AUTHORIZATION TO RELEASE INFORMATION

TO: American Family File Assurance Company of Columbus (AFLAC)
1932 Wynnton Road
Columbus, Georgia 31999-0001

RE: Name: _____
DOB: _____
SSN: _____
AFLAC Policy No(s).: _____

I, the undersigned, hereby authorize AFLAC or any person or entity acting on its part to release any information (defined below) concerning me or any of my policies to the person or entity identified. "Information" includes information in AFLAC's possession relation to my physical or mental health or condition (including, for example, medical diagnosis/treatment information related to underwriting or a claim for benefits), and non-medical financial information (including, for example, policy premium and status information).

Name	**Relationship to Policyholder**
MINUTE MAN SERVICES	NONE/COPY SERVICE
Please Type or Print Name Legibly	

Address: 3905 ROCHESTER RD
ROYAL OAK, MI 48073

In understand that this Information will be used for purpose of legal representation and/or litigation.

This authorization shall remain in effect for one (1) year from the date hereof, unless revoked by me. I understand that I may revoke this authorization at anytime, except to the extent that AFLAC had taken action in reliance on this authorization. To revoke this authorization, I must provide a written and signed revocation to AFLAC at the address above.

I agree that a copy of this authorization is as valid as the original.

I understand that AFLAC is not conditioning payment, enrollment or eligibility for benefits on whether I sign this authorization. I understand that if the information disclosed is protected health information relating to a health plan and if the person or entity receiving the information is not a health care provider or health plan covered by federal privacy regulations, the information disclosed may be re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulations. The undersigned hereby waives any restrictions on disclosure imposed by law on AFLAC and releases AFLAC, its officers, directors, employees and agents from any liability associated with the release of any information pursuant to this authorization.

_____
Policyholder Signature

_____
Please Type or Print Name Legibly

Date:_____

SWORN to and subscribed before me this
_____ day of _____, 20____.

_____
NOTARY PUBLIC

State of _____
Country of_____
My Commission Expires_____