

AMERICAN FAMILY LIFE ASSURANCE COMPANY OF COLUMBUS (AFLAC)
 ATTN: CLAIMS DEPT., WORLDWIDE HEADQUARTERS: 1932 WYNNTON ROAD, COLUMBUS, GA 31999-7251
 FOR INFORMATION, CALL TOLL-FREE 1-800-99-AFLAC (1-800-992-3522) OR VISIT OUR WEBSITE AT WWW.AFLAC.COM
 TOLL FREE FAX NUMBER 1-877-44AFLAC (1-877-442-3522)

PATIENT'S CLAIM FORM - Please fully complete the top half.

FOR ASSOCIATE USE ONLY:

Check the appropriate box: <input type="checkbox"/> Send the insured's check to the agent for delivery. <input type="checkbox"/> Contact the associate only if additional information is needed to complete processing of this claim.	Writing #: _____ Name: _____ Address: _____ _____
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PATIENT'S INFORMATION

POLICYHOLDER'S INFORMATION

LAST	FIRST	MIDDLE	SEX	LAST	FIRST	MIDDLE	
ADDRESS - STREET & NUMBER				ADDRESS - STREET & NUMBER			
CITY			STATE/ZIP CODE	CITY			STATE/ZIP CODE
BIRTH DATE	MARITAL STATUS ___ SINGLE ___ MARRIED ___ OTHER			PATIENT'S SOCIAL SECURITY NUMBER		(AREA CODE & PHONE NO.)	
RELATIONSHIP TO POLICYHOLDER ___ SELF ___ SPOUSE ___ CHILD ___ STEPCCHILD ___ OTHER:				IS PATIENT: ___ EMPLOYED ___ PART-TIME STUDENT ___ FULL-TIME STUDENT			

TYPE OF CLAIM

_____ CANCER	POLICY NO(S) _____		BRIEFLY DESCRIBE NATURE OF ILLNESS OR HOW INJURY OCCURRED: _____
_____ INTENSIVE CARE	POLICY NO(S) _____		_____
_____ ACC/DISABILITY	POLICY NO(S) _____		_____
_____ HOSPITAL INDEMNITY	POLICY NO(S) _____		_____
_____ SPECIFIED MAJOR EVENT / OTHER	POLICY NO(S) _____		IF ACCIDENT, LOCATION: _____
			DATE: _____ TIME: _____ AM/PM

ATTACH HOSPITAL BILL IF APPLICABLE

DO NOT WRITE ANYTHING BELOW THIS LINE EXCEPT PATIENT'S SIGNATURE. DOING SO MAY RESULT IN THE DELAY OF YOUR CLAIM.

AUTHORIZATION TO RELEASE INFORMATION
 (TO BE COMPLETED BY AFLAC CLAIMS DEPARTMENT)

TO:

RE: Patient: _____
 Patient Hospital #: _____
 Patient's SS #: _____

TREATMENT DATE	DISCHARGE SUMMARY	HISTORY & PHYSICAL	OPERATIVE REPORT

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.

I hereby request and authorize you to furnish to AMERICAN FAMILY LIFE ASSURANCE COMPANY OF COLUMBUS (AFLAC) or its representative any and all medical information concerning any illness or injury I may have suffered, including HIV testing, and the diagnosis and treatment of communicable diseases, ARC, AIDS, chemical dependency or psychiatric illness.

TO BE COMPLETED BY THE PATIENT

Persons signing may receive a copy of this authorization. Any copy of this authorization shall have the same authority as the original.

SIGNATURE OF PATIENT (IF MINOR, PARENT MUST SIGN) _____ DATE _____
 IF SIGNED IN BEHALF OF ANOTHER, RELATIONSHIP _____ (ONLY IF PATIENT IS UNABLE TO SIGN)

Expires six months from date written above unless indicated otherwise or revoked earlier.

PHYSICIAN'S
STATEMENT

AMERICAN FAMILY LIFE ASSURANCE COMPANY OF COLUMBUS (AFLAC)
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TO BE COMPLETED IN FULL BY ATTENDING PHYSICIAN

PATIENT'S INFORMATION				POLICYHOLDER'S INFORMATION			
LAST	FIRST	MIDDLE	SEX	LAST	FIRST	MIDDLE	
ADDRESS - STREET & NUMBER				ADDRESS - STREET & NUMBER			
CITY			STATE/ZIP CODE	CITY			STATE/ZIP CODE
BIRTH DATE	STATUS ____ SINGLE ____ MARRIED ____ OTHER:			PATIENT'S RELATIONSHIP TO POLICYHOLDER: ____ SELF ____ SPOUSE ____ CHILD ____ STEPCHILD ____ OTHER:			PHONE
POLICY NUMBER(S):							

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DIAGNOSIS 1. _____ ICD _____ 2. _____ ICD _____ LIST ANY CHRONIC ILLNESS OR DISEASE 1. _____ ONSET DATE _____ 2. _____ ONSET DATE _____ 3. _____ ONSET DATE _____	IF INJURY, GIVE DATE AND PLACE OF INCIDENT. _____ IF LOSS IS DUE TO ACCIDENTAL INJURY, EXPLAIN HOW ACCIDENT OCCURRED. _____ _____ _____	
IF AUTO ACCIDENT, WAS PATIENT ____ DRIVER ____ PASSENGER ____ UNKNOWN	IS THIS ACCIDENT/ILLNESS COVERED BY WORKER'S COMPENSATION? ____ YES ____ NO	IS THIS ACCIDENT/ILLNESS COVERED BY MEDICAID / STATE AID? ____ YES ____ NO

1. DATE SYMPTOMS FIRST OCCURRED _____ DATE PATIENT FIRST CONSULTED YOU FOR THIS CONDITION _____
2. HAS PATIENT EVER HAD SAME OR SIMILAR CONDITION? ____ NO ____ YES (IF YES, STATE WHEN AND DESCRIBE) _____
3. REFERRING PHYSICIAN (NAME/ADDRESS) _____
4. WAS PATIENT HOSPITALIZED FOR THIS CONDITION? ____ NO ____ YES **IF YES, HAVE CLAIMANT ATTACH A COPY OF THE ITEMIZED HOSPITAL BILLING WHEN SUBMITTING CLAIM FOR REVIEW.**
5. DATE PATIENT LAST EXAMINED BY YOU _____ FREQUENCY OF VISITS ____ WEEKLY ____ MONTHLY ____ OTHER
6. IS PATIENT UNABLE TO PERFORM JOB DUTIES? ____ NO ____ YES (IF YES, GIVE DATES) _____
7. WHAT SPECIFIC JOB DUTIES IS PATIENT UNABLE TO PERFORM? _____
8. IS PATIENT ____ AMBULATORY ____ BED CONFINED ____ HOUSE CONFINED ____ HOSPITAL CONFINED ____ OTHER _____
9. IF RETIRED, WHICH ACTIVITIES OF DAILY LIVING (ADLs) IS PATIENT UNABLE TO PERFORM? _____

DATES OF SERVICE	PLACE OF SERVICE IN/OP	PROCEDURE DESCRIPTION	# UNITS	CODE CPT HOPCS/RVS	DIAGNOSIS CODE ICD.0	CHARGE

Date _____ SIGNED _____

Name of Attending Physician (Please Print) _____

Tax ID or Social Security Number _____

(Street Address) (City or Town) (State) (Zip Code) (Area Code - Phone)

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SIGNATURE OF PATIENT (IF MINOR, PARENT MUST SIGN) _____ DATE _____

(Expires six months from this date unless indicated or revoked earlier.)

If signed on behalf of another, relationship _____ (Only if patient is unable to sign)