Accident/Hospital Indemnity Wellness Benefit Claim Form

Policy Number:

All Fields are required.

Policyholder Information:

Last Name | Suffix | First Name | MI

Date of Birth (mm/dd/yy) | Telephone Number where we can reach you

Home Address

City | State | Zip Code

☐ *Check box if this is permanent address change.*

Patient Information:

Last Name | First Name | Date of Birth (mm/dd/yy)

Sex: ☐ Male ☐ Female

Relationship: ☐ Primary Policyholder ☐ Spouse ☐ Dependent Child

Treatment and Physician Information

Treatment Date: M M D D Y Y Y Y

Mammogram Date: M M D D Y Y Y Y

Pap Smear Date: M M D D Y Y Y Y

☐ Annual Physical
☐ Ultrasound
☐ PSA (blood test for prostate cancer)
☐ Pap Smear
☐ Blood Screening
☐ Immunizations
☐ Eye Exam
☐ Mammogram
☐ Dental Exam
☐ Flexible Sigmoidoscopy

Physician's Phone Number:

Physician's Name

Physician's Street Address

Physician's City | State: | Zip:

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.

The Provider listed above is authorized to validate the information I have provided.

POLICYHOLDER/PATIENT SIGNATURE | FAMILY RELATIONSHIP, IF NOT POLICYHOLDER | DATE

American Family Life Assurance Company of Columbus (Aflac)
ATTN: Claims Department • 1932 Wynnton Road • Columbus, GA 31999
For information or to check claim status, visit aflac.com or call 1-800-99-AFLAC (1-800-992-3522)
Claims may be faxed to 1-877-44-AFLAC (1-877-442-3522)

If you have additional bills or medical documentation that relates to this diagnosis other than the documentation defined, please submit them for review of additional benefits.

***Policy Number:**

Policyholder Information:

*Last Name | Suffix | *First Name | MI

*Date of Birth (mm/dd/yy)

Patient Information:

*Last Name | *First Name | *Date of Birth (mm/dd/yy)

- Was the patient transported by an ambulance as a result of this injury? ☐ No ☐ Yes (If yes, please submit the ambulance bill.)
- Was an aid in locomotion (mobility) prescribed as a result of this injury? (I.e. crutches, wheelchairs, leg braces, back braces, walkers, cervical collars, etc.) ☐ No ☐ Yes (If yes, please submit documentation from the prescribing provider, UB04 or HCFA 1500.)
- If any of the following were the result of your injury, please provide medical records, physician's office notes, or any bills received for these conditions that describe the diagnosis or type of treatment received:
  - Coma
  - Paralysis
  - Burn
  - Injury to the Eye
  - Laceration
  - Dislocation
  - Concussion (major diagnostic exam reports are acceptable)
  - Fractures (x-ray reports or major diagnostic exam reports are acceptable)
- Was surgery performed as a result of this injury? ☐ No ☐ Yes (If yes, please submit a copy of the operative report or detailed billing from the surgeon's office, such as UB04 or HCFA 1500.)
- Was a major diagnostic exam (i.e. CT Scan, MRI, MRA, EEG) performed as a result of this condition? ☐ No ☐ Yes (If yes, please submit a copy of the exam report, billing information, UB04 or HCFA 1500.)
- Dates of treatment related to injury (please submit supporting medical documentation for each visit indicated below):

Date	Provider Name	Provider Address	Provider Phone Number	Type of Treatment
				☐ Follow up ☐ Therapy *
				☐ Follow up ☐ Therapy *

* Some policies provide benefits for therapy including physical, speech, and occupational therapy. Not all types are available on all policies. Please submit information indicating date of treatment, treatment type, and who provided it to determine benefit.

- Transportation/Lodging Information: Please complete if you are filing a claim for transportation or lodging and please submit the hotel receipts and mileage information. For additional information, please refer to your policy language.

Date	To/From	Round-Trip Mileage

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