

# 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 estimated 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 health care provider(s) by requesting a UB04 (hospital bill) or HCFA1500 (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:  Primary Policyholder     Spouse    Sex:  Male     Female    Patient Birth Date: \_\_\_\_\_

If unemployed, date unemployment began: \_\_\_\_\_

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

Date of Incident: \_\_\_\_\_

Describe where and how the incident occurred: \_\_\_\_\_

**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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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: \_\_\_\_\_ .
4. Gross annual income (without overtime, unless contractual, bonuses, or other incentives) [prior to disability]  
\$ \_\_\_\_\_. If you are self-employed, your gross annual income is your net earnings.
5. Has policyholder returned to work?  Yes  No If yes, is policyholder working:  full-time?  part-time?  light duty?
6. Date policyholder began light duty: \_\_\_\_ / \_\_\_\_ / \_\_\_\_
7. 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 7 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.)**

8. 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 policyholder’s Salary Redirection Agreement/Premium Deduction Authorization card for the answer to this question.)**

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

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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: \_\_\_\_\_

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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

6. If not delivered, expected delivery date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Please advise of any complications.

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 (applicable only to certain Pennsylvania policies.)

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



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:
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Policyholder Address:

Claimant/Patient Name (if different from named policyholder listed above):	Date of Birth:
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<p><b>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:</b></p>	<p><b>Name and Address of health care provider(s), company, or individual authorized to release the requested information:</b> (this section will be completed by Aflac):</p>
<p><b>Purpose of Disclosure:</b> Evaluate claims for benefits during the time this authorization is valid.</p>	

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 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.

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

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