

PLEASE USE THIS FORM TO REQUEST A DUPLICATE POLICY



A member of the American Fidelity Group

PO BOX 25523, OKLAHOMA CITY, OK 73125

PHONE 800-323-3748

FAX 800-522-6343

www.AFAdvantage.com

INSURED \_\_\_\_\_

ACCOUNT NUMBER \_\_\_\_\_

SOCIAL SECURITY NUMBER \_\_\_\_\_

POLICYOWNER (if other than Insured) \_\_\_\_\_

INSURED'S ADDRESS \_\_\_\_\_

POLICYOWNER'S ADDRESS (if other than Insured) \_\_\_\_\_

**VERIFICATION OF LOST POLICY**

Surrender of Life Policy # \_\_\_\_\_

Conversion of Life Policy # \_\_\_\_\_

**REQUEST FOR DUPLICATE POLICY**

Cancer

Disability

Life

Other (please specify) \_\_\_\_\_

My policy issued by AMERICAN FIDELITY ASSURANCE COMPANY of OKLAHOMA CITY, OKLAHOMA, has been lost, destroyed or never received, and I declare that said policy has not been pledged, assigned or transferred. In the event that policy should be found, I agree to return it to the Company.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Insured

\_\_\_\_\_  
Signature of Owner (if different from Insured)