ACCIDENTAL INJURY CLAIM FORM

Thank you for trusting Aflac with your Accidental Injury needs.

- **If you are interested in filing your claim online or uploading documentation on an existing claim, register using aflac.com/smartclaim.**

To prevent delays, please provide documentation from your healthcare provider to support this claim. 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.

- **Service related items can be obtained directly from the patient's healthcare provider(s) by requesting a UB04 hospital bill or HCFA 1500 non-hospital bill.**
- **Failure to complete all sections may result in a delay in processing this claim.**
- **Disclaimer: Some of the services listed may not be covered by your policy.**

*Policy Number: ☐☐☐☐☐☐☐☐

Policyholder Information: This * denotes a required field.

*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 a permanent address change.*

Patient Information:

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

*Sex: ☐ Male ☐ Female

*Relationship: ☐ Primary Policyholder ☐ Spouse ☐ Dependent Child

Accidental Injury Checklist

- Date of the injury: ____/____/____
- Describe how the injury occurred: ____________________
- Was this injury caused by an incident that occurred while performing the duties of his/her employment? ☐ No ☐ Yes
- Was this a motor vehicle accident in which the patient was the driver? ☐ No ☐ Yes (If yes, please submit a copy of the Police Report.)
- Was death a result of this injury? ☐ No ☐ Yes (If yes, please submit the certified death certificate and the Life-Beneficiary's Statement.)
- Was the patient confined to the hospital as a result of this injury? ☐ No ☐ Yes (If yes, please submit the UB04 (Universal Billing 2004), itemized hospital bill, or HCFA 1500.)
- Hospital Name: ____________________
- City ____________________ State ____________________

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 ☐ Physical Therapy
				☐ Follow up ☐ Physical Therapy
				☐ Follow up ☐ Physical Therapy

- 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

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.

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)

Claims Authorization to Obtain Information

AU

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

1. **All areas, with the exception of the health care provider section of this form, should be completed.**
2. **This form must be signed and dated by the claimant/patient, guardian or authorized representative below.**
3. **IMPORTANT: If you are filing a claim on behalf of a deceased person, 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 his or her 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 will 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 abuse, 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, Attn: Claims Department, Worldwide Headquarters, 1932 Wynnton Road, Columbus, GA 31999**, 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**