Insuring Over 40 Million People Worldwide

American Family Life Assurance Company (Aflac) 1-800-433-3036 | PO Box 427 Columbia, SC 29202

Complete the below and fold along the above line and detach bottom portion to remit with payment if you wish to PORT your coverage.

Group Number: _____ Group Name: _____ Customer Name: _____

Date of Termination from employer: _____ Were you employed Part or Full Time? Check one ☐Part-time ☐Full-time

Termination Reason:_____ Examples: Disability, Group Cancelled, Laid Off, New Job, Reduced Hours, Retired, Terminated, Resignation, etc.

Customer Signature: _____ Today's Date: _____

(by signing the above, you agree to continue coverage on a direct basis for the products indicated below)

Choose the policies you wish to continue and select the desired payment plan listed below:

Initial the box(es) below of the items you wish to continue coverage	**Type of Policy**	**Type of Coverage** (Individual or family)	**Monthly Amount Due Per Policy**
	Accident		$
	Cancer		$
	Critical Illness		$
	Hospital		$
	Term Life		$
	Whole Life		$
	Long Term Disability*		$
	Short Term Disability*		$

**Disability not portable if group is not active*

I would like to pay (Please check one)	**Total Amount Due:**
Monthly Draft	$
Quarterly	$
Semi Annual	$
Annual	$

Payment is due by: *<today's date + 30 days>*

Amount Enclosed: $ _____

PLEASE DO NOT STAPLE, FOLD OR BEND

Aflac
Worldwide Headquarters
PO Box 84069
Columbus GA 31908-4069

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AUTHORIZATION AGREEMENT FOR ACH DEBITS

I hereby request and authorize Continental American Insurance Company, a member of the Aflac family of companies, hereinafter called Company, to initiate ACH debit entries to my financial institution account indicated below and the financial institution named below to debit the same to such account.

This authority is to remain in full force and effect until the Company has received notification from me of its termination. I have the right to discontinue debit entry by giving written notice 10 days prior to the scheduled draft date. I have the right to stop payment of a debit entry by notification to the financial institution at such time as to afford the financial institution a reasonable opportunity to act on it prior to charging the accounts.

Please include a voided check.

For Home Office Use Only

<Name>

Control Policy Number
#<certificate number>

_____
NAME OF FINANCIAL INSTITUTION

_____
ADDRESS

_____
CITY STATE ZIP CODE

_____ _____ CHECKING / SAVINGS
TRANSIT/ABA NUMBER ACCOUNT NUMBER (Circle type of account)

_____ _____
DATE SIGNATURE OF PREMIUM PAYOR

If you have any questions, please contact Customer Service Center at 1-800-524-5298.