



American Family Life Assurance Company (Aflac) 1-800-433-3036 | PO Box 84069 Columbus, GA 31908-4069  
**Complete the below information within 31 days of terminating employment and remit with payment if you wish to Port/Continue 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, etc.

Customer Signature: \_\_\_\_\_ Today's Date: \_\_\_\_\_  
*(By signing the above, you agree to continue coverage on a direct bill basis for the products indicated below.)*

**Choose the plans you wish to continue and select the desired payment listed below:**

Initial the box(es) below for the insurance plans you wish to continue.	Type of Plan	Type of Coverage (Individual or Family)	Monthly Amount Due Per Plan
<input type="checkbox"/>	Accident		\$
<input type="checkbox"/>	Cancer		\$
<input type="checkbox"/>	Critical Illness		\$
<input type="checkbox"/>	Hospital		\$
<input type="checkbox"/>	Term Life		\$
<input type="checkbox"/>	Whole Life		\$
<input type="checkbox"/>	Long Term Disability*		\$
<input type="checkbox"/>	Short Term Disability*		\$

*\*Disability is not portable if group is not active.*

<u>I would like to pay</u> (Please check one)	Total Amount Due:
<input type="checkbox"/> Monthly Draft	\$
<input type="checkbox"/> Quarterly	\$
<input type="checkbox"/> Semi Annual	\$
<input type="checkbox"/> Annual	\$

**Amount Enclosed:** \$ \_\_\_\_\_

PLEASE DO NOT STAPLE



**Aflac**  
**Worldwide Headquarters**



## 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 business days prior to the scheduled draft date and send it to American Family Life Assurance Company (Aflac) P.O Box 84069 Columbus, GA 31908-4069. 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

\_\_\_\_\_  
TRANSIT/ABA NUMBER

\_\_\_\_\_  
ACCOUNT NUMBER

CHECKING/SAVINGS  
(Circle type of account)

\_\_\_\_\_  
DATE

\_\_\_\_\_  
SIGNATURE OF PREMIUM PAYOR

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If you have any questions, please contact our Customer Service Center at 1-800-433-3036, Monday through Friday from 8 a.m. to 8 p.m. Eastern time.