# INITIAL DISABILITY CLAIM FORM

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

**FILING CLAIM FOR** (check all that apply)**:**

☐ Disability due to an Accident ☐ Disability due to a Sickness ☐ Disability due to Pregnancy / Complications ☐ Disability due to Cancer

| Cancer Policy Number | Accident Policy Number | Short-Term Disability/ Sickness Disability Rider Policy Number | Hospital Indemnity Policy Number | Hospital Intensive Care Policy Number | Life Policy Number |
|---|---|---|---|---|---|
| | | | | | |

**INSTRUCTIONS:** **Be sure to include your policy number(s) on all documents.**

- ☐ Complete and sign **Section A: Policyholder/Patient Information**.
- ☐ Your employer should complete and sign **Section B: Employer's Statement.**
- ☐ Your physician should complete and sign **Section C: Physician's Statement**.
- ☐ This form should be completed on or after the initial date of your disability, hospitalization, and/or surgery. Forms completed prior to the initial date of your disability, hospitalization, and/or surgery, may result in a delay in processing this claim.
  **If you are a Contract, 1099, or Self Employed worker, Please submit your prior year tax return (Schedule C) and current year estimates tax payments (1040ES).**
- ☐ If hospitalized and/or confined to an intensive care unit/step-down unit, please send a copy of your hospital bill showing charges and the number of days you were confined. These items can be obtained directly from your healthcare provider (s) by requesting a UB04 (hospital bill) or HCFA 1500 (nonhospital bill).
- ☐ Please include a certified copy of the death certificate if the patient is deceased.
- ☐ This claim form should be completed on or after the initial date of your disability, hospitalization, and/or surgery. Forms completed prior to the initial date may result in a delay in processing this claim.

## Policyholder Information
(Please print.)

First Name _____ Initial _____ Last Name _____

Mailing Address _____

City _____ State _____ ZIP _____

Check box if this is a new permanent address: ☐

Social Security Number _____ Phone Number _____

## Patient Information
(Please print.)

First Name _____ Initial _____ Last Name _____

Relationship: Sex:

☐ Primary Policyholder ☐ Spouse ☐ Male ☐ Female Patient Birth Date: _____

**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.**

CLAIMANT SIGNATURE _____ FAMILY RELATIONSHIP, IF NOT POLICYHOLDER _____ DATE _____

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)

# INITIAL DISABILITY CLAIM FORM – EMPLOYER'S STATEMENT

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**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.**

Policy Number: _____ Policyholder Name: _____

Patient Name: _____ Date of Birth: _____

## SECTION B: EMPLOYER'S STATEMENT

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

1. First date of disability: _____ /_____ /_____
2. Was this disability caused by an incident that occurred while performing the duties of his/her employment? ☐ Yes ☐ No
3. Prior to this disability, number of hours worked per week: _____ Annual base salary (prior to disability): $_____
4. Has policyholder returned to work? ☐ Yes ☐ No If yes, is employee working: ☐ full-time? ☐ part-time? ☐ light duty?
5. Date policyholder began light duty: _____ /_____ /_____
6. Is the policyholder currently earning at least 80% of his or her predisability salary? ☐ Yes ☐ No

   If yes, is the policyholder currently using paid leave (sick or vacation) days? ☐ Yes ☐ No

(If the policyholder is not currently on disability, please complete question 6 as it pertains to the disability period.)

**Please complete this section only for W-2 Employees. (Contract 1099 or Self Employed worker; please see instructions.)**

7. Are Disability Rider or Short-Term Disability premiums deducted from the policyholder's paycheck on a pre-tax basis? ☐Yes ☐No

**(Please contact payroll and/or check the employee's Salary Redirection Agreement/Premium Deduction Authorization card for the answer to this question.)**

8. Date of hire: _____ /_____ /_____
9. Is the person still employed? ☐ Yes ☐ No If no, last date of employment: _____ /_____ /_____
10. Date returned (or expected to return) to Full-Time Duty: _____ /_____ /_____
11. Does the employer pay a portion of the disability premium for the employee? ☐ Yes ☐ No If yes, what percent?_____ %
12. 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

EMPLOYER'S PRINTED NAME | DIRECT PHONE NUMBER

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# INITIAL DISABILITY CLAIM FORM – PHYSICIAN'S STATEMENT

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

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Policy Number: _____ Policyholder Name: _____

Patient Name: _____ Date of Birth: _____

**SECTION C: PHYSICIAN'S STATEMENT Must be completed by physician or physician's staff (Continued on Page 4).**

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

Diagnosis description and ICD code: _____

If due to an accident, please give the date, details and location of the accident: _____

1 Symptoms first occurred on: _____/_____/_____ If diagnosed with cancer, date of initial diagnosis: _____/_____/_____

2. Patient first consulted you for this condition on: _____/_____/_____

3. Was the patient referred to you by another physician? ☐ Yes ☐ No

If yes, physician's name: _____

Referring physician's address: _____ Phone number: _____

4. Was patient hospitalized as a result of this diagnosis? ☐ Yes ☐ No

Admission: _____/_____/_____ Discharge: _____/_____/_____

Hospital Name: _____

City: _____ State: _____

# INITIAL DISABILITY CLAIM FORM – PHYSICIAN'S STATEMENT

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Policy Number: _____ Policyholder Name: _____

Patient Name: _____ Date of Birth: _____

**SECTION C: PHYSICIAN'S STATEMENT Must be completed by physician or physician's staff (Continued from Page 3).**

5. Pregnancy claims: Date of delivery: _____/_____/_____ ☐ Vaginal ☐ Cesarean

   Please advise of any complications.

   _____

6. If not delivered, expected delivery date: _____/_____/_____

7. First date of disability: _____/_____/_____ Date patient was last treated: _____/_____/_____

8. Is patient currently working: ☐ Full-time? ☐ Part-time? ☐ Light duty?

   Date patient was released to return to work: _____/_____/_____

9. If patient has not been released to return to work or if patient is working light duty, please provide the next appointment date or expected return to work date: _____/_____/_____

10. If patient is not employed, or employed less than 30 hours, which Activities of Daily Living (ADLs) is the patient unable to perform (Please note this does not apply to all policies)?

Check and **initial** all that apply: ☐ Continence ☐ Transferring ☐ Dressing ☐ Toileting ☐ Eating ☐ Bathing (PA only)

11. Does this patient require direct personal assistance to perform ADLs? ☐ Yes ☐ No

    If yes, how many days will the patient require direct personal assistance? _____

PHYSICIAN'S SIGNATURE DATE TAX ID NUMBER

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## Claims Authorization to Obtain Information

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**Instructions for completing this Health Insurance Portability and Accountability Act of 1996 (HIPAA) compliant form:**

1. **All areas of this form should be completed.**
2. **This form must be signed and dated by the claimant/patient below.**
3. **IMPORTANT: If you are filing a claim on behalf of a deceased, please check here**
4. **If you are the Authorized Representative, please sign below and indicate your relationship to the claimant/patient/deceased. In addition, include a copy of the legal document(s) authorizing you to act on their behalf.**
5. **Fax this form to 1-877-442-3522 or return the form to Aflac, Attn: Claims Department, Worldwide Headquarters, 1932 Wynnton Road, Columbus, GA 31999, as soon as possible in order to expedite claim review.**

| **Policyholder Name:** | **Policy Number(s):** | **Date of Birth:** |
|---|---|---|
| **Policyholder Address:** | | |
| **Claimant/Patient Name (if different from named policyholder listed above):** | | **Date of Birth:** |

| **This authorization shall be valid for a period of two years from the sign date unless a lesser time frame is indicated. Alternate Expiration Date:** | **Name and Address of health care provider(s), company, or individual authorized to release the requested information:** (this section will be completed by Aflac): |
|---|---|
| **Purpose of Disclosure:** Evaluate claims for benefits during the time this authorization is valid. | |

I, or my authorized representative, request that information regarding my past, present, or future physical or mental health condition (excluding psychotherapy notes), employment, other insurance coverage, or any other nonmedical facts be released to **American Family Life Assurance Company of Columbus (Aflac)** or any person or entity acting on its part. This could include, but is not limited to, 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.

**I understand that:**

1. Protected health information may include information and records protected under Federal and State Law such as: alcohol, drug abuse, mental health, AIDS or HIV testing or treatment, or the presence of a communicable or noncommunicable disease.
2. My treatment, payment or eligibility for benefits may not be conditioned on signing this authorization.
3. I understand that I may revoke this authorization at any time by writing to **Aflac, Claims Department, Worldwide Headquarters, 1932 Wynnton Road, Columbus, GA** , except to the extent that:
   a. Aflac has taken action in reliance to this authorization, or
   b. Other law provides Aflac with the right to contest a claim under the policy or the policy itself.
4. If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. It is recommended I retain a copy of this signed form for my records, understanding that a copy is as valid as the original.

**Signature of claimant/patient, guardian or authorized representative** **Date**

**Printed name of claimant/patient, guardian or authorized representative** **Relationship**