REQUEST FOR BENEFICIARY CHANGE

Please use blue or black ink only and print legibly when completing this form in its entirety. Keep a copy of the supporting documentation and this completed form for your records. **Sign, date and mail the completed form to the address below or fax to 1.888.694.1265.**

American Family Life Assurance Company of New York
(herein referred to as Aflac New York)
22 Corporate Woods Boulevard • Suite 2 • Albany, NY 12211
For information call toll-free 1.800.366.3436
Toll-Free Fax: 1.888.694.1265

Name of Policyholder/Certificateholder _____ SSN _____
Last Name First Name MI Suffix

Policy/Certificate Number _____ Policy/Certificate Type _____ Date of Birth _____

Policyholder's/Certificateholder's E-Mail Address _____

❑ **BENEFICIARY INFORMATION**

PLEASE NOTE: We do not recommend that you name a minor child as your beneficiary. If you name a minor child as your beneficiary, any benefits due your minor beneficiary will not be payable until a guardian for the financial estate of the minor is appointed by the court or such beneficiary reaches the age of majority as defined by your state. If there is no beneficiary, Aflac New York will pay any applicable benefit to your estate.

If you reside in a community property state, are married, and designate a person other than your spouse as the primary beneficiary, your spouse may have rights to the death benefit of the policy/certificate under state law even if you choose not to name them as your beneficiary. We recommend submitting documentation signed by your spouse consenting to your beneficiary designation and waiving any right to proceeds payable under the policy/certificate. If you are unsure whether these laws apply to you, consult with your legal or tax advisor to determine whether submission of such documentation is necessary. Unless Aflac New York has been notified of a community or marital property interest in the policy/certificate, Aflac New York will presume that no such interest exists and disclaims any responsibility for determining the applicability of community property laws or the validity of the beneficiary designation. However, if your spouse claims a community property interest in the proceeds, it may delay in the payment of proceeds under the policy/certificate. By signing this form, you agree to indemnify and hold Aflac New York harmless from the consequences of making the designation requested in this form.

Effective Date of Change _____

Change the Primary Beneficiary(ies) from: (If no beneficiary previously named, please put N/A in the space below.)

(1) Name _____ (2) Name _____
Last Name First Name MI Suffix Last Name First Name MI Suffix

(3) Name _____ (4) Name _____
Last Name First Name MI Suffix Last Name First Name MI Suffix

To the following new Primary Beneficiary(ies): **NOTE: Total % of Proceeds must equal 100%**

(1) Name _____ % of Proceeds _____
Last Name First Name MI Suffix

Address _____
Street Address City State Zip

Telephone No. _____ SSN _____ - _____ - _____

Date of Birth _____ Relationship to Insured _____

(2) Name _____ % of Proceeds _____
Last Name First Name MI Suffix

Address _____
Street Address City State Zip

Telephone No. _____ SSN _____ - _____ - _____

Date of Birth _____ Relationship to Insured _____

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(3) Name _____ % of Proceeds _____
Last Name First Name MI Suffix

Address _____
Street Address City State Zip

Telephone No. _____ SSN _____ - _____ - _____

Date of Birth _____ Relationship to Insured _____

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(4) Name _____ % of Proceeds _____
Last Name First Name MI Suffix

Address _____
Street Address City State Zip

Telephone No. _____ SSN _____ - _____ - _____

Date of Birth _____ Relationship to Insured _____

Change the Contingent Beneficiary(ies) from: (If no beneficiary previously named, please put N/A in the space below.)

(1) Name _____ (2) Name _____
Last Name First Name MI Suffix Last Name First Name MI Suffix

(3) Name _____ (4) Name _____
Last Name First Name MI Suffix Last Name First Name MI Suffix

To the following new Contingent Beneficiary(ies): **NOTE: Total % of Proceeds must equal 100%**

(1) Name _____ % of Proceeds _____
Last Name First Name MI Suffix

Address _____
Street Address City State Zip

Telephone No. _____ SSN _____ - _____ - _____

Date of Birth _____ Relationship to Insured _____

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(2) Name _____ % of Proceeds _____
Last Name First Name MI Suffix

Address _____
Street Address City State Zip

Telephone No. _____ SSN _____ - _____ - _____

Date of Birth _____ Relationship to Insured _____

(3) Name _____ % of Proceeds _____
Last Name First Name MI Suffix

Address _____
Street Address City State Zip

Telephone No. _____ SSN _____ -_____ -_____

Date of Birth _____ Relationship to Insured _____

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(4) Name _____ % of Proceeds _____
Last Name First Name MI Suffix

Address _____
Street Address City State Zip

Telephone No. _____ SSN _____ -_____ -_____

Date of Birth _____ Relationship to Insured _____

Policyholder's/Certificateholder's Signature _____ Date _____