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

REQUEST FOR DUPLICATE POLICY

Name of Insured:_____ Year of Birth:_____
Last First Middle Initial

Address of Insured:_____ Phone:_____

City:_____ State:_____ ZIP:_____

I certify that Policy No. _____, dated _____ and issued by the company indicated above, has been lost or destroyed. I, therefore, request a duplicate of said policy and agree that if the original policy is found or in any way comes into my possession, I will return; or cause it to be returned to the company. It is distinctly understood and agreed that the original policy shall become void immediately upon issue of the duplicate policy.

Dated at _____this _____day of _____, 2_____

X_____
Policy Owner

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