Aflac CONTINENTAL AMERICAN INSURANCE COMPANY

Service Request Form

Certificate Number	Insured	Owner (If other than insured)
Address		Phone Number

1. ☐ Change of Beneficiary (Witness must be someone other than beneficiary)

It is requested that the beneficiary under the above Certificate be changed as follows:

Primary Beneficiary	Relationship to Insured
Address	
Contingent Beneficiary	Relationship to Insured
Address	

2. ☐ Change of Name (Please attach official document of name change)

Former Name	New Name
Reason for Change	

3. ☐ Change of Address

Former Address	
New Address	Phone Number

4. ☐ Transfer of Ownership Request

I request that all benefits, rights and privileges incident to ownership of the policy vested in the new Owner named below, or to such new Owner's executors, administrators and assigns, or successors and assigns.

New Owner (Full Name)	Relationship to Insured
Address of New Owner	

5. ☐ Universal Life Only – Discontinue Premium Deduction Only/Allow Policy to Continue

I request that all payroll deductions or billings be discontinued at this time. I understand that I must notify American Bankers to start payroll deductions or billings at a later date. I understand that my policy will continue to remain in force until all accumulated value capable of continuing the policy is depleted or until I request continuation of premium payments. I understand that once accumulated value capable of continuing the policy is depleted, the policy will lapse.

6. ☐ Cancellation/Change of Coverage

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.

☐ Short Term Disability

☐ Long Term Disability

☐ Hospital Indemnity
☐ employee ☐ spouse ☐ child*

☐ Cancer
☐ employee ☐ spouse ☐ child*

☐ Critical Illness
☐ employee ☐ spouse*

☐ Term Life
☐ employee ☐ spouse ☐ child*

☐ Accident
☐ employee ☐ spouse ☐ child*

☐ Other

☐ Reduce Face Amount
(applies to Critical Illness, Disability, and Universal Life only)
☐ new face amount employee
$_____
☐ new face amount spouse
$_____

*If you have spouse or dependent coverage on the plan(s) you wish to cancel, please specify if you wish to cancel the entire plan or if you want to cancel only a portion of your plan by checking the appropriate boxes above. If you want to cancel your spouse and/or dependents from the plan, please provide their name(s) and date of birth below:

Name(s) and Date(s) of Birth:

7. ☐ Lost Certificate Notification

I, _____hereby certify that Certificate No._____, dated _____, and issued by the Continental American Insurance Company has been lost or destroyed and that said Certificate is not assigned, hypothecated, or pledged in any way whatsoever. I, therefore, request a Certificate of Lost Certificate and agree that should the original Certificate be found or in any way come into my possession, I will return or cause the same to be returned to the Continental American Insurance Company, its successors or assigns. It is distinctly understood and agreed that the original Certificate shall become null and void immediately upon issuance of the Certificate herein requested.

8. ☐ Loan/Withdrawal Request (Please allow a minimum of 45 days for processing.)

I request a loan of $_____, or the maximum amount, if less.

9. ☐ Surrender for Cash Value (Please allow a minimum of 45 days for processing.)

Please note: Your Certificate must accompany this request. If unavailable, Section 7 of this form MUST be completed.
I request payment of the cash value in exchange for surrender of the attached Certificate. No bankruptcy proceedings are outstanding against me and no liens are pending against the Certificate, except as follows:

Sign and Date Here for Above Requests

Date	Signature of Owner
Address	
Witness	
Signature of Assignee (if applicable)	Signature of Irrevocable Beneficiary (if any)

Request for Service • **Mail:** Continental American Insurance Company
PO Box 427 • Columbia, SC 29202 **Fax:** (803) 799-7737 **Phone:** (800) 433-3036

For Internal Use Only

New Premium Pre-Tax $	New Premium Post-Tax $	Effective Date
Signature/VP Human Resources	Signature/New Business Analyst Mgr	