



SICKNESS CLAIM FORM

Filing claim for:

- Sickness
- Pregnancy
- Deceased
- Date Deceased: ___/___/___

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

For associate use only:

- Check to the agent for delivery
- Writing # _____
- Name _____
- Address _____

Cancer Policy Number	Short-Term Disability Policy Number	Hospital Indemnity Policy Number	Hospital Intensive Care Policy Number	Specified Health Event Policy Number

SECTION A: PATIENT/POLICYHOLDER INFORMATION: Please print.

PATIENT'S INFORMATION			POLICYHOLDER'S INFORMATION		
LAST	FIRST	INITIAL	LAST	FIRST	INITIAL
BIRTHDATE	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> OTHER		ADDRESS		CHECK IF NEW ADDRESS <input type="checkbox"/>
RELATIONSHIP: <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> DEPENDENT CHECK IF CHILD IS FULL-TIME STUDENT: <input type="checkbox"/>			CITY	STATE	ZIP
SOCIAL SECURITY NUMBER (optional)			SOCIAL SECURITY NUMBER (optional)		BIRTHDATE

SECTION B: PHYSICIAN'S STATEMENT: Please print. Must be completed by physician or physician's staff.

PHYSICIAN'S NAME	ADDRESS	PHONE NUMBER
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DATES OF SERVICE	DIAGNOSIS CODE ICD	DIAGNOSIS DESCRIPTION	PROCEDURE CODE	PROCEDURE DESCRIPTION	ACTUAL CHARGES

1. Is this condition covered by Medicaid/State aid? Yes No
 2. Symptoms first occurred on: ___/___/___ Patient first consulted you for this condition on: ___/___/___
 3. Has any other physician ever treated the patient for this condition? Yes No
- If yes, Physician's name: _____ Phone Number: _____
4. If pregnant, date of delivery: ___/___/___ Vaginal Cesarean If not delivered, expected delivery date: ___/___/___
 5. Was patient hospitalized? Yes No If yes, Admission: ___/___/___ Discharge: ___/___/___
- Hospital Name: _____ City: _____ State: _____

ATTENTION PHYSICIAN: If patient is disabled, please ALSO complete SECTION C ON PAGE 2 OF THIS FORM.

PHYSICIAN'S SIGNATURE_____
DATE_____
TAX ID NUMBER

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.

AMERICAN FAMILY LIFE ASSURANCE COMPANY OF COLUMBUS (AFLAC)
 MAIL COMPLETED CLAIM FORMS TO: ATTN: CLAIMS DEPT., WORLDWIDE HEADQUARTERS, 1932 WYNNTON ROAD, COLUMBUS, GA 31999
 OR FAX COMPLETED CLAIMS TO: TOLL FREE FAX NUMBER 1-877-44-AFLAC (1-877-442-3522)
 OR VISIT OUR WEB SITE AT www.aflac.com OR CALL TOLL FREE 1-800-99-AFLAC (1-800-992-3522)



SICKNESS CLAIM FORM DISABILITY SECTION

Patient Name _____

Policy Number _____

**Failure to complete this form in its entirety may result in a delay in processing this claim.
Complete only if claiming disability benefits under an AFLAC policy.**

SECTION C: PHYSICIAN'S DISABILITY STATEMENT

• **Please print. Must be completed by physician or physician's staff.**

1. First date of disability: ___/___/___ Last date of treatment: ___/___/___
2. Date released to return to work: ___/___/___ If not released, next appointment date: ___/___/___
3. Is patient: ambulatory? bed-confined? house-confined? hospital-confined?
4. If not employed, or employed less than 30 hours per week, which Activities of Daily Living (ADLs) is the patient unable to perform?
Check all that apply: Contingence Transferring Dressing Toileting Eating Bathing
5. Has patient been treated for this condition within the last 12 months? Yes No If yes, Date of treatment: ___/___/___

PHYSICIAN'S SIGNATURE

DATE

TAX ID NUMBER

SECTION D: EMPLOYER'S DISABILITY STATEMENT

- **Please print. This section to be completed by employer if filing for disability.**
- **If self-employed complete this section and submit a copy of business license and previous year's tax return.**

EMPLOYER'S NAME	ADDRESS	PHONE NUMBER

WORK STATUS

1. Is the employee currently earning at least 80% of their salary prior to disability? Yes No
2. Prior to this disability, number of hours worked per week: _____ Annual Base Salary: \$ _____
3. Is the person still employed? Yes No If no, date left employment: ___/___/___
4. First date employee unable to work: ___/___/___
5. Last date employee unable to work: ___/___/___
6. Is employee currently working? Yes No If yes, is employee working full-time? part-time? light duty?
7. Date to return to Full Time Duty: ___/___/___

PREMIUM/TAX INFORMATION

Please note:

The employer is required to report disability benefits paid on pre-tax plans on its Form 941 and the employee's Form W-2.

1. Does the employee pay disability premiums with pre-tax dollars? Yes No
2. Does employer pay a portion of the disability premium for the employee? Yes No If yes, what percent? ____%
3. Employee is: (Check all that apply) exempt from Social Security exempt from Medicare subject to RRTA

EMPLOYER'S SIGNATURE

TITLE

DATE

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