REQUEST FOR CHANGE/APPLICATION FOR REINSTATEMENT – DENTAL

American Family Life Assurance Company of Columbus (AFLAC), Worldwide Headquarters: Columbus, GA 31999
For information, call toll-free 1-800-99-AFLAC (1-800-992-3522).

Name of Policyholder _____ SSN _____

Policy Number _____ Date of Birth _____

Current Address of Policyholder _____
(Street) (Apt. No.)

City _____ State _____ ZIP _____ Telephone No. _____

Former Address of Policyholder _____
(Street) (Apt. No.)

City _____ State _____ ZIP _____

Associate/Agent's Signature _____ Writing Number _____
Licensed Resident Associate/Agent

PLEASE MAKE THE FOLLOWING CHANGES TO MY POLICY:

❑ **REINSTATEMENT ONLY**

❑ **TRANSFERS ONLY**

Transfer From _____
To _____
(Employer or Account Name and Number)

Amount Remitted $_____ Months _____

Payroll Billing Name _____

Effective Date of Transfer _____

❑ **NAME CHANGE ONLY**

Name Shown on Policy _____
Change Name to _____

Reason _____
(Marriage/Divorce/Death/Other)

Effective Date of Change _____

❑ **DELETIONS ONLY**

Person to Be Deleted _____ Relationship _____

If the deletion involves a dependent child, please complete the table below.

Effective Date of Deletion _____ Reason _____
(Divorce/Death/Other)

New Policy/Contract Holder's Full Name _____

Birth Date of New Policy/Contract Holder _____

Type of Coverage Now Desired ❑ Individual ❑ One-Parent Family
❑ Two-Parent Family ❑ Named Insured/Spouse Only

❑ **ADDITION**

Person(s) to Be Added _____

If the addition involves a dependent child, please complete the table below.

Date(s) of Birth _____ Relationship _____

SSN _____

Reason(s) for Addition(s) _____

Effective Date of Addition(s) _____

Type of Coverage Now Desired ❑ Two-Parent Family ❑ One-Parent Family ❑ Named Insured/Spouse Only

The following information must be completed on each dependent child to be covered.
If additional space is needed please complete Supplemental Application Form Series A-80005.

Name – Last, First, MI	Date of Birth	Sex	SSN	Check if:
		❑ M ❑ F		❑ Handicapped child
		❑ M ❑ F		❑ Handicapped child
		❑ M ❑ F		❑ Handicapped child
		❑ M ❑ F		❑ Handicapped child
		❑ M ❑ F		❑ Handicapped child
		❑ M ❑ F		❑ Handicapped child
		❑ M ❑ F		❑ Handicapped child
		❑ M ❑ F		❑ Handicapped child

ANSWER QUESTIONS 1 AND 2 FOR REINSTATEMENTS OR ADDITIONS ON NONPAYROLL SALES ONLY

1. Have you or has anyone to be covered been diagnosed with or treated for any gum disease such as gingivitis within the last 24 months? ❑ Yes ❑ No

2. **If Question 1 is answered yes, was it the:**

❑ Named Insured ❑ Spouse ❑ Child? If "Child," please list the name of the child(ren)

_____.

Any person(s) so designated will not be covered under the policy.

I understand that the reinstated policy will cover only loss resulting from covered dental treatment that begins after the date of reinstatement. I understand that the information on this form applies **ONLY** to my dental policy.

I have read, or had read to me, the completed application and realize that policy reinstatement is based upon statements and answers provided herein. They are complete and true to the best of my knowledge and belief, and I understand that AFLAC and I will have the same rights as provided under the policy(s) immediately before the due date of the defaulted premium, subject to any provisions endorsed on or attached to the policy(s) in connection with the reinstatement. I further understand that coverage under the reinstated policy is subject to the terms set forth in my policy(s) Reinstatement provision.

I understand that any covered person will be subject to new Waiting Periods, if any, beginning from the effective date of reinstatement.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent act, which is a crime.

Policyholder's Signature _____ Date _____

Section 125 Account Approval _____ Date _____
(Section 125 Plan Administrator Signature)

FOR WORLDWIDE HEADQUARTERS USE ONLY

PTD _____
Lapsed _____
Reinstated _____
Premiums Applied From _____
Initials _____

No. of Months Dropped _____
$ Applied _____
No. of Months _____
New PTD _____