CONTINUING DISABILITY 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)**:**

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

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

INSTRUCTIONS: **Be sure to include your policy number(s) on all documents.**

- ☐ Complete and sign **Section A: Policyholder/Patient Information**.
- ☐ Your employer should complete and sign **Section B: Employer's Statement**.
  If you are a contract, 1099, or self-employed worker, please submit your prior-year tax return (Schedule C) and current-year estimated tax payments (1040ES).
- ☐ Your physician should complete and sign **Section C: Physician's Statement**.
- ☐ If hospitalized and/or confined to an intensive care unit/step-down unit, please send a copy of your hospital bill showing charges and the number of days you were confined. These items can be obtained directly from your healthcare provider(s) by requesting a UB04 (hospital bill) or HCFA 1500 (nonhospital bill).
- ☐ Please include a certified copy of the death certificate if the patient is deceased.
- ☐ This claim form should be completed on or after the initial date of your disability, hospitalization, and/or surgery. Forms completed prior to the initial date may result in a delay in processing this claim.

SECTION A: POLICYHOLDER INFORMATION (please print)

First Name _____ Initial _____ Last Name _____

Mailing Address _____

City _____ State _____ ZIP _____

Check box if this is a new permanent address: ☐

Social Security Number _____ Phone Number _____

PATIENT INFORMATION (please print)

First Name _____ Initial _____ Last Name _____

Relationship: ☐ Primary Policyholder ☐ Spouse

Sex: ☐ Male ☐ Female

Patient Date of Birth: _____/_____/_____

Have you returned to work at any job? ☐ Yes ☐ No

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)
Attn: Claims Department • Worldwide Headquarters • 1932 Wynnton Road • Columbus, GA 31999
For information or help filing your claim, please call toll-free or visit our Web site at aflac.com.
Toll-free fax number: 1.877.44.AFLAC (1.877.442.3522)

CONTINUING DISABILITY CLAIM FORM - EMPLOYER'S STATEMENT

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Policy Number: Policyholder's Name:

Patient Name:_____ Date of Birth:_____

SECTION B: EMPLOYER'S STATEMENT

EMPLOYER'S NAME	PHONE NUMBER ( )	FAX NUMBER ( )
RICHMOND COUNTY SCHOOL SYSTEM	706 826-1000	706 826-4622

MAILING ADDRESS	CITY	STATE	ZIP
864 BROAD ST STE 208	AUGUSTA	GA	30901

1. First date of disability: _____ /_____ /_____
2. Has the policyholder returned to work? ☐ Yes ☐ No
   If yes, is the policyholder working ☐ Full-Time ☐ Part-Time
   If the policyholder is working part-time, date he or she began part-time: _____ /_____ /_____
   Date returned (or expected to return) to full-time duty: _____ /_____ /_____
3. Is the policyholder currently earning at least 80% of his or her predisability salary? ☐ Yes ☐ No
4. Is the person still employed? ☐ Yes ☐ No If no, last date of employment: _____ /_____ /_____

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.

	BENEFITS ASSOCIATE	
EMPLOYER'S SIGNATURE	TITLE	DATE
LARISSA BRIGGS	706-826-1301	
EMPLOYER'S PRINTED NAME	DIRECT PHONE NUMBER	

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CONTINUING DISABILITY CLAIM FORM - PHYSICIAN'S STATEMENT

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Policy Number: Policyholder Name:

Patient Name:_____ Date of Birth:_____

SECTION C: PHYSICIAN'S STATEMENT (Must be completed by physician or physician's staff. If completed by a member of the physician's staff, then physician must sign the form)

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

1. First date of disability:_____ /_____ /_____
   Date patient was last treated: _____ /_____ /_____
2. If this is a pregnancy claim, date of delivery: _____ /_____ /_____ ☐ Vaginal ☐ Cesarean
   If not delivered, expected delivery date: _____/_____/_____
   Please advise of any complications. _____
   _____
3. Diagnosis Description and ICD code: _____
4. Was patient hospitalized as a result of this diagnosis? ☐ Yes ☐ No
   Admission: _____ /_____ /_____ Discharge: _____ /_____ /_____
   Hospital Name: _____ City: _____ State: _____
5. Have you released the patient to return to work? ☐ Yes ☐ No
6. If patient has not been released to return to work, please provide the next appointment date: _____ /_____ /_____
   Please also provide the date of expected release: _____ /_____ /_____.
7. If the patient has been released, please provide the date released: _____ /_____ /_____.
   Patient released to work: ☐ Full-time ☐ Part-time
   If part-time, please provide the date the patient is expected to return to full duty: _____ /_____ /_____.
8. If patient is not employed ful-time, which Activities of Daily Living (ADLs) is the patient unable to perform?
   Check and **initial** all that apply: ☐ Continence ☐ Transferring ☐ Dressing
   ☐ Bathing ☐ Toileting ☐ Eating
9. Does this patient require direct personal assistance to perform these ADLs **each and every time**? ☐ Yes ☐ No
   If yes, how many days will the patient require direct personal assistance? _____

PHYSICIAN'S SIGNATURE DATE TAX ID NUMBER

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