AFLAC CANCELLATION NOTICE

Date: _____

I, _____, do hereby request cancellation of _____
(Employee Name) *(Type of Policy)*

policy # _____.
(Policy Number)

Please make this cancellation effective on: _____/ 01 / 2018 .
(1st of the month following receipt by HR)

Insured Signature: _____ Date: _____

Insured's SSN: _____

Associate/Agent: Raymond R. DeRosa (#YE076) – 617-658-1834

Internal Use Only

Received by HR on: _____ by _____
(Date) *(Initial)*

Faxed to Aflac by HR on: _____ by _____
(Date) *(Initial)*

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