REQUEST FOR CHANGE

American Family Life Assurance Company of New York
(herein referred to as Aflac New York)
22 Corporate Woods Boulevard • Suite 2 • Albany, NY 12211
For information call toll-free 1.800.366.3436
Toll-Free Fax: 1.888.694.1265

❑ **Pre-tax** ❑ **After-tax**

Name of Policyholder/Certificateholder ______________________ SSN ____________
Last Name First Name MI Suffix

Policy/Certificate Number ____________ Policy/Certificate Type ____________ Date of Birth ____________

Policyholder's/Certificateholder's E-Mail Address ______________________

Agent's Signature ______________________ Writing Number ____________
Licensed Agent

PLEASE MAKE THE FOLLOWING CHANGES TO MY POLICY/CERTIFICATE.

❑ **ADDRESS CHANGE ONLY**

New Address of Policyholder/Certificateholder ______________________
Street Apt. No.

City ____________ State ____________ ZIP ____________ Telephone No. ____________

Former Address of Policyholder/Certificateholder ______________________
Street Apt. No.

City ____________ State ____________ ZIP ____________

❑ **NAME CHANGE ONLY**

Name Shown on Policy/Certificate ______________________
Last Name First Name MI Suffix

Change Name To ______________________
Last Name First Name MI Suffix

Reason ❑ Marriage ❑ Divorce ❑ Death ❑ Request

Billing Name ______________________
(If policy/certificate is on payroll/association)

Draftee/Cardholder Name ______________________
(If policy/certificate is on bank draft/credit card)

Effective Date of Change ______________________

❑ **GENDER IDENTITY CHANGE/REASSIGNMENT ONLY**

PLEASE NOTE: Changing the gender/sex from the gender/sex you selected at the time of application may impact the premium you will be charged for this policy/certificate.

Change the gender of: ☐ Insured ☐ Spouse

Gender requested: ☐ Male ☐ Female

Date of gender change (surgery) ______________________

Please provide one of the following:
☐ Court Order
☐ New/modified Birth Certificate
☐ Physician Letter

❑ **TRANSFERS TO PAYROLL/UNION/ASSOCIATION BILLING ONLY**

Transfer From ______________________ (Account Name) ______________________ (Account Number)

Transfer To ______________________ (Account Name) ______________________ (Account Number)

Department No. ______________________ Employee/Member No. ______________________

Amount Remitted $______________________ Months ______________________

Billing Name ______________________
Last Name First Name MI Suffix

Effective Date of Transfer ______________________

❑ **TRANSFERS TO DIRECT BILLING ONLY**

❑ Bill at Home ❑ Bank Draft ❑ Credit Card

Transfer From ______________________ Effective Date of Transfer ______________________

Direct Billing Mode (select one) ❑ Monthly (Bank Draft/Credit Card Only) ❑ Quarterly ❑ Semiannual ❑ Annual

Amount Remitted $______________________ Months ______________________

When would you like your premiums deducted?______________________ (Please choose any day 1-28.)

❑ **I choose to pay by electronic draft.**

Account Holder's Name ______________________

Account Holder's Address ______________________

City ______________________ State______________________ ZIP ______________________

Transit/ABA Number ______________________

Account Number ______________________ ❑ Checking ❑ Savings

❑ **I choose to pay by credit or debit card (only Visa, MasterCard, and American Express are accepted).**

Card Holder's Name ______________________

Card Holder's Address______________________City______________________ State______ ZIP________

Card Number ______________________ Expiration Date ______________________

Confirmation

I authorize Aflac New York to initiate debit entries or charges electronically to my account indicated above and I authorize the institution named above to debit or charge same to such account. I authorize Aflac New York to continue to initiate debit entries or charges to the account beyond the expiration date of the card and automatically update card information as necessary to continue initiating debit entries or charges. This authorization remains effective and in full force until Aflac New York and the institution receive written notification from me of its termination in such time and in such manner to afford Aflac New York and the institution a reasonable opportunity to act on it.

Account Holder/Card Holder's Signature______________________Date ______________________
(If different from Policyholder/Certificateholder/Applicant)

Policyholder's/Certificateholder's/Applicant's Signature ______________________ Date ______________________

❑ **DELETIONS ONLY**

Person to be Deleted ______________________________
Last Name First Name MI Suffix

Gender ❑ Male ❑ Female Relationship ❑ Insured ❑ Spouse ❑ Dependent

Address of person being deleted ______________________________

Reason for Deletion ❑ Divorce/Annulment/Dissolution of Domestic Partnership*
❑ Death ❑ Dependent attaining age ❑ Request

Date of Divorce*/Death/Request or Date of birth of dependent attaining age ______________

New Policyholder's/Certificateholder's Full Name ______________________________
Last Name First Name MI Suffix

Gender ❑ Male ❑ Female Birth Date of New Policyholder/Certificateholder ______________

Billing Name (only applicable if policy/certificate on payroll/association)______________
Last Name First Name MI Suffix

New Coverage Desired ❑ Individual ❑ One-Parent Family ❑ Two-Parent Family ❑ Named Insured-Spouse Only

***Please attach a copy of the divorce decree, court order verifying annulment, or order dissolving the domestic partnership. Failure to attach documentation may prevent Aflac New York from processing the deletion and/or issuing a refund of premium.**

❑ **BENEFICIARY INFORMATION**

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 New York will pay any applicable benefit to your estate.

If you reside in a community property state, are married, and designate a person other than your spouse as the primary beneficiary, your spouse may have rights to the death benefit of the policy/certificate under state law even if you choose not to name them as your beneficiary. We recommend submitting documentation signed by your spouse consenting to your beneficiary designation and waiving any right to proceeds payable under the policy/certificate. If you are unsure whether these laws apply to you, consult with your legal or tax advisor to determine whether submission of such documentation is necessary. Unless Aflac New York has been notified of a community or marital property interest in the policy/certificate, Aflac New York will presume that no such interest exists and disclaims any responsibility for determining the applicability of community property laws or the validity of the beneficiary designation. However, if your spouse claims a community property interest in the proceeds, it may delay in the payment of proceeds under the policy/certificate. By signing this form, you agree to indemnify and hold Aflac New York harmless from the consequences of making the designation requested in this form.

Effective Date of Change ______________

Change the Primary Beneficiary(ies) from: (If no beneficiary previously named, please put N/A in the space below.)

(1) Name ______________________ (2) Name ______________________
Last Name First Name MI Suffix Last Name First Name MI Suffix

(3) Name ______________________ (4) Name ______________________
Last Name First Name MI Suffix Last Name First Name MI Suffix

To the following new Primary Beneficiary(ies): **NOTE: Total % of Proceeds must equal 100%**

(1) Name ______________________________ % of Proceeds ________
Last Name First Name MI Suffix

Address ______________________________
Street Address City State Zip

Telephone No. ______________ SSN ________ -________ -________

Date of Birth ______________ Relationship to Insured ______________

(2) Name ______________________________ % of Proceeds ________
Last Name First Name MI Suffix

Address ____
Street Address City State Zip

Telephone No. ____________________ SSN ______ -_____ -______

Date of Birth ____________________ Relationship to Insured ____________

(3) Name ______________________________ % of Proceeds ________
Last Name First Name MI Suffix

Address ____
Street Address City State Zip

Telephone No. ____________________ SSN ______ -_____ -______

Date of Birth ____________________ Relationship to Insured ____________

(4) Name ______________________________ % of Proceeds ________
Last Name First Name MI Suffix

Address ____
Street Address City State Zip

Telephone No. ____________________ SSN ______ -_____ -______

Date of Birth ____________________ Relationship to Insured ____________

Change the Contingent Beneficiary(ies) from: (If no beneficiary previously named, please put N/A in the space below.)

(1) Name ______________________ (2) Name ______________________
Last Name First Name MI Suffix Last Name First Name MI Suffix

(3) Name ______________________ (4) Name ______________________
Last Name First Name MI Suffix Last Name First Name MI Suffix

To the following new Contingent Beneficiary(ies): **NOTE: Total % of Proceeds must equal 100%**

(1) Name ______________________________ % of Proceeds ________
Last Name First Name MI Suffix

Address ____
Street Address City State Zip

Telephone No. ____________________ SSN ______ -_____ -______

Date of Birth ____________________ Relationship to Insured ____________

(2) Name ______________________________ % of Proceeds ________
Last Name First Name MI Suffix

Address ____
Street Address City State Zip

Telephone No. ____________________ SSN ______ -_____ -______

Date of Birth ____________________ Relationship to Insured ____________

(3) Name ____ % of Proceeds __________
Last Name First Name MI Suffix

Address ____
Street Address City State Zip

Telephone No. ______________________ SSN __________ - ________ - __________

Date of Birth ______________________ Relationship to Insured ________________

(4) Name ____ % of Proceeds __________
Last Name First Name MI Suffix

Address ____
Street Address City State Zip

Telephone No. ______________________ SSN __________ - ________ - __________

Date of Birth ______________________ Relationship to Insured ________________

❑ **OCCUPATION CLASS CHANGE ONLY**

Please note that all occupation class changes are subject to review and approval.

Class ❑ A ❑ B ❑ C ❑ D ❑ E

Type of Business ____

Job Duties ____

Job Title ____

❑ **RIDER DELETIONS ONLY**

❑ Delete optional benefit rider(s) titled ____

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❑ **ACCIDENT/DISABILITY DOWNGRADES ONLY**

❑ (a) – Decrease the monthly benefit amount under the policy/certificate from $_____________ to $__________

❑ (b) – Increase the policy/certificate elimination period from ___________ days to ______________ days.

❑ (c) – Decrease the maximum benefit period under the policy/certificate from __________ to ____________

❑ (d) – Decrease the monthly benefit amount under the ________________________________ rider from $____________ to $________________

❑ **CANCER RIDER DOWNGRADES ONLY**

❑ (a) – Decrease the benefit amount under the Initial Diagnosis Benefit Rider from $__________ to $__________

❑ (b) – Decrease the benefit amount under the Cancer Screening and Annual Care Benefit Rider from $_________ to $_________

For downgrades:

- I have reviewed the benefits and premium of the insurance policy/certificate and/or rider(s) that I am changing and agree to the following:
  - I understand the impact that the premium for this coverage has on my paycheck/income;
  - I understand the impact that the total Aflac New York premium for this coverage and any other Aflac New York coverage has on my paycheck/income and believe it to be appropriate for me; and
  - I have considered all of my existing health insurance coverage, with Aflac New York and/or with other carriers, and believe this change in coverage is appropriate for my insurance needs. I further understand that I can contact Aflac New York and/or other insurance carriers to assist in evaluating the suitability of insurance coverage for me.

Policyholder's/Certificateholder's Signature ________________________ Date ______________