SERVICE REQUEST FORM- GROUP TERM LIFE

Product Number	Insured Name

Address	Phone Number

1. Change of Name (Please attach official documentation of the name change.)

Former Name	New Name

Reason for Change

2. Change of Address

Former Address

New Address	Phone Number

3. ☐ Cancellation/Change of Coverage

Requested Effective Date of Cancellation:

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.

Term Life

☐ Employee ☐ Spouse* ☐ Child*

*If you have spouse or dependent coverage on the plan(s) you wish to cancel, please indicate whether you wish to cancel the entire plan **or** only coverage for your spouse and/or dependent child.

For Employer Use Only

Cancellation authorized by:_____ Date:_____

(Plan administrator/employer) **(must be on or after cancellation date)**

Please sign and date here for above requests:

Date	Signature of Employee

Return to: **Mail:** Aflac • 300 Southborough Drive, Suite 200 • South Portland, ME 04106 • **Fax:** 877-820-5311
Email: AFLACcustomersvc@disabilityrms.com

Questions? **Toll-Free:** 1.888.862.5732

Continental American Insurance Company (CAIC), a proud member of the Aflac family of insurers, is a wholly-owned subsidiary of Aflac Incorporated and underwrites group coverage.