INITIAL DISABILITY CLAIM FORM – EMPLOYER'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 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 _____

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 – 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 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

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
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