



REQUEST FOR DELETION

Please use blue or black ink only and print legibly when completing this form in its entirety. Keep a copy of the supporting documentation and this completed form for your records. Sign, date and mail the completed form to the address below or fax to 1.888.694.1265.

American Family Life Assurance Company of New York
(herein referred to as Aflac)
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 Last Name First Name MI Suffix SSN
Policy/Certificate Number Policy/Certificate Type Date of Birth
Policyholder's/Certificateholder's E-Mail Address

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's/Certificateholder's

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.

Policyholder's/Certificateholder's Signature Date