AFLAC CANCELLATION NOTICE

Date:			
I,(print name	of insured)	, do hereb	y request cancellation
of(type of poli	icy)	policy	(policy number)
Please make this cancellation effective		(date	
Insured's signature:			
Insured's SSN:			
Associate/Agent:	(na:	me and writing number)	

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

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