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

FILING CLAIM FOR (check all that apply): Sickness Pregnancy Hospitalization Deceased - Date Deceased: Short-Term Disability/ Hospital Indemnity **Hospital Intensive Care Specified Health Event** Cancer Life Sickness Disability Rider Policy Number Policy Number Policy Number Policy Number Policy Number **Policy Number**

INSTRUCTIONS:

- Complete Section A: Policyholder/Patient Information.
- Have your doctor complete Section B: Physician's Statement. 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:

- Submit all bills related to this claim, such as ambulance, radiation treatments, physical therapy, etc. All bills should be itemized and should include the diagnosis, services rendered and actual charges for the service.
- 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.
- If filing for cancer, 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.
- If filing on your Specified Disease policy, medical documentation of tissue specimen, culture and/or titer, or other diagnostic studies that initially
 diagnosed the specified disease must accompany your first claim.
- · 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'S INFORMATION									
LAST NAME	FIRST NAME		MIDE	DLE INITIAL					
SOCIAL SECURITY NUMBER (optional)	BIRTH DATE		РНО (2				
MAILING ADDRESS					CHECK BOX IF THIS IS A NEW PERMANENT ADDRESS				
CITY	STATE		ZIP						
PLACE OF EMPLOYMENT:	· · ·		РНО (NE NUMBER	ł				
MAILING ADDRESS									
CITY	STATE		ZIP						
	PA	TIENT'S INF	FORM/	ATION					
LAST NAME	FIRST NAM	1E		MIDI	DLE INITIAL				
SOCIAL SECURITY NUMBER (optional)	BI	IRTH DATE							
MALE FEMALE SINGLE	MARRIED OTHER RI	ELATIONSHIP:	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)

SICKNESS CLAIM FORM – PHYSICIAN'S STATEMENT

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

Policy Number:			Pol	licyholder Name	:			
Patient Name:								
SECTION B: F	HYSICIAN'	S STATEMENT	Please ans	wer each que	estion COMI	PLETELY.		
PHYSICIAN'S NAME				PHONE N	JMBER)		FAX NUMBER	
MAILING ADDRESS				CITY			STATE	ZIP
DATES OF SERVICE	DIAGNOSIS CODE ICD	DIAGNOSIS DESCR	IPTION	PROCEDURE CODE	PROCEDUR	E DESCRIPTION		PLACE OF SERVICE
L Commentering first a								
 Patient first cons Is there a referrin Referring physic 	ulted you for this g physician? cian's address:	// s condition on: Yes No 	// If yes, p	ohysician's nam	e:	Phone num	nber:	
 Patient first cons Is there a referrin Referring physic Was patient hosp Hospital Name 	ulted you for this g physician? cian's address: pitalized as a res	Yes No	// If yes, p Yes N	bhysician's nam	e: on:/ City:	Phone num	nber: Discharge:	
 Patient first cons Is there a referrin Referring physic Was patient hosp Hospital Name Pregnancy claims 	ulted you for this g physician? cian's address: bitalized as a res : 	Yes No	// If yes, p Yes N	bhysician's nam	e: 	Phone num	nber: Discharge:	//
 Patient first cons Is there a referrin Referring physic Was patient hosp Hospital Name Pregnancy claims 	ulted you for this g physician? cian's address: bitalized as a res :	Yes No	// If yes, p Yes N	ohysician's nam No Admissi Vaginal	e:/ on:/ _ City: Cesarean	Phone num	nber: Discharge:	// State:
 Patient first cons Is there a referring Referring physic Was patient hosp Hospital Name Pregnancy claims If not delivered, e PHYSICIAN'S SIGNATION (2016)	ulted you for this g physician? cian's address: bitalized as a res : :	Yes No ult of this diagnosis?	// If yes, p Yes N	No Admissi Vaginal DATE	e:/ on:/ Cesarean Cesarean	Phone num	nber: Discharge: TAX CTION C be	// State: G ID NUMBER NOW.
 Patient first cons Is there a referring Referring physic Was patient hosp Hospital Name Pregnancy claims If not delivered, e PHYSICIAN'S SIGNATION 	ulted you for this g physician? cian's address: bitalized as a res : :	S condition on:	// If yes, p Yes N	No Admissi Vaginal DATE	e:/ on:/ City: Cesarean see ALSO co pompleted by	Phone num // omplete SEC	nber: Discharge: 	// State: G ID NUMBER NOW.
 Patient first cons Is there a referring Referring physic Was patient hosp Hospital Name Pregnancy claims If not delivered, e PHYSICIAN'S SIGNATION SECTION C: F First date of disa 	ulted you for this g physician? cian's address: bitalized as a res : : : : : : : : : : : : : : : : : : :	S condition on: Yes No sult of this diagnosis? ry:// date:/ DN PHYSICIAN: If [S DISABILITY ST /	// If yes, p Yes N	Vaginal Vaginal DATE	e: on:/ _ City: Cesarean isse ALSO co pmpleted by date of treatme	Phone num	nber: Discharge: 	/ / State: (ID NUMBER NOW. 1's staff.
 Patient first cons Is there a referring Referring physic Was patient hosp Hospital Name Pregnancy claims If not delivered, e PHYSICIAN'S SIGNATION FITST date of disal Is patient current 	ulted you for this g physician? cian's address: bitalized as a res : :	s condition on:	// If yes, p Yes N / patient is d ATEMENT e? Light	No Admissi Vaginal DATE DATE DATE DATE DATE DATE DATE DATE	e:/ on:/ Cesarean Cesarean ase ALSO co ompleted by date of treatme atient was relea	Phone num / omplete SEC physician c ent:/_ used to return to	TAX TAX CTION C be pr physiciar / p work:	// State: GID NUMBER How. I's staff.
 Patient first cons Is there a referrin Referring physic Was patient hosp Hospital Name Pregnancy claims If not delivered, e PHYSICIAN'S SIGNATU SECTION C: F First date of disal Is patient current If patient has not 	ulted you for this g physician? cian's address: bitalized as a res : s: Date of delivery JRE ATTENTIC PHYSICIAN'S bility:/_ ly working: F been released to	s condition on:	// If yes, p Yes N patient is d ATEMENT e? Light tient is working	vaginal Vaginal DATE Isabled, plea Must be co Last duty? Date pa	e:/ on:/ _ City: Cesarean ise ALSO co ompleted by date of treatme atient was relea se provide the	Phone num / pmplete SEC physician c ent:/_ used to return to next appointme	nber: Discharge: 	/ / State: (ID NUMBER low. h's staff.
 Patient first cons Is there a referrin Referring physic Was patient hosp Hospital Name Pregnancy claims If not delivered, e PHYSICIAN'S SIGNATE SECTION C: F First date of disal Is patient current If patient has not 	ulted you for this g physician? cian's address: bitalized as a res : s: Date of deliver xpected delivery JRE ATTENTIC PHYSICIAN'S bility:/ ly working: F been released to mployed, or emp	s condition on:	// If yes, p Yes N patient is d ATEMENT e? Light tient is working	vaginal Vaginal Date lisabled, plea duty? Date pa g light duty, plea vities of Daily Liv	e:/ on:/ _ City: Cesarean ise ALSO co ompleted by date of treatme atient was relea se provide the	Phone num / pmplete SEC physician c ent:/_ used to return to next appointme	nber: Discharge: 	/ / State: (ID NUMBER low. h's staff.

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

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SICKNESS CLAIM FORM - EMPLOYER'S DISABILITY STATEMENT

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

Policy Number: Poli	icyholder Name:
Patient Name:	
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: /	_1
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:	
 Prior to this disability, number of hours worked per week: Has employee returned to work? Yes No If yes 	Annual base salary (prior to disability): \$
 4. Prior to this disability, number of hours worked per week: 5. Has employee returned to work? Yes No If yes 6. Date employee began light duty:// 	Annual base salary (prior to disability): \$s, is employee working: full-time? part-time? light duty?
 4. Prior to this disability, number of hours worked per week: 5. Has employee returned to work? Yes No If yes 6. Date employee began light duty:/ 7. Is the employee currently earning at least 80% of his or her predisability 	Annual base salary (prior to disability): \$ s, is employee working: full-time? part-time? light duty? ty salary? Yes No
 4. Prior to this disability, number of hours worked per week:	Annual base salary (prior to disability): \$ s, is employee working: full-time? part-time? light duty? ty salary? Yes No by the employee with pre-tax dollars? Yes No (Please contact payro
 4. Prior to this disability, number of hours worked per week:	Annual base salary (prior to disability): \$ s, is employee working: full-time? part-time? light duty? ty salary? Yes No by the employee with pre-tax dollars? Yes No (Please contact payro uestion.)
4. Prior to this disability, number of hours worked per week:	Annual base salary (prior to disability): \$ s, is employee working: full-time? part-time? light duty? ty salary? Yes No by the employee with pre-tax dollars? Yes No (Please contact payro uestion.) oyee? Yes No If yes, what percent?%

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.

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

Policy #:				



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 #:				



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