

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 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 |

| DATES OF SERVICE | DIAGNOSIS CODE ICD | DIAGNOSIS DESCRIPTION | PROCEDURE CODE | PROCEDURE DESCRIPTION | PLACE OF SERVICE |
|------------------|--------------------|-----------------------|----------------|-----------------------|------------------|
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- Symptoms first occurred on: ____/____/____ If diagnosed with cancer, date of initial diagnosis: ____/____/____
- Patient first consulted you for this condition on: ____/____/____
- Is there a referring physician? Yes No If yes, physician's name: _____
Referring physician's address: _____ Phone number: _____
- Was patient hospitalized as a result of this diagnosis? Yes No Admission: ____/____/____ Discharge: ____/____/____
Hospital Name: _____ City: _____ State: _____
- Pregnancy claims: Date of delivery: ____/____/____ Vaginal Cesarean
- If not delivered, expected delivery date: ____/____/____

PHYSICIAN'S SIGNATURE

DATE

TAX ID NUMBER

ATTENTION PHYSICIAN: If patient is disabled, please ALSO complete SECTION C below.

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

- First date of disability: ____/____/____ Last date of treatment: ____/____/____
- Is patient currently working: Full-time? Part-time? Light duty? Date patient was released to return to work: ____/____/____
- If patient has not been released to return to work or if patient is working light duty, please provide the next appointment date: ____/____/____
- If patient is not employed, or employed less than 30 hours, which Activities of Daily Living (ADLs) is the patient unable to perform?
Check and initial all that apply: Continence Transferring Dressing Toileting Eating Bathing (PA only)

PHYSICIAN'S SIGNATURE

DATE

TAX ID NUMBER

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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Printed Name

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RETAIN THIS COPY FOR YOUR RECORDS