SICKNESS CLAIM FORM

Failure to complete this form in its entirety may result in a delay in processing this claim.

FILING CLAIM FOR (check all that apply)**:**

☐ Sickness ☐ Pregnancy ☐ Hospitalization ☐ Deceased - Date Deceased:_____/_____/_____

Cancer Policy Number	Short-Term Disability/ Sickness Disability Rider Policy Number	Hospital Indemnity Policy Number	Hospital Intensive Care Policy Number	CareAssist Policy Number	Life Policy Number	Specified Health Event Policy Number

INSTRUCTIONS:

☐ Complete Section A: Policyholder/Patient Information and sign your claim form.

☐ Have the treating physician complete Section B: Physician's Statement and sign the claim form.

☐ If you are filing for disability, please complete the Initial Disability Claim Form (S00224) as well. **Forms are available on our web site at aflac.com.**

☐ Submit all bills related to this claim, such as hospital, surgery, etc. All bills should include the diagnosis, services rendered, and actual charges for the service.

☐ If hospitalized and/or confined to an intensive care unit, please send a copy of your hospital bill showing charges and the number of days you were confined.

☐ The items above can be obtained directly from your healthcare provider(s) by requesting a UB04 (hospital bill) or HCFA1500 (non-hospital bill).

Be sure to include your policy number(s) on all documents.

Policyholder Information
(Please print.)

First Name _____ Initial ____ Last Name _____

Mailing Address _____

City _____ State _____ ZIP _____

Check box if this is a new permanent address: ☐

Social Security Number _____ Phone Number _____

Patient Information
(Please print.)

First Name _____ Initial ____ Last Name _____

Relationship:
☐ Primary Policyholder ☐ Spouse ☐ Dependent Child

Sex:
☐ Male ☐ Female

Patient Birth Date: _____

☐ Check here if dependant child is a full-time student (if over the age 19, please provide school name and contact information).

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime, and subjects such person to criminal and civil penalties.

CLAIMANT SIGNATURE **FAMILY RELATIONSHIP, IF NOT POLICYHOLDER** **DATE**

American Family Life Assurance Company of Columbus (Aflac)
Attention: Claims Department • Worldwide Headquarters • 1932 Wynnton Road • Columbus, GA 31999
For information or help filing your claim, please call toll-free 1-800-99-AFLAC (1-800-992-3522) or visit our Web site at aflac.com
Toll-free fax number 1-877-44-AFLAC (1-877-442-3522)

SICKNESS CLAIM FORM – PHYSICIAN'S STATEMENT

Failure to complete this form in its entirety may result in a delay in processing this claim.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime, and subjects such person to criminal and civil penalties.

Policy Number: _____ Policyholder Name: _____

Patient Name: _____ Date of Birth: _____

SECTION B: PHYSICIAN'S STATEMENT **Please answer each question COMPLETELY.**

PHYSICIAN'S NAME	PHONE NUMBER ( )	FAX NUMBER ( )
MAILING ADDRESS	CITY	STATE ZIP

DATES OF SERVICE	DIAGNOSIS CODE ICD	DIAGNOSIS DESCRIPTION	PROCEDURE CODE	PROCEDURE DESCRIPTION	PLACE OF SERVICE

1. Symptoms first occurred on: _____/_____/_____ If diagnosed with cancer, date of initial diagnosis: _____/_____/_____

2. Patient first consulted you for this condition on: _____/_____/_____

3. Was the patient referred to you by another physician? ☐ Yes ☐ No

   If yes, physician's name: _____

   Referring physician's address: _____ Phone number: _____

4. Was patient hospitalized as a result of this diagnosis? ☐ Yes ☐ No

   Admission: _____/_____/_____ Discharge: _____/_____/_____

   Hospital Name: _____

   City: _____ State: _____

5. Was patient treated in an emergency room of a hospital as a result of this diagnosis? ☐ Yes ☐ No

   Hospital Name:_____ Date of treatment:_____

6. Pregnancy claims: Date of delivery: _____/_____/_____ ☐ Vaginal ☐ Cesarean

   Please advise of any complications.

   _____

7. If not delivered, expected delivery date: _____/_____/_____

PHYSICIAN'S SIGNATURE **DATE** **TAX ID NUMBER**

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Attention: Claims Department • Worldwide Headquarters • 1932 Wynnton Road • Columbus, GA 31999
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Claims Authorization to Obtain Information

Instructions for completing this Health Insurance Portability and Accountability Act of 1996 (HIPAA) compliant form:

1. **All areas of this form should be completed.**
2. **This form must be signed and dated by the claimant/patient below.**
3. **IMPORTANT: If you are filing a claim on behalf of a deceased, please check here ☐**
4. **If you are the Authorized Representative, please sign below and indicate your relationship to the claimant/patient/deceased. In addition, include a copy of the legal document(s) authorizing you to act on their behalf.**
5. **Fax this form to 1-877-442-3522 or return the form to Aflac, Claims Department, Worldwide Headquarters, 1932 Wynnton Road, Columbus, GA 31999 as soon as possible to expedite the review of your claim.**

Policyholder Name:	**Policy Number(s):**	**Date of Birth:**
Policyholder Address:		
Claimant/Patient Name (if different from named policyholder listed above):		**Date of Birth:**

Name and Address of health care provider(s), company, or individual authorized to release the requested information:

This authorization shall be valid for a period of two years from the sign date unless a lesser time frame is indicated. Alternate Expiration Date:

Purpose of Disclosure: Evaluate claims for benefits during the time this authorization is valid.

I, or my authorized representative, request that information regarding my past, present, or future physical or mental health condition (excluding psychotherapy notes), employment, other insurance coverage, or any other nonmedical facts be released to **American Family Life Assurance Company of Columbus (Aflac)** or any person or entity acting on its part. This could include, but is not limited to, any medical professional, medical care institution, insurer (including Aflac, with respect to other Aflac coverages), reinsurer, government agency (including departments of public safety and motor vehicle departments), consumer reporting agency or employer.

I understand that:

1. Protected health information may include information and records protected under Federal and State Law such as: alcohol, drug abuse, mental health, AIDS or HIV testing or treatment.
2. My treatment, payment or eligibility for benefits may not be conditioned on signing this authorization.
3. I understand that I may revoke this authorization at any time by writing to **Aflac, Claims Department, Worldwide Headquarters, 1932 Wynnton Road, Columbus, GA 31999**, except to the extent that:
   a. Aflac has taken action in reliance to this authorization, or
   b. Other law provides Aflac with the right to contest a claim under the policy or the policy itself.
4. If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.

It is recommended I retain a copy of this signed form for my records, understanding that a copy is as valid as the original.

Signature of claimant/patient, guardian or authorized representative ☐ **Date**

Printed name of claimant/patient, guardian or authorized representative **Relationship**