ACCIDENTAL INJURY CLAIM FORM

FOR ASSOCIATE USE ONLY:

Send the insured’s check to the associate for delivery.

Writing No.: ______ Name:____________________
Address: ________________________________

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.

FILING CLAIM FOR:

<table>
<thead>
<tr>
<th>Accidental Injury Only</th>
<th>Injury with Disability</th>
<th>Injury with Hospitalization</th>
<th>Deceased: Date Deceased: ___ / ___ / ___</th>
</tr>
</thead>
</table>

SECTION A: PATIENT/POLICYHOLDER INFORMATION

<table>
<thead>
<tr>
<th>PATIENT’S INFORMATION</th>
<th>POLICYHOLDER’S INFORMATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>LAST</td>
<td>FIRST</td>
</tr>
<tr>
<td>MALE</td>
<td>FEMALE</td>
</tr>
<tr>
<td>SINGLE</td>
<td>MARRIED</td>
</tr>
<tr>
<td>RELATIONSHIP: SELF</td>
<td>SPouse</td>
</tr>
<tr>
<td>SOCIAL SECURITY NUMBER (optional)</td>
<td>PHONE NUMBER</td>
</tr>
</tbody>
</table>

Date of accident: _____ / _____ / ______ Describe how the accident occurred: ____________________________________________________________

“ If the injury resulted from an auto accident, a copy of the police report is required.”

SECTION B: PHYSICIAN’S INFORMATION

<table>
<thead>
<tr>
<th>PHYSICIAN’S NAME</th>
<th>ADDRESS</th>
<th>PHONE NUMBER</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>DATES OF SERVICE</th>
<th>DIAGNOSIS CODE ICD</th>
<th>DIAGNOSIS DESCRIPTION</th>
<th>PROCEDURE CODE</th>
<th>PROCEDURE DESCRIPTION</th>
<th>ACTUAL CHARGES</th>
</tr>
</thead>
</table>

Date of accident: _____ / _____ / ______ Describe how the accident occurred: ____________________________________________________________

Is this accident covered by Medicaid/state aid? Yes No
Was patient hospitalized? Yes No If yes: Admission: _____ / _____ / _____ Discharge: _____ / _____ / _____
Hospital Name: _________________________ City: _________________________ State: _________________________

ATTENTION PHYSICIAN: If patient is disabled, please ALSO complete SECTION C ON PAGE 2 OF THIS FORM.

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 www.aflac.com
Toll-free fax number 1-877-44-AFLAC (1-877-442-3522)

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

1. **First date of disability:** __/__/____
   **Last date of treatment:** __/__/____

2. **Date released to return to work:** __/__/____
   **If not released, next appointment date:** __/__/____

3. **Is patient:**
   - ambulatory?
   - bed-confined?
   - house-confined?
   - hospital-confined?

4. **If not employed, or employed less than 30 hours per week, which Activities of Daily Living (ADLs) is patient unable to perform?**
   Check all that apply:
   - Continent
   - Transferring
   - Dressing
   - Toileting
   - Eating
   - Bathing

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**PHYSICIAN’S SIGNATURE**

---

**DATE**

**TAX ID NUMBER**

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## SECTION D: EMPLOYER’S INFORMATION
Please complete if filing for disability.

<table>
<thead>
<tr>
<th>EMPLOYER’S NAME</th>
<th>ADDRESS</th>
<th>PHONE NUMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### WORK STATUS

1. **Is this disability caused by an accident that occurred at the workplace?** Yes No

2. **Is the employee currently earning at least 80% of their salary prior to disability?** Yes No

3. **Prior to this disability, number of hours worked per week:** ________ **Annual Base Salary:** $ ________

4. **Is the person still employed?** Yes No **If no, date person left employment:** __/__/____

5. **First date employee unable to work:** __/__/____ **Last date employee unable to work:** __/__/____

6. **Is employee currently working?** Yes No **If yes, is employee working full-time?** part-time? light duty?

7. **Date to return to Full Time Duty:** __/__/____

8. **Please list job duties employee is unable to perform and the percentage of time this requires daily:**
   - _____________________________________________________________ __________ %
   - _____________________________________________________________ __________ %

### PREMIUM/TAX INFORMATION

The employer is required to report disability benefits paid on pre-tax plans on its Form 941 and the employee’s Form W-2.

1. **Does the employee pay disability premiums with pre-tax dollars?** Yes No

2. **Does employer pay a portion of the disability premium for the employee?** Yes No **If yes, what percent?** %

3. **Employee is:**
   - (Check all that apply)
   - exempt from Social Security
   - exempt from Medicare
   - subject to RRTA

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**EMPLOYER’S SIGNATURE**

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**TITLE**

**DATE**

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**CLAIMANT SIGNATURE**

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**FAMILY RELATIONSHIP, IF NOT POLICYHOLDER**

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**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 www.aflac.com
Toll-free fax number 1-877-44-AFLAC (1-877-442-3522)
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:
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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:

RETAI N THIS COPY FOR YOUR RECORDS