Request for Cancellation of Policy

Cancellation of riders on existing coverage should be completed using the Request for Change Form (HL0046) or the applicable product application for downgrade.

Policyholder Name:			
Billing Name (if different than policyholder)		Policyholder's SSN or EEID:	
Email Address:			
Requested Effective Date:			

Policy Number	Coverage Type	Current Payroll Deduction Status	
		☐ Pre-tax**	☐ Post-tax
		☐ Pre-tax**	☐ Post-tax
		☐ Pre-tax**	☐ Post-tax
		☐ Pre-tax**	☐ Post-tax
		☐ Pre-tax**	☐ Post-tax
		☐ Pre-tax**	☐ Post-tax

** *If your premium deduction is pre-tax and you are requesting cancellation outside of your open enrollment period, this form must be signed by both you and your employer.*

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.

Policyholder's Signature Date

Associate/Agent Signature and Writing Number ____

Below section is not required to be completed for post-tax deductions

TO THE EMPLOYER: IMPORTANT! READ BEFORE SIGNING!

If your Aflac insurance premiums are paid through an IRS Section 125 Cafeteria Plan, which is governed by strict IRS guidelines, the IRS does not allow changes to insurance premium during the plan year unless there is a valid change in status such as marriage, divorce, birth, death, adoption, or change in employment.

Therefore, your authorization to allow the cancellation during the plan year is required to ensure a valid change in status has occurred. If you do not authorize cancellation, the cancellation request may be made during your open enrollment period.

Employer's/ Plan Administrator's Signature (Authorizing Cancellation) Date

Printed Name of Authorized Employer Plan Administrator

American Family Life Assurance Company of Columbus (Aflac)
Worldwide Headquarters • 1932 Wynnton Road • Columbus, Georgia 31999
1.800.992.3522 telephone • 1.800.448.8922 fax • aflac.com