CANCER 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)**:**

☐ Cancer ☐ Cancer With Disability ☐ Cancer With Hospitalization ☐ Deceased - Date Deceased:_____/_____/_____

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

INSTRUCTIONS:

- Complete **Section A: Policyholder/Patient Information**.
- Have your doctor complete and sign Section B: Physician's Statement (Pages 2 and 3). If you are filing for disability, your doctor also should complete and sign Section C: Physician's Disability Statement.
- If you are filing for disability, have your employer complete and sign Section D: Employer's Disability Statement.
- Be sure to sign your claim form at the bottom of Page 1.

ADDITIONAL NOTES:

- A pathology report diagnosing cancer **must** accompany your first claim. (The hospital or doctor will furnish this report to you at your request.) If the diagnosis of cancer was made clinically instead of pathologically, please submit the clinical evidence that established the diagnosis of cancer.
- Submit all bills related to this claim, such as ambulance, radiation treatments, chemotherapy treatments, etc. All bills should be itemized and should include the diagnosis, services rendered, and actual charges for the service. If filing for chemotherapy, itemized billing should also include drug names.
- Send a copy of your hospital bill that lists the number of days confined.
- If confined to an intensive care unit, please send a copy of your hospital bill that shows charges and the number of days you spent in the intensive care unit. Your intensive care claim cannot be processed without the hospital bill.
- Please include a certified copy of the death certificate if the patient is deceased.
- **Be sure to include your policy number(s) on all documents.**

SECTION A: POLICYHOLDER/PATIENT INFORMATION

POLICYHOLDER INFORMATION

LAST NAME	FIRST NAME	MIDDLE INITIAL

SOCIAL SECURITY NUMBER (optional)	BIRTH DATE	PHONE NUMBER ( )

MAILING ADDRESS ☐ CHECK BOX IF THIS IS A NEW PERMANENT ADDRESS.

CITY	STATE	ZIP

PLACE OF EMPLOYMENT	PHONE NUMBER ( )

MAILING ADDRESS

CITY	STATE	ZIP

PATIENT INFORMATION

LAST NAME	FIRST NAME	MIDDLE INITIAL

SOCIAL SECURITY NUMBER (optional)	BIRTH DATE

☐ MALE ☐ FEMALE ☐ SINGLE ☐ MARRIED ☐ OTHER

RELATIONSHIP: ☐ SELF ☐ SPOUSE ☐ DEPENDENT - CHECK IF DEPENDENT IS FULL-TIME STUDENT ☐

For your protection California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

_____ _____ _____

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)

CANCER CLAIM FORM – PHYSICIAN'S STATEMENT

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

For your protection California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Policy Number: _____ Policyholder Name: _____

Patient Name: _____

SECTION B: PHYSICIAN'S STATEMENT Please answer each question COMPLETELY.

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

1. Has patient been diagnosed with cancer? ☐ Yes ☐ No

   Type of cancer: _____ ICD code: _____

2. Date of initial diagnosis: _____/_____/_____

   Please provide the patient with a copy of the pathology report that diagnosed cancer, as it is required for all initial claims.

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

4. Did any other physician previously treat the patient? ☐ Yes ☐ No If yes, physician's name: _____

   Referring physician's address: _____ Phone number: _____

Hospitalization Information:

Was patient hospitalized as a result of this diagnosis? ☐ Yes ☐ No If additional dates exist, please attach a copy of itemized billing.

Admission Date	Discharge Date	Admitting Diagnosis/ICD Code	Hospital Name (Please include city and state.)
- -	- -		
- -	- -		
- -	- -		
- -	- -		

Surgery Information:

Did patient undergo surgery for this condition? ☐ Yes ☐ No If additional dates exist, please attach a copy of itemized billing.

Date	CPT Code	Description	Charge
- -			
- -			
- -			
- -			

(PHYSICIAN'S STATEMENT CONTINUED ON PAGE 3)

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Toll-free fax number 1-877-44-AFLAC (1-877-442-3522)

CANCER CLAIM FORM - PHYSICIAN'S STATEMENT

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

Policy Number: _____ Policyholder Name: _____

Patient Name: _____

Chemotherapy Information

Has patient received chemotherapy? ☐ **Yes** ☐ **No** **If additional dates exist, please attach a copy of itemized billing.**

Date	HCPCS/CPT Code	Drug Name and Method of Administration	Drug Charge
- -			
- -			
- -			
- -			
- -			
- -			
- -			
- -			
- -			
- -			

Radiation Therapy Information

Has patient received radiation therapy? ☐ **Yes** ☐ **No** **If additional dates exist, please attach a copy of itemized billing.**

Date	CPT Code	Description	Charge
- -			
- -			
- -			
- -			
- -			
- -			
- -			
- -			
- -			
- -			
- -			
- -			

PHYSICIAN'S SIGNATURE DATE TAX ID NUMBER

American Family Life Assurance Company of Columbus (Aflac)
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Toll-free fax number 1-877-44-AFLAC (1-877-442-3522)

CANCER CLAIM FORM - DISABILITY STATEMENT

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

For your protection California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Policy Number: _____ Policyholder Name: _____

Patient Name: _____

SECTION C: PHYSICIAN'S DISABILITY STATEMENT Must be completed by physician or physician's staff.

1. Please indicate the specific reason the insured is unable to work: _____
2. First date of disability: _____/_____/_____ Date patient was released to return to work: _____/_____/_____
3. Is patient currently working: ☐ Full-time? ☐ Part-time? ☐ Light duty? Last date of treatment: _____/_____/_____
4. If patient has not been released to return to work or if patient is working light duty, please provide the next appointment date: _____/_____/_____
5. If patient is not employed, or employed less than 30 hours, which Activities of Daily Living (ADLs) is the patient unable to perform and must have personal assistance to perform each time?

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

PHYSICIAN'S SIGNATURE | DATE | TAX ID NUMBER

SECTION D: EMPLOYER'S DISABILITY STATEMENT Please complete if filing for disability.

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

1. Date of hire: _____/_____/_____ **First date of disability:** _____/_____/_____
2. Date returned (or expected to return) to Full-Time Duty: _____/_____/_____
3. Is the person still employed? ☐ Yes ☐ No If no, last date of employment: _____/_____/_____
4. Prior to this disability, number of hours worked per week: _____ Annual base salary (prior to disability): $_____
5. Has employee returned to work? ☐ Yes ☐ No If yes, is employee working: ☐ full-time? ☐ part-time? ☐ light duty?
6. Date employee began light duty: _____/_____/_____
7. Is the employee currently earning at least 80% of his or her predisability salary? ☐ Yes ☐ No
8. Are Sickness Disability Rider or Short-Term Disability premiums paid by the employee with pre-tax dollars? ☐ Yes ☐ No **(Please contact payroll and/or check the employee's SRA/PDA card for the answer to this question.)**
9. Does the employer pay a portion of the disability premium for the employee? ☐ Yes ☐ No If yes, what percent?_____ %
10. 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

Please review and sign the attached authorization. Two copies are attached: return one copy to Aflac and keep one for your records. By returning the signed authorization with your claim, you will help us process your claim as quickly and efficiently as possible.

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)

Policy #: | | | | | | | | |

AU

AUTHORIZATION TO OBTAIN INFORMATION

I authorize the following to give information (as defined below) to American Family Life Assurance Company of Columbus (Aflac) or any person or entity acting on its part: 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. "Information" means facts or opinions relating to my past, present, or future physical or mental health or condition (excluding psychotherapy notes), employment, other insurance coverage, or any other non-medical facts that Aflac deems appropriate to evaluate claims for benefits during the time this authorization is valid. I understand that any disclosure of information to Aflac for the purpose of evaluating claims for benefits for coverage other than health plan coverage means the information may no longer be protected by federal privacy regulations. I further understand, however, that such information may be re-disclosed only in accordance with other applicable laws or regulations.

I understand that this information will be used by Aflac to evaluate claims for benefits.

I understand that I may revoke this authorization at any time, except to the extent that (1) Aflac has taken action in reliance on this authorization, or (2) other law provides Aflac with the right to contest a claim under the policy or the policy itself. My revocation must be submitted in writing to Aflac, Claims Department, Worldwide Headquarters, 1932 Wynnton Road, Columbus, GA 31999.

Unless otherwise revoked, I agree that this authorization will expire two years from the date indicated below.

I agree that a copy of this authorization is as valid as the original.

_____ _____

Signature Date Printed Name

Individual/Guardian/Personal Representative

_____

Printed Name

If this authorization has been signed by a personal representative on behalf of an individual, his/her authority to act on behalf of the individual must be set forth here:

Policy #: | | | | | | | | |

AU

AUTHORIZATION TO OBTAIN INFORMATION

I authorize the following to give information (as defined below) to American Family Life Assurance Company of Columbus (Aflac) or any person or entity acting on its part: 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. "Information" means facts or opinions relating to my past, present, or future physical or mental health or condition (excluding psychotherapy notes), employment, other insurance coverage, or any other non-medical facts that Aflac deems appropriate to evaluate claims for benefits during the time this authorization is valid. I understand that any disclosure of information to Aflac for the purpose of evaluating claims for benefits for coverage other than health plan coverage means the information may no longer be protected by federal privacy regulations. I further understand, however, that such information may be re-disclosed only in accordance with other applicable laws or regulations.

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I agree that a copy of this authorization is as valid as the original.

_____ _____

Signature Date Printed Name

Individual/Guardian/Personal Representative

_____

Printed Name

If this authorization has been signed by a personal representative on behalf of an individual, his/her authority to act on behalf of the individual must be set forth here:

RETAIN THIS COPY FOR YOUR RECORDS