AFLAC CANCELLATION NOTICE

Please Fax completed form to 714/573-2924

Date:			
I,(print name	e of insured)	, do herel	by request cancellation
of(type of pol	icy)	policy	(policy number)
Please make this can	cellation effective	(da	
Insured's signature:			
Insured's SSN:			
Associate/Agent:		writing number)	
	(name and writing number)		

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

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