INITIAL DISABILITY CLAIM FORM

Thank you for trusting Aflac with your Initial Disability needs.

- **If you are interested in uploading documentation on an existing claim, register using aflac.com/smartclaim.**

To prevent delays, please provide documentation from your healthcare provider to support this claim. If you have additional bills or medical documentation that relates to this diagnosis other than the documentation defined, please submit them for review of additional benefits.

- **Service related items can be obtained directly from the patient's healthcare provider(s) by requesting a UB04 hospital bill or HCFA 1500 non-hospital bill.**
- **Failure to complete all sections may result in a delay in processing this claim.**
- **Disclaimer: Some of the services listed may not be covered by your policy.**

***Policy Number:**

Policyholder Information: This * denotes a required field.

*Last Name | Suffix | *First Name | MI

*Date of Birth (mm/dd/yy) | Telephone Number where we can reach you

*Home Address

*City | *State | *Zip Code

☐ *Check box if this is a permanent address change.*

Patient Information:

*Last Name | *First Name | *Date of Birth (mm/dd/yy)

*Sex: ☐ Male ☐ Female

*Relationship: ☐ Primary Policyholder ☐ Spouse

Initial Disability Checklist

Is disability due to a sickness? ☐ No ☐ Yes

Is disability due to an injury? ☐ No ☐ Yes

- If yes, please complete the following questions related to the injury:
- Date of the injury: _____/_____/_____
- Describe how the injury occurred: _____
- Was this disability caused by an incident that occurred while performing the duties of the patient's employment? ☐ No ☐ Yes
- Was this a motor vehicle accident in which the patient was the driver? ☐ No ☐ Yes (If yes, please submit a copy of the Police Report)

For all claims, please complete all remaining sections.

- Was the patient confined to the hospital as a result of this condition? ☐ No ☐ Yes (If yes, please submit the itemized hospital bill, UB04, or HCFA 1500)
- Hospital name: _____
- City: _____ State: _____

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.

POLICYHOLDER/PATIENT SIGNATURE | **FAMILY RELATIONSHIP, IF NOT POLICYHOLDER** | **DATE**

American Family Life Assurance Company of Columbus (Aflac)
ATTN: Claims Department • 1932 Wynnton Road • Columbus, GA 31999
For information or to check claim status, visit aflac.com or call 1-800-99-AFLAC (1-800-992-3522)
Claims may be faxed to 1-877-44-AFLAC (1-877-442-3522)

INITIAL DISABILITY CLAIM FORM - EMPLOYER'S STATEMENT

***Policy Number:**

Policyholder Information: This * denotes a required field.

*Last Name | Suffix | *First Name | MI

*Date of Birth (mm/dd/yy)

*Employee's Name (Last Name, Suffix, First Name, MI)

*Employer's Name/Account # | *Employer's Phone Number

*Employer's Address

*City | *State | *Zip Code

- First date of disability: _____/_____/_____
- Was this disability caused by an incident that occurred while performing the duties of his/her employment? ☐ No ☐ Yes
- Prior to this disability, number of hours worked per week: _____
- Gross annual income prior to disability: _____ ***Income is subject to verification at time of claim.**
  Self-employed? ☐ No ☐ Yes (If yes, your gross annual income is the average of your net earnings for the past two years. Please submit tax records for the past two years.)
- Has the employee returned to work? ☐ No ☐ Yes
- If no, expected return to work date: _____/_____/_____ If yes, date returned to work: _____/_____/_____
- If the employee has returned to work is he or she working: ☐ Full-Time ☐ Part-Time ☐ Light Duty
  If working part time or light duty, please provide the number of working hours per week: _____
  If part-time/light duty, date expected to return to work to full-time: _____/_____/_____
  If part-time/light duty, is/was the employee earning at least 80% of his/her pre-disability salary? ☐ No ☐ Yes

Please complete this section only for W-2 Employees and/or Contract 1099. (Please contact payroll and/or check the policyholder's Salary Redirection Agreement/Premium Deduction Authorization card for the answer to these questions.)

- Are Disability Rider or Short-Term Disability premiums deducted from the policyholder's paycheck on a pre-tax basis? ☐ No ☐ Yes
- Does the employer pay a portion of the disability premium for the policyholder? ☐ No ☐ Yes (If yes, what percent? _____%)
- Policyholder is: (Check all that apply.) ☐ Exempt from Social Security ☐ Exempt from Medicare ☐ Subject to RRTA
- Date of hire: _____/_____/_____
- Is the person still employed? ☐ No ☐ Yes
  - 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.

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EMPLOYER'S SIGNATURE | **EMPLOYER'S PRINTED NAME** **TITLE** | **DIRECT PHONE NUMBER** **DATE**

American Family Life Assurance Company of Columbus (Aflac)
ATTN: Claims Department • 1932 Wynnton Road • Columbus, GA 31999
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INITIAL DISABILITY CLAIM FORM - PHYSICIAN'S STATEMENT

***Policy Number:**

Policyholder Information: This * denotes a required field.

*Last Name | Suffix | *First Name | MI

*Date of Birth (mm/dd/yy)

Patient Information:

*Last Name | *First Name | *Date of Birth (mm/dd/yy)

Physician Information:

*Phone Number | *Fax Number

*Physician's Name

*Address

*City | State | Zip Code

- Primary diagnosis for disability and ICD code: _____ Additional diagnoses: _____
- If due to an injury, please provide the date and details of the injury: ____/____/____

  _____
- Was this disability caused by an incident that occurred while performing the duties of his/her employment? ☐ No ☐ Yes
- Symptoms first occurred on: ____/____/____ If diagnosed with cancer, date of initial diagnosis: ____/____/____
- Patient first consulted you for this condition on: ____/____/____
- Was the patient treated for the primary diagnosis by another physician? ☐ No ☐ Yes

  If yes, physician's name: _____

  Treating physician's address: _____ Phone Number: _____

  ***If filing for disability within the first two years of the policy, medical records may be requested.**
- Pregnancy claims: Date of delivery: ____/____/____ ☐ Vaginal ☐ Cesarean
- If not delivered, expected delivery date: ____/____/____
- Please advise of any complications: _____
- First date of disability: ____/____/____
- Date patient was last treated: ____/____/____
- Have you released the patient to return to work? ☐ No ☐ Yes (Date released: ____/____/____)

  Patient released to work: ☐ Full Time ☐ Part Time ☐ Light Duty

  If part time/light duty, please provide the date the patient is expected to return to full duty: _____
- If patient has not been released, please provide the next appointment date: ____/____/____ Please also provide the date of expected release: ____/____/____
- Is patient permanently disabled? ☐ No ☐ Yes (Medical records will be required if permanent disability is indicated; please provide medical records to patient.)

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.

PHYSICIAN'S SIGNATURE | **DATE** | **TAX ID**

American Family Life Assurance Company of Columbus (Aflac)
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