SERVICE REQUEST FORM- GROUP TERM LIFE, SHORT & LONG-TERM DISABILITY

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	Short Term Disability	Long Term Disability
☐ Employee ☐ Spouse* ☐ Child*	☐ Employee	☐ Employee

*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

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