

AFLAC CANCELLATION NOTICE

Date: _____

I, _____, do hereby request cancellation
(print name of insured)

of _____ policy _____
(type of policy) (policy number)

Please make this cancellation effective _____
(date)

Insured's signature: _____

Insured's SSN: _____

Associate/Agent: _____
(name and writing number)

American Family Life Assurance Company of Columbus (AFLAC) • Worldwide Headquarters: Columbus, Georgia 31999

M-0784

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