PLEASE USE THIS FORM TO DELETE DEPENDENTS. **IF THIS COVERAGE IS PART OF A SECTION 125 FLEXIBLE BENEFIT PLAN, PLEASE REFER TO YOUR PLAN DOCUMENT BEFORE MAKING ANY CHANGES.**

AMERICAN FIDELITY
a different opinion

PO BOX 25523
OKLAHOMA CITY, OK 73125
PHONE 800-662-1113
FAX 800-522-6343
www.americanfidelity.com

EMPLOYEE NAME _____

EMPLOYEE ADDRESS _____

_____

_____

ACCOUNT NUMBER _____

REQUESTED EFFECTIVE DATE _____

DELETE DEPENDENTS

Please check the box below of the Dependent to be deleted.

- ☐ All
- ☐ Spouse Spouse Name: _____
- ☐ Child(ren) Child(ren) Name: _____

Will other children still be covered? ☐ Yes ☐ No

Please check the coverage that you are requesting to be changed. (Check all that apply.)

- ☐ Cancer
- ☐ GAP
- ☐ Critical Illness
- ☐ Hospital Indemnity
- ☐ Accident Only

_____ _____
Employee's Signature Date

_____ _____
Payroll Supervisor's Signature Date

_____
Employer Name

FOR HOME OFFICE USE ONLY – The foregoing request has been recorded at the Home Office of American Fidelity Assurance Company, Oklahoma City, Oklahoma.

_____ _____ _____
Date Approved By