



Underwritten by Trustmark Insurance Company

PO Box 7937  
Lake Forest IL 60045-7937

**Phone:** (800) 225-3859  
**Fax:** (847) 615-4943  
**Hours:** Monday – Thursday 7:00am to 7:00pm CST  
Friday 7:00am to 6:00pm CST  
**Email:** CustomerCare@ulaflac.com  
**Website:** www.Aflacgroupinsurance.com

**NOTICE OF INSURED’S RIGHT TO DESIGNATE A SECONDARY ADDRESSEE**

You have the right to designate an additional contact to receive notification should the Policy/Certificate listed below ever be in jeopardy of lapsing or terminating due to insufficient premium payments. Please indicate if you desire to have an additional contact notified. Upon receipt of this information, we will update our records to provide the designated contact a copy of the notice in the event of a pending lapse or termination of coverage.

Insured’s Name: \_\_\_\_\_ Social Security Number of Insured: \_\_\_\_\_

Owner of Policy: \_\_\_\_\_ Policy/Certificate Number: \_\_\_\_\_

**The purpose of this document is for the insured to designate a secondary addressee or waive such right.**

Insured’s Name: \_\_\_\_\_

Owner’s Name: \_\_\_\_\_

I elect the option by indicating the name and address of my designated contact below.

Designee’s Name: \_\_\_\_\_

Designee’s Address: \_\_\_\_\_

Designee’s City, State: \_\_\_\_\_

**Waiver of Designation of Secondary Addressee - Protection Against Unintended Lapse.**

I understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination for nonpayment of premium. I understand that notice will not be given until 30 days after a premium is due and unpaid.

I elect NOT to designate a person to receive this notice.

X

\_\_\_\_\_  
Owner’s Signature (if minor child, parent or guardian’s signature required)

Date \_\_\_\_\_

Underwritten by Trustmark Insurance Company  
Trustmark Life Insurance Company of New York