

AFLAC BENEFITS CANCELLATION FORM



- CANCELLATION DURING THE OPEN ENROLLMENT PERIOD WILL BE EFFECTIVE JANUARY 1ST.
 - CANCELLATION THROUGHOUT THE PLAN YEAR MUST BE DONE THROUGH AFLAC
- SUBMIT VIA FAX TO: 305-355-2324

| EMPLOYEE NAME | | LAWSON/INFOR# |
|--|---------------------------|--------------------------------|
| | | |
| ONSITE FBMC REPRESENTATIVE | | |
| | | |
| I WOULD LIKE TO CANCEL MY AFLAC BENEFITS COVERAGE(S): | | |
| <input type="checkbox"/> CANCEL | GROUP CRITICAL ILLNESS | |
| <input type="checkbox"/> CANCEL | GROUP ACCIDENTAL COVERAGE | |
| <input type="checkbox"/> CANCEL | GROUP HOSPITAL INDEMNITY | |
| | | |
| EMPLOYEE SIGNATURE | | DATE |
| | | |
| | TERM DATE(S): | LAWSON ENTRY (DATE): |
| | | COPY TO FBMC (DATE): |
| | | COPY TO AFLAC BENEFITS (DATE): |
| | | PAYROLL DATE |