

Service Request Form						
Certificate Number	Insured		Certificateholder (if other than insured)			
Address			Phone Number			
1. Change of Beneficiary	(Note: The witness must b	e someone other	than the	beneficiary.)		
	ciary under the above certific			,		
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 (Plea	ase attach official docume	entation of the nar	ne chan	ge.)		
Former Name	New Name					
Reason for Change						
2.00						
3. Change of Address Former Address						
New Address			F	Phone Number		
A Transfer of Own and him	/This amplies amb to M/h als		11:6- \			
	(This applies only to Whole ohts and privileges incident		•	ed in the new owner		
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)				ship to Insured		
Address of New Owner						

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	Critical Illness	Universal Life	☐ Short-Term	Critical Illness	Universal Life		
Disability	□ Employee□ Spouse*	☐ Employee ☐ Spouse* ☐ Child*	Disability	□ Employee □ Spouse*	☐ 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 ☐ Em p lo ye e ☐ Spouse* ☐ Child*	Reduce Face Amount (applies to Critical Illness, Disability, and Universal Life only)		
Hospital Indemnity	Whole Life	Cancel	Hospital	Whole Life	_Cancel		
□Em p lo ye e	☐ Em p lo ye e	Dollar	Indemnity	☐ Em p lo ye e	Dollar		
□Spouse*	□Spouse*	Per Week	□Em p lo ye e	□Spouse*	Per Week		
□Child*	□Child*		□Spouse* □Child*	□Child*			
Cancer Accident			Cancer Accident				
	☐ Employee ☐ Spouse* ☐ Child*				☐ Em p lo ye e		
	se * LChild *	Em p lo ye e					
Dental		☐ Sp o u se *	Dental		☐ Spouse*		
Dental ☐ Employee ☐ Spo	use* □Child*		Dental ☐ Employee ☐ Spe	ouse*	☐ Spouse * ☐ Child *		
Dental ☐ Employee ☐ Spo ☐ New face	use* □Child* □ New face	☐ Spouse* ☐ Child* ☐ Open	Dental ☐ Employee ☐ Spo ☐ New face	ouse* Child* New face	☐ Child*		
Dental ☐ Employee ☐ Spo ☐ New face amount	use* □Child* □ New face amount	☐ Spouse* ☐ Child*	Dental ☐ Employee ☐ Spo ☐ New face amount	ouse * Child * Ne w face amount	☐ Child * ☐ Open Enrollment		
Dental ☐ Employee ☐ Spo ☐ New face	use* Child* New face amount (spouse)	☐ Spouse* ☐ Child* ☐ Open Enrollment Cancellation	Dental ☐ Employee ☐ Spo ☐ New face amount (certificateholder)	Ouse* Child* New face amount (spouse)	☐ Child*		
Dental ☐ Employee ☐ Spo ☐ New face amount (certificateholder) \$ *If you have spouse or wish to cancel the ent cancel your spouse ar	use* Child* New face amount (spouse) to dependent coverable plan or only cond/or dependent	Spouse* Child* Open Enrollment Cancellation erage on the plan(soverage for your sp	Dental ☐ Employee ☐ Sport ☐ New face amount (certificateholder) \$) you wish to cancel, ouse and/or dependent	Ouse * Child * New face amount (spouse) \$ please indicate volume	☐ Child * ☐ Open Enrollment Cancellation whether you vould like to		
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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					
	st Cash Value Amount (Please allow the cash value for the following ce	low at least 5 days for processing.)			
request to know the easit value for the following certificate humber					
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					

Continental American Insurance Company (CAIC), a proud member of the Aflac family of insurers, is a wholly-owned subsidiary of Aflac Incorporated and underwrites group coverage.

Questions?

Toll-Free: 1.800.433.3036