Clackamas County
Aflac Cancellation/Change Form

Name:_____ Employee ID#_____
Please Print

Employee Department:_____

☐ I would like to cancel my **after-tax** Aflac coverage effective _____ on the policies listed below (this coverage can be cancelled the end of the month following receipt of the completed form):

Short Term Disability	Policy #: _____
Life Insurance	Policy #: _____

☐ I would like to cancel my **before-tax** Aflac coverage on the policies listed below (this coverage can be cancelled only during Open Enrollment and is effective January 1st following receipt of the completed form):

Accident	Policy #: _____
Cancer	Policy #: _____
Specified Health Event	Policy #: _____
Hospital	Policy #: _____
Personal Sickness	Policy #: _____
Dental	Policy #: _____
Vision	Policy #: _____
Other	Policy #: _____

☐ I need to make a change to my Aflac coverage due to a **Change in Family Status**. Please have an Aflac Representative contact me at the following:

- ☐ Phone: _____
- ☐ E-mail:_____

Note: to find out whether your coverage is after-tax or before-tax, please refer to your first of the month paycheck or contact our Aflac Representative Bill Meditz, phone:503-409-7425 or e-mail: william_meditz@us.aflac.com

_____ _____
Signature Date Signed