



REQUEST FOR NAME CHANGE

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 _____

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 _____

Policyholder's/Certificateholder's Signature _____ Date _____