



# CANCER 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 injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.**

Policy Number: \_\_\_\_\_ Policyholder Name: \_\_\_\_\_

Patient Name: \_\_\_\_\_

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

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

1. Has patient been diagnosed with cancer?     Yes     No  
     Type of cancer: \_\_\_\_\_ ICD code: \_\_\_\_\_
2. Date of initial diagnosis: \_\_\_\_/\_\_\_\_/\_\_\_\_  
     **Please provide the patient with a copy of the pathology report that diagnosed cancer, as it is required for all initial claims.**
3. Patient first consulted you for this condition on: \_\_\_\_/\_\_\_\_/\_\_\_\_
4. Did any other physician previously treat the patient?     Yes     No    If yes, physician's name: \_\_\_\_\_  
     Referring physician's address: \_\_\_\_\_ Phone number: \_\_\_\_\_

**Hospitalization Information:**

Was patient hospitalized as a result of this diagnosis?     Yes     No    If additional dates exist, please attach a copy of itemized billing.

Admission Date	Discharge Date	Admitting Diagnosis/ICD Code	Hospital Name (Please include city and state.)
- -	- -		
- -	- -		
- -	- -		
- -	- -		

**Surgery Information:**

Did patient undergo surgery for this condition?     Yes     No    If additional dates exist, please attach a copy of itemized billing.

Date	CPT Code	Description	Charge
- -			
- -			
- -			
- -			

**(PHYSICIAN'S STATEMENT CONTINUED ON PAGE 3)**

# CANCER CLAIM FORM - PHYSICIAN'S STATEMENT

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Policy Number: \_\_\_\_\_

Policyholder Name: \_\_\_\_\_

Patient Name: \_\_\_\_\_

## Chemotherapy Information

Has patient received chemotherapy?  Yes  No

If additional dates exist, please attach a copy of itemized billing.

Date	HCPCS/CPT Code	Drug Name and Method of Administration	Drug Charge
- -			
- -			
- -			
- -			
- -			
- -			
- -			
- -			
- -			
- -			
- -			

## Radiation Therapy Information

Has patient received radiation therapy?  Yes  No

If additional dates exist, please attach a copy of itemized billing.

Date	CPT Code	Description	Charge
- -			
- -			
- -			
- -			
- -			
- -			
- -			
- -			
- -			
- -			
- -			
- -			

\_\_\_\_\_  
PHYSICIAN'S SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
TAX ID NUMBER

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)

# CANCER CLAIM FORM - DISABILITY 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 injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Policy Number: \_\_\_\_\_ Policyholder Name: \_\_\_\_\_

Patient Name: \_\_\_\_\_

## SECTION C: PHYSICIAN'S DISABILITY STATEMENT Must be completed by physician or physician's staff.

1. Please indicate the specific reason the insured is unable to work: \_\_\_\_\_
2. First date of disability: \_\_\_\_/\_\_\_\_/\_\_\_\_ Date patient was released to return to work: \_\_\_\_/\_\_\_\_/\_\_\_\_
3. Is patient currently working:  Full-time?  Part-time?  Light duty? Last date of treatment: \_\_\_\_/\_\_\_\_/\_\_\_\_
4. If patient has not been released to return to work or if patient is working light duty, please provide the next appointment date: \_\_\_\_/\_\_\_\_/\_\_\_\_
5. If patient is not employed, or employed less than 30 hours, which Activities of Daily Living (ADLs) is the patient unable to perform and must have personal assistance to perform each time?  
Check and initial all that apply:  Contingence  Transferring  Dressing  Toileting  Eating  Bathing (PA only)

\_\_\_\_\_  
PHYSICIAN'S SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
TAX ID NUMBER

## SECTION D: EMPLOYER'S DISABILITY STATEMENT Please complete if filing for disability.

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

1. Date of hire: \_\_\_\_/\_\_\_\_/\_\_\_\_ First date of disability: \_\_\_\_/\_\_\_\_/\_\_\_\_
2. Date returned (or expected to return) to Full-Time Duty: \_\_\_\_/\_\_\_\_/\_\_\_\_
3. Is the person still employed?  Yes  No If no, last date of employment: \_\_\_\_/\_\_\_\_/\_\_\_\_
4. Prior to this disability, number of hours worked per week: \_\_\_\_\_ Annual base salary (prior to disability): \$\_\_\_\_\_
5. Has employee returned to work?  Yes  No If yes, is employee working:  full-time?  part-time?  light duty?
6. Date employee began light duty: \_\_\_\_/\_\_\_\_/\_\_\_\_
7. Is the employee currently earning at least 80% of his or her predisability salary?  Yes  No
8. Are Sickness Disability Rider or Short-Term Disability premiums paid by the employee with pre-tax dollars?  Yes  No **(Please contact payroll and/or check the employee's SRA/PDA card for the answer to this question.)**
9. Does the employer pay a portion of the disability premium for the employee?  Yes  No If yes, what percent? \_\_\_\_\_ %
10. Employee is: (Check all that apply.)  Exempt from Social Security  Exempt from Medicare  Subject to RRTA

### **Please note:**

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

\_\_\_\_\_  
EMPLOYER'S SIGNATURE

\_\_\_\_\_  
TITLE

\_\_\_\_\_  
DATE

**Please review and sign the attached authorization. Two copies are attached: return one copy to Aflac and keep one for your records. By returning the signed authorization with your claim, you will help us process your claim as quickly and efficiently as possible.**

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)



Policy #: 

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**AUTHORIZATION TO OBTAIN INFORMATION**

I authorize the following to give information (as defined below) to American Family Life Assurance Company of Columbus (Aflac) or any person or entity acting on its part: 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. "Information" means facts or opinions relating to my past, present, or future physical or mental health or condition (excluding psychotherapy notes), employment, other insurance coverage, or any other non-medical facts that Aflac deems appropriate to evaluate claims for benefits during the time this authorization is valid. I understand that any disclosure of information to Aflac for the purpose of evaluating claims for benefits for coverage other than health plan coverage means the information may no longer be protected by federal privacy regulations. I further understand, however, that such information may be re-disclosed only in accordance with other applicable laws or regulations.

I understand that this information will be used by Aflac to evaluate claims for benefits.

I understand that I may revoke this authorization at any time, except to the extent that (1) Aflac has taken action in reliance on this authorization, or (2) other law provides Aflac with the right to contest a claim under the policy or the policy itself. My revocation must be submitted in writing to Aflac, Claims Department, Worldwide Headquarters, 1932 Wynnton Road, Columbus, GA 31999.

Unless otherwise revoked, I agree that this authorization will expire two years from the date indicated below.

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

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

Individual/Guardian/Personal Representative

\_\_\_\_\_  
Printed Name

If this authorization has been signed by a personal representative on behalf of an individual, his/her authority to act on behalf of the individual must be set forth here:



Policy #:

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Signature

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Date

\_\_\_\_\_  
Printed Name

Individual/Guardian/Personal Representative

\_\_\_\_\_  
Printed Name

If this authorization has been signed by a personal representative on behalf of an individual, his/her authority to act on behalf of the individual must be set forth here:

***RETAIN THIS COPY FOR YOUR RECORDS***