



### Pre-Tax Policy Cancellation Form

(Fill out only to request change in participation during the plan year to a pre-tax policy.)

Full name: \_\_\_\_\_

Terminating Benefits

Group account no.: \_\_\_\_\_

I wish to cancel the following policies:  
(List each policy number to be cancelled.)

Employer: \_\_\_\_\_

#### Instructions

This form is for your employer to document your Change in Status event, and to notify Aflac of your intent to cancel a pre-taxed policy based on a qualified Change in Status.

- Check the appropriate box to indicate a Change in Status or a Change in Cost or Coverage that may qualify you to cancel your coverage for the plan year.
- Fill out a new Salary Redirection Form (M-0019) to indicate the change(s) you wish to make as a result of the qualified Change in Status.

#### Change in Status

- Change in marital status**
  - Divorce or annulment
  - Death of spouse
  - Legal separation
- Change in number of tax dependents**
  - Death of dependent
- Change in employment status that affects eligibility**

A change in employment status must directly impact eligibility to qualify as a valid Change in Status. Some examples of a possible employment change could be terminating employment, changing from full-time to part-time, returning from an unpaid leave of absence, beginning an unpaid leave of absence, or changing worksites.
- Change in spouse or dependent's eligibility under employer's plan**

Loss of eligibility (age, student status, marital status)

#### Change in Cost or Coverage

- Addition or elimination of benefit package option under your/your dependent's employer's plan.
- Change in coverage or open enrollment of spouse or dependent under other employer's plan.

Please explain the event(s) marked above and describe how the requested benefit/election change is consistent with the event(s).

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I understand that I may be required to provide appropriate documentation for any of the changes that I have checked above. The status and participation changes must comply with my employer's plan, and the Plan Administrator has the sole discretion to make this determination. If my change in participation is denied, I will have 60 days to appeal the decision.

I hereby elect the participation change(s) noted on the redirection form attached, and attest that the change is made on account of and conforms with the Change in Status or Change in Cost or Coverage event.

Employee's signature: \_\_\_\_\_ Date: \_\_\_\_\_

Accepted and agreed to by: \_\_\_\_\_ Date: \_\_\_\_\_  
(Plan Administrator/Employer Signature - REQUIRED)