

Policyholo	der/Applicant Info	ormation		
-	Policy	Premium	Policy	Premium
Name:	Numbers	Amount	Numbers	Amount
Address:				<u> </u>
City, State, ZIP:				-
Phone:	No. of policies:		Total: \$	
Ded	luction Informati	on		
For newly issued policies only: For ease of your policy administration, if the policy is issued, we will make the effective date of coverage the same as your selected draft date following the receipt of your application at Aflac Worldwide Headquarters. For Direct Life only, if the policy is issued, we will make the effective date of coverage the same as your selected draft date following the approval by Underwriting of your application.				
Applicant's Initials				
When would you like your premiums deducted?				
How often? □ Monthly □ Quarterly □ Semiannually □ Annually				
Please choose a month for the first deduction.				
Please choose any day 1–28 for the first deduction.				
□ I choose to pay by electronic draft.				
Account Holder's Name: Account Holder's Address:				
City:	_State:		ZIP:	
Routing Transit Number:	Account Number	er:		
□ Checking □ Savings				
□ I choose to pay by credit or debit card (only Visa, MasterCard, and American Express are accepted).				
Card Holder's Name:				
Card Holder's Address:	City:		State:	Zip:
Card Number:		Expiration	n Date:	,
				<i>'</i>
Confirmation				
I authorize Aflac to initiate debit entries electronically to my account indicated above, and I authorize the depository institution named above to debit same to such account. This authorization remains effective and in full force until Aflac and the depository/institution receives written notification from me of its termination in such time and in such manner to afford Aflac and the depository/institution a reasonable opportunity to act on it.				
Account Holder's/Card Holder's Signature: (If different from Policyholder/Applicant)			Date:	
Policyholder's/Applicant's Signature:			Date:	
Agent's Signature:(Required for SNG Only)	 Writing Numbe	r:	Date:	

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