Critical Illness Claim Filing Instructions

Save Time and Paper – File Your Claim Online!

We offer two ways to file your Critical Illness claim: online or by mail/fax.

How to File Online:

1. Login to your secured Online Service Center (OSC) account at www.americanfidelity.com/MyAccount.
2. From the "My Claims" tab, click "File A Claim" to get started.
3. Follow the step-by-step instructions to complete your online claim filing process.
4. Conveniently upload your completed Attending Physician's Statement and the Authorization to Disclose Protected Health Information during your claim filing process and upload the following if applicable:
    a. If claim is for Cancer, upload Pathologist's report.
    b. If claim is for Hospital Confinement, upload a copy of the itemized hospital bill.
    c. If claim is for Occupational HIV or Hepatitis B/C/D, upload a copy of the incident report or notice of exposure.
    d. If claim is for Sudden Death Due to Cardiac Arrest, upload a copy of the death certificate.
5. Check the status of your claim by selecting the "My Claims" tab at the top of the screen!

How to File By Mail or Fax:

1. Complete the Authorization to Disclose Protected Health Information and the Statement of Insured Application.
2. Have your attending physician complete the Attending Physician's Statement.
3. Mail the completed forms to American Fidelity and include the following if applicable:
    a. If claim is for Cancer, include Pathologist's report.
    b. If claim is for Hospital Confinement, include a copy of the itemized hospital bill.
    c. If claim is for Occupational HIV or Hepatitis B/C/D, attach a copy of the incident report or notice of exposure.
    d. If claim is for Sudden Death Due to Cardiac Arrest, attach a copy of the death certificate.
4. If you wish to fax your completed forms, please fax to 800-818-3453.

FOR ALL CLAIMS, PLEASE ATTACH COPIES OF ALL **OFFICE NOTES OR MEDICAL RECORDS** FROM THE DATE YOU WERE FIRST TREATED FOR SYMPTOMS ASSOCIATED WITH THE CONDITION UP TO THE PRESENT. PLEASE REFER TO YOUR (SCHEDULE OF BENEFITS) FOR AVAILABLE COVERAGE.

Whether completing this claim online or with the below packet, all portions must be completed to avoid undue delay in processing your request for benefits. If you have any questions regarding completion of your claim, please call:

Toll Free: 800-662-1113

Local: 405-523-5025

American Fidelity Assurance Company

Our Family, Dedicated To Yours.®

Educational Services Division
Benefits Department
P.O. Box 25160
Oklahoma City, Oklahoma 73125-0160
Fax: 1-800-818-3453
www.americanfidelity.com

BN-727-AFES-0515

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize the entities specified below to disclose any information about my entire medical record, benefits payable, or benefit eligibility for this disability and history of treatment for physical and/or emotional illness to include psychological testing, except psychotherapy notes, to individuals representing American Fidelity Assurance Company (AFAC) who are involved in determining whether I am eligible for benefits under my insurance coverage. Those so authorized are: a) licensed physicians or medical practitioners; b) hospitals, clinics or medically-related facilities; c) health plans; d) Veteran's Administration; e) past or present employers; f) pharmacy; g) insurance companies; h) the Social Security Administration; i) retirement systems; j) Department of Motor Vehicles; and k) Workers' Compensation Carrier.

NOTICE: Information authorized for release may include information on communicable or venereal diseases such as hepatitis, syphilis, gonorrhea, HIV/AIDS (Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome) or other conditions for which you may have been treated. This authorization excludes disclosure of the result of a test for HIV if you have tested HIV positive but have not developed symptoms of the disease AIDS. Such test results shall not be discovered or published. Nothing in this caveat will prohibit this authorization from including the fact that you have AIDS.

I understand that I may refuse to sign this authorization; however, if I do not sign the authorization, my failure to sign the authorization may result in a denial or a delay of benefits.

I understand that I may revoke this authorization at any time by writing to AFES Benefits Department, PO Box 25160, Oklahoma City, OK 73125-0160 or by calling, toll-free, 1-800-662-1113. I understand that my right to revoke this authorization is limited to the extent that: AFAC has taken action in reliance on the authorization; or, the law provides AFAC with the right to contest my insurance coverage or a claim under my insurance coverage. A copy of this authorization will be as valid as the original. I understand that if protected health information is disclosed to a person or organization that is not required to comply with federal privacy regulations, the information may be redisclosed and no longer protected by the federal privacy regulations. For health insurance coverage this authorization will expire twenty-four months from the date it is signed or upon termination of my insurance policy, whichever occurs first. For insurance coverage other than health insurance, this authorization will expire twenty-four months from the date it is signed or upon expiration of my claim for benefits, whichever occurs first.

Signature (Patient) or Personal Representative (if applicable)	Printed Name (Patient)
Relationship of Personal Representative to Patient	Date

If authorization is supplied by a personal representative, a description of the authority to act on behalf of the Insured must be included.

Please retain a copy for your personal records, or you may request a copy from our Company.

Warning: Any person who knowingly and with intent to injure, defraud, or deceive an insurer files a statement of claim containing any false, incomplete, or misleading information may be guilty of insurance fraud and subject to criminal and civil penalties.

California - For your protection, California law requires the following to appear on this form. Any person who knowingly presents 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.

AR, DC, LA, MD, NJ, NM, TX, and WV - ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

DE, ID, IN, MN, OH, and OK - WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

Colorado - It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

New Hampshire - Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

Kentucky - Any person who knowingly and with intent to defraud any insurance company or other person files a 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.

Oregon - Any person who knowingly and with intent to defraud or solicit another to defraud an insurer: (1) by submitting an application, or (2) by filing a claim containing a false statement as to any material fact, may be guilty of insurance fraud.

Pennsylvania - 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.

Arizona - For your protection, Arizona law requires the following statement to appear on this form: Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

Florida - Any person who knowingly, and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Alabama - Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

Maryland - Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

REQUEST FOR CRITICAL ILLNESS POLICY BENEFITS

American Fidelity Assurance Company

Our Family, Dedicated To Yours.®

ATTN: AFES BENEFITS DEPT.
P.O. Box 25160
Oklahoma City, Oklahoma 73125
Toll Free: 1-800-662-1113
Fax: 1-800-818-3453
www.americanfidelity.com

See page 2 for fraud statements.

STATEMENT OF INSURED

A. About You	Insured's Last Name	First Name	Initial	Date of Birth	Account Number
	Mailing Address (City, State, Zip)			Insured's Social Security #	
	Employer - Name		Home Telephone # ( )		Email Address
B. About The Patient	Patient Information **(check one)** For whom do you make this request? ☐ Self ☐ Wife ☐ Husband ☐ Son ☐ Daughter ☐ Other (Identity) _____	Patient's Name	Patient's Birth Date		Patient's Social Security #
C. About the Claim	Benefit for which claim is being made (Refer to Summary of Benefits for available coverage.) ☐ Cancer ☐ Coma ☐ Coronary Angioplasty ☐ Coronary Bypass Surgery ☐ End Stage Renal Failure ☐ Heart Attack (Myocardial Infarction) ☐ Major Burns ☐ Major Organ Failure ☐ Occupational HIV or Hepatitis B, C, D ☐ Stroke ☐ Paralysis ☐ Sudden Death Due to Cardiac Arrest ☐ Hospital Confinement				
	Date first treated	Have you ever had a similar condition? ☐ Yes ☐ No			If Yes, when?
	Provide names, addresses and telephone numbers for all attending physicians for the Critical Illness (Attach additional sheet of paper, if necessary):				

STATEMENT OF THE ATTENDING PHYSICIAN

Please complete the appropriate Section for each condition with which the patient has been diagnosed.

SECTION 1 CANCER

Does the patient have cancer? ☐ Yes ☐ No Cancer diagnosed: _____

Stage of Cancer: _____ Is this an In Situ Cancer? ☐ Yes ☐ No

SECTION 2 COMA DUE TO A COVERED ACCIDENT

Coma means a continuous profound state of unconsciousness persisting for a minimum of 14 or more consecutive days. A coma must be characterized by severe neurologic dysfunction and unresponsiveness of a prolonged nature. Unresponsiveness means the absence of (1) spontaneous eye movements, (2) response to painful stimuli, and (3) vocalization. The condition must require significant medical intervention, intubation for respiratory assistance, and life support measures. A coma does not include a medically induced coma or a coma resulting from non-accidental causes.

Is the patient in a comatose state? ☐ Yes ☐ No Was the coma medically induced? ☐ Yes ☐ No

Date the coma was diagnosed based on documented neurological dysfunction and prolonged unresponsiveness:

What caused the coma:

Did the patient's coma produce severe neurological dysfunction and unresponsiveness persisting for more than 14 days? ☐ Yes ☐ No

SECTION 3 CORONARY ANGIOPLASTY

Does the patient have coronary artery disease? ☐ Yes ☐ No Date Coronary Artery Disease was diagnosed:

Date Coronary Angioplasty was recommended: Date Coronary Angioplasty occurred:

Coronary Angioplasty procedure performed: ☐ balloon angioplasty ☐ laser angioplasty ☐ stenting

SECTION 4 CORONARY BYPASS SURGERY

Does the patient have coronary artery disease? ☐ Yes ☐ No Date Coronary Artery Disease was diagnosed:

Date Coronary Bypass Surgery was recommended: Date surgery occurred:

SECTION 5 END STAGE RENAL FAILURE

Does the patient have End Stage Renal Failure presenting as chronic, irreversible failure to function of both kidneys? ☐ Yes ☐ No

Does the patient's kidney failure necessitate regular peritoneal or hemodialysis (at least weekly) or kidney transplantation? ☐ Yes ☐ No

Date of recommendation for patient to begin renal dialysis or kidney transplant: _____

What is the cause for patient's End Stage Renal Disease: _____

Date patient was first treated for signs or symptoms of this condition: _____

STATEMENT OF THE ATTENDING PHYSICIAN CONTINUED

Patient Name: Date of Birth: Social Security Number:

SECTION 6 HEART ATTACK (MYOCARDIAL INFARCTION)

Are new and serial electrocardiographic (EKG) findings consistent with Myocardial Infarction? ☐ Yes ☐ No If YES, attach a copy of the EKG

Were cardiac enzymes elevated above generally accepted laboratory levels of normal for creatine physphokinase (CPK)? ☐ Yes ☐ No

Did diagnostic studies confirm a Myocardial Infarction and the occlusion of one or more coronary arteries? ☐ Yes ☐ No

Did the patient have symptoms consistent with Myocardial Infarction? ☐ Yes ☐ No What symptoms? _____

Date the patient was diagnosed with a Myocardial Infarction: _____

SECTION 7 MAJOR BURNS

Date the burns occurred: _____ Percentage of body surface covered by the burns: _____ %

Degree of the burns: ☐ 1st degree ☐ 2nd degree ☐ 3rd degree ☐ 4th degree

What condition caused the burns: ☐ fire ☐ prolonged exposure to the sun/heat ☐ caustics ☐ electricity ☐ radiation ☐ Other: _____

SECTION 8 MAJOR ORGAN FAILURE

Has the patient been placed on the UNOS (United Network for Organ Sharing) list, requiring transplantation of any of the following:

☐ heart ☐ liver ☐ lung ☐ entire pancreas? Date patient was placed on UNOS list: _____

What condition caused the need for transplant: _____

Date patient first treated for signs or symptoms of this condition: _____

SECTION 9 OCCUPATIONAL HIV or OCCUPATIONAL HEPATITIS B, C, D

Is the claim for: ☐ Occupational HIV – or – Hepatitis ☐ B ☐ C or ☐ D Date patient positively diagnosed: _____

Date the of accidental exposure to HIV or Hepatitis B/C/D-contaminated body fluids: _____

Did the accidental exposure occur during the normal course of duties of the occupation? ☐ Yes ☐ No

Has the patient previously tested positive for HIV or Hepatitis B/C/D? ☐ Yes ☐ No If YES, give date: _____

What event caused the HIV or Hepatitis B/C/D: _____

Was a preliminary screening test performed within 14 days of the accidental exposure? ☐ Yes ☐ No Date of the test: _____

Was a subsequent screening test performed within 26 weeks of the accidental exposure? ☐ Yes ☐ No Date of the test: _____

Were all HIV or Hepatitis B/C/D tests blood tests approved by the FDA? ☐ Yes ☐ No If YES, provide name of test: _____

Were all HIV or Hepatitis B/C/D tests performed by a state certified, licensed laboratory? ☐ Yes ☐ No

SECTION 10 PERMANENT DAMAGE DUE TO A STROKE

Did the patient have a stroke, meaning an aneurysm rupture, acute cerebral occlusion, or acute cerebral hemorrhage from a cerebral artery, which causes permanent damage to the nervous system which results in a sudden neurological impairment of sensory and/or motor functions? (A Stroke does not mean head injury, subdural hematoma, transient ischemic attack, multi-infarct dementia, chronic cerebrovascular insufficiency, or reversible neurological deficits.)
☐ Yes ☐ No

For how many days did the patient's stroke produce persisting neurological deficits?_____

Date stroke occurred based on documented neurological deficits and neuroimaging or other neurodiagnostic study: _____

SECTION 11 PERMANENT PARALYSIS DUE TO A COVERED ACCIDENT

Has the patient experienced permanent paralysis due to injuries to the spinal cord resulting in paraplegia or quadriplegia persisting for a period of 90 consecutive days or more? ☐ Yes ☐ No Is paralysis expected to be permanent in nature? ☐ Yes ☐ No

Date patient first diagnosed with permanent paralysis: _____ What event resulted in paralysis: _____

Date patient first treated for signs or symptoms of this condition: _____

SECTION 12 SUDDEN DEATH DUE TO CARDIAC ARREST

Date the Cardiac Arrest occurred: _____ Date of the patient's Death: _____

What condition resulted in the Cardiac Arrest: _____

SECTION 13 ☐ ☐ HOSPITAL CONFINEMENT

Was the patient or is the patient currently hospitalized? Yes No Diagnosis: _____

Dates the patient was hospitalized - From: _____ To: _____

Name and address of the hospital: _____

SIGNATURE OF ATTENDING PHYSICIAN

_____	_____	_____	_____
Attending Physician's Printed Name	Specialty	Telephone	#Fax #
_____	_____	_____	_____
Signature of Attending Physician	Date Signed	Email Address	Federal Tax ID #

_____

Address