

CONTINUING DISABILITY CLAIM FORM

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

FILING CLAIM FOR:

- Disability due to an Accident
 Disability due to a Sickness
 Disability due to Pregnancy / Complications
 Disability due to Cancer

Accident Policy Number	Short-Term Disability Policy Number

INSTRUCTIONS:

- ◆ Complete **Section A: Policyholder/Patient Information**.
- ◆ Your doctor should complete and sign Section B: Physician's Disability Statement.
- ◆ Your employer should complete and sign Section C: Employer's Disability Statement.
- ◆ Be sure to sign your claim form at the bottom of Page 1.

SECTION A: POLICYHOLDER/PATIENT INFORMATION

POLICYHOLDER'S INFORMATION			
LAST	FIRST	INITIAL	
SOCIAL SECURITY NUMBER (optional)	BIRTHDATE	PHONE NUMBER ()	
ADDRESS			CHECK BOX IF THIS IS A NEW PERMANENT ADDRESS } <input type="checkbox"/>
CITY	STATE	ZIP	
PLACE OF EMPLOYMENT:		PHONE NUMBER ()	
ADDRESS			
CITY	STATE	ZIP	
PATIENT'S INFORMATION			
LAST	FIRST	INITIAL	
SOCIAL SECURITY NUMBER (optional)	BIRTHDATE		
<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> OTHER			RELATIONSHIP: <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> DEPENDANT – CHECK IF CHILD IS FULL-TIME STUDENT <input type="checkbox"/>

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 www.aflac.com

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

CONTINUING DISABILITY – PHYSICIAN'S DISABILITY STATEMENT

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

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

1. First date of disability: ____/____/____ First date out of work: ____/____/____ Last date of treatment: ____/____/____
2. Pregnancy claims: Date of delivery: ____/____/____ Vaginal Cesarean If not delivered, expected delivery date: ____/____/____
Please advise of any complications: _____
3. Was patient hospitalized as a result of this diagnosis? Yes No Admission: ____/____/____ Discharge: ____/____/____
Hospital Name: _____ City: _____ State: _____
4. Is patient currently working: full-time? part-time? light duty? Date patient was released to return to work: ____/____/____
5. If patient has not been released to return to work or if patient is working light duty, please provide the next appointment date: ____/____/____
6. If patient is not employed, or employed less than 30 hours, which Activities of Daily Living (ADLs) is patient unable to perform?
Check and initial all that apply: Continence Transferring Dressing Toileting Eating Bathing

PHYSICIAN'S SIGNATURE

DATE

TAX ID NUMBER

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

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

1. Date of Hire: ____/____/____ First date of disability: ____/____/____
2. Is the person still employed? Yes No If no, last date of employment: ____/____/____
3. Prior to this disability, number of hours worked per week: _____ Annual Base Salary (prior to disability): \$ _____
4. Was this disability caused by an accident that occurred at the workplace? Yes No
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: ____/____/____ Date returned (or expected to return) to Full-Time Duty: ____/____/____
7. Is the employee currently earning at least 80% of their pre-disability salary? Yes No
8. Does the employee pay Accident Disability Rider or Short-Term Disability premiums with pre-tax dollars? Rider Short-Term Disability
9. Does 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 its Form 941 and the employee's Form W-2.

EMPLOYER'S SIGNATURE

TITLE

DATE

American Family Life Assurance Company of Columbus (Aflac)
Attention: Claims Department

Worldwide Headquarters: 1932 Wynnton Road, Columbus, GA 31999

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