.)

Former Name	New Name
Reason for Change	

3. Change of Address

Former Address	
New Address	Phone Number

4. Transfer of Ownership (This applies only to Whole Life and Universal Life.)

I request that all benefits, rights, and privileges incident to ownership of the plan vested in the new owner named below, or to such new owner's executors, administrators and assigns, or successors and assigns.

New Owner (Full Name)	Relationship to Insured
Address of New Owner	

5. ☐ Discontinue Premium Deduction Only/Allow Plan to Continue (This applies only to Universal Life.)

I request that all payroll deductions or billings be discontinued at this time. I understand that I must notify Continental American Insurance Company (a wholly-owned subsidiary of Aflac Incorporated) to start payroll deductions or billings at a later date. I understand that my plan will continue to remain in force until all accumulated value capable of continuing the plan is depleted or until I request continuation of premium payments. I understand that once accumulated value capable of continuing the plan is depleted, the coverage will lapse.

6. ☐ Cancellation \ Change of Coverage

Please check one: ☐ **Pre-tax** ☐ **After-tax**

Requested Effective Date of Cancellation:

I have reviewed the benefits of the plan and have decided to cancel my coverage. I understand that by waiving my rights to continue my coverage, I may be required to show evidence of insurability to re-qualify for coverage.

☐ **Cancellation**			☐ **Change of Coverage**		
☐ **Short-Term Disability**	**Critical Illness** ☐ Employee ☐ Spouse*	**Universal Life** ☐ Employee ☐ Spouse* ☐ Child*	☐ **Short-Term Disability**	**Critical Illness** ☐ Employee ☐ Spouse*	**Universal Life** ☐ Employee ☐ Spouse* ☐ Child*
☐ **Long-Term Disability**	**Term Life** ☐ Employee ☐ Spouse* ☐ Child*	☐ **Reduce Face Amount** (applies to Critical Illness, Disability, and Universal Life only)	☐ **Long-Term Disability**	**Term Life** ☐ Employee ☐ Spouse* ☐ Child*	☐ **Reduce Face Amount** (applies to Critical Illness, Disability, and Universal Life only)
Hospital Indemnity ☐ Employee ☐ Spouse* ☐ Child*	**Whole Life** ☐ Employee ☐ Spouse* ☐ Child*	☐ **Cancel Dollar Per Week**	**Hospital Indemnity** ☐ Employee ☐ Spouse* ☐ Child*	**Whole Life** ☐ Employee ☐ Spouse* ☐ Child*	☐ **Cancel Dollar Per Week**
Cancer ☐ Employee ☐ Spouse* ☐ Child* **Dental** ☐ Employee ☐ Spouse* ☐ Child*		**Accident** ☐ Employee ☐ Spouse* ☐ Child*	**Cancer** ☐ Employee ☐ Spouse* ☐ Child* **Dental** ☐ Employee ☐ Spouse* ☐ Child*		**Accident** ☐ Employee ☐ Spouse* ☐ Child*
☐ New face amount (certificateholder) $	☐ New face amount (spouse) $	☐ Open Enrollment Cancellation	☐ New face amount (certificateholder) $	☐ New face amount (spouse) $	☐ Open Enrollment Cancellation

*If you have spouse or dependent coverage on the plan(s) you wish to cancel, please indicate whether you wish to cancel the entire plan **or** only coverage for your spouse and/or dependent child. If you would like to cancel your spouse and/or dependent coverage, please provide each name and date of birth below:

Name(s) and Date(s) of Birth:

For Employer Use Only

Cancellation authorized by:_____ Date:_____

(Plan administrator/employer) **(must be on or after cancellation date)**

7. ☐ Lost Certificate Notification

I, _____ hereby certify that Certificate No. _____, dated _____, and issued by Continental American Insurance Company, has been lost or destroyed and that said certificate is not assigned, hypothecated, or pledged in any way whatsoever. I, therefore, request a replacement certificate and agree that should the original certificate be found or in any way come into my possession, I will return or cause the same to be returned to Continental American Insurance Company, its successors, or assigns. It is distinctly understood and agreed that the original certificate will become null and void immediately upon issuance of the certificate herein requested.

8. ☐ Loan/Withdrawal Request (Please allow at least 45 days for processing.)

I request a loan of $_____ (or the maximum amount, if less than the amount I am requesting).

9. ☐ Surrender for Cash Value (Please allow at least 45 days for processing.)

I request payment of the cash value in exchange for surrender of the attached certificate. I _____ hereby certify that Certificate No.: _____ has been destroyed and that said certificate is not assigned, hypothecated, or pledged in any way whatsoever. I further certify that there are no outstanding bankruptcy proceeding against me and that no liens are pending against the certificate.

10. ☐ Request Cash Value Amount (Please allow at least 5 days for processing.)

I request to know the cash value for the following certificate number _____.

Please sign and date here for above requests:

Date	**Signature of Owner**
Witness	
Signature of Signee (if applicable)	**Signature of Irrevocable Beneficiary (if any)**

Return to: **Mail:** Aflac • P.O. Box 84075 • Columbus, GA 31993 • **Fax:** 866. 849.2974 • **Email:** cscmail@aflac.com

Questions? **Toll-Free:** 1.800.433.3036