REQUEST FOR GENDER IDENTITY CHANGE/REASSIGNMENT

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 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

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 _____

❑ **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

Policyholder's/ Certificateholder's Signature _____ Date _____