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 Disability Rider Policy Number	Hospital Indemnity Policy Number	Hospital Intensive Care Policy Number	Life Policy Number

INSTRUCTIONS:

- ☐ Complete **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 estimates 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.

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 Birth Date: _____

If unemployed, date unemployment began: _____

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 aflac.com
Toll-free fax number 1.877.44.AFLAC (1.877.442.3522)

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Policy Number: _____ Policyholder Name: _____

SECTION B: EMPLOYER'S STATEMENT

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

1. First date of disability: _____ /_____ /_____
2. Prior to this disability, number of hours worked per week:_____ Annual Base Salary (prior to disability):$_____
3. Was this disability caused by an incident that occurred while performing the duties of his/her employment? Yes No
4. Has policyholder returned to work? ☐ Yes ☐ No If yes, is policyholder working ☐ full-time? ☐ part-time? ☐ light duty?
5. Date policyholder began light duty: _____ /_____ /_____
   Date returned (or expected to return) to Full-Time Duty: _____ /_____ /_____
6. Is the policyholder currently earning at least 80% of their pre-disability salary? ☐ Yes ☐ No
   If yes, is the policyholder currently using paid leave (sick or vacation) days? ☐ Yes ☐ No

(If the policyholder is not currently on disability, please complete question 6 as it pertains to the disability period.)

Please complete this section only for W-2 Employees.

7. Are Accident/Sickness Disability Rider or Short-Term Disability premiums deducted from the policyholder's paycheck on a pre-tax basis? ☐ Rider ☐ Short-Term Disability **(Please contact payroll and/or check the policyholder's Salary Redirection Agreement/Premium Deduction Authorization card for the answer to this question.)**
8. Does employer pay a portion of the disability premium for the policyholder? Yes No If yes, what percent?_____%
9. Date of Hire: _____ /_____ /_____
10. Is the person still employed? ☐ Yes ☐ No If no, last date of employment: _____ /_____ /_____
11. Policyholder 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 policyholder's Form W-2.

EMPLOYER'S SIGNATURE | TITLE | DATE

EMPLOYER'S PRINTED NAME | DIRECT PHONE NUMBER

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Policy Number: _____ Policyholder Name: _____

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

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

1. First date of disability: _____/_____/_____

   Date patient was last treated: _____/_____/_____

2. Pregnancy claims: 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. Is patient currently working: ☐ full-time? ☐ part-time? ☐ light duty?

   Date patient was released to return to work: _____/_____/_____

6. If patient has not been released to return to work or if patient is working light duty, please provide the next appointment date or estimated return to work date: _____/_____/_____

7. 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 (PA only)

8. Does patient require direct personal assistance to perform ADLs? ☐ Yes ☐ No If yes, for how many days will the patient require direct personal assistance? _____

PHYSICIAN'S SIGNATURE _____ DATE _____ TAX ID NUMBER _____

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