

# SPECIFIED HEALTH EVENT CLAIM FORM

Accident Policy Number	Hospital Indemnity/Specified Health Event Policy Number	Hospital Intensive Care Policy Number

**Be sure to include your policy number(s) on all documents.  
Failure to complete this form in its entirety may result in a delay in processing this claim.**

## INSTRUCTIONS:

- Complete Section A: Policyholder/Patient Information and sign your claim form.
- Have the treating physician complete Section B: Physician's Statement and sign the claim form.
- If you are filing for disability, please complete the Initial Disability Claim Form (S00224) as well. **Forms are available on our web site at aflac.com.**
- Submit all bills related to this claim, such as hospital, surgery, etc. All bills should include the diagnosis, services rendered, and actual charges for the service.
- If hospitalized and/or confined to an intensive care unit, please send a copy of your hospital bill showing charges and the number of days you were confined. If confined to an intensive care unit, the bill must specify the number of days you spent in the intensive care unit.
- The items above can be obtained directly from your healthcare provider(s) by requesting a UB04 (hospital bill) or HCFA1500 (non-hospital bill).

## Policyholder Information

(Please print.)

\_\_\_\_\_  
First Name Initial Last Name

\_\_\_\_\_  
Mailing Address

\_\_\_\_\_  
City State ZIP

Check box if this is a new permanent address:

## Patient Information

(Please print.)

\_\_\_\_\_  
Social Security Number Phone Number

\_\_\_\_\_  
First Name Initial Last Name

Relationship:  Primary Policyholder  Spouse Sex:  Male  Female Patient Birth Date: \_\_\_\_\_

Dependent Child  Check here if dependant child is a full-time student (if over the age 19, please provide school name and contact information).

**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)

# SPECIFIED HEALTH EVENT CLAIM FORM - PHYSICIAN'S STATEMENT

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

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Policy Number: \_\_\_\_\_ Policyholder Name: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

## SECTION B: PHYSICIAN'S STATEMENT

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

1. Symptoms first occurred on: \_\_\_\_/\_\_\_\_/\_\_\_\_ Date of initial diagnosis: \_\_\_\_/\_\_\_\_/\_\_\_\_

2. Patient first consulted you for this condition on: \_\_\_\_/\_\_\_\_/\_\_\_\_

3. Did patient undergo surgery for this diagnosis?  Yes  No Procedure Code: \_\_\_\_\_

Procedure Description: \_\_\_\_\_

4. Was patient hospitalized as a result of this diagnosis?  Yes  No

Admission: \_\_\_\_/\_\_\_\_/\_\_\_\_ Discharge: \_\_\_\_/\_\_\_\_/\_\_\_\_

Hospital Name: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_

5. Is there a referring physician?  Yes  No If yes, physician's name: \_\_\_\_\_

Referring physician's address: \_\_\_\_\_ Phone number: \_\_\_\_\_

**Please indicate diagnosis below (Continued on Page 3):**

**All events listed may not be covered by your policy. Please check your policy for a list of covered events or call 1-800-99-AFLAC (1-800-992-3522).**

<input type="checkbox"/> <b>Coma</b> Physician's Initials _____ Duration _____ Glasgow Coma Scale _____ <input type="checkbox"/> Absence of spontaneous eye movement <input type="checkbox"/> Absence of response to painful stimuli <input type="checkbox"/> Absence of vocalization <input type="checkbox"/> Requires intubation for respiratory assistance	<input type="checkbox"/> <b>Major Third-Degree Burns</b> Physician's Initials _____ Percent of Total Body Area _____ <input type="checkbox"/> Destruction of the entire epidermis and underlying dermis <input type="checkbox"/> Covers 10% or more of body surface <input type="checkbox"/> Caused by heat, electricity, radiation, or chemicals
<input type="checkbox"/> <b>Coronary Angioplasty</b> Physician's Initials _____ <input type="checkbox"/> Opening of narrowed or blocked blood vessels of the heart (with or without stents)	<input type="checkbox"/> <b>End-Stage Renal Failure</b> Physician's Initials _____ Date Dialysis Began _____ <input type="checkbox"/> Permanent and irreversible kidney failure <input type="checkbox"/> Requires dialysis or kidney transplant to maintain life

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Policy Number: \_\_\_\_\_ Policyholder Name: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Please indicate diagnosis below (Continued from Page 2):**

<input type="checkbox"/> <b>Coronary Artery Bypass Surgery</b> <b>Physician's Initials</b> _____ <i>CPT Code</i> _____ <input type="checkbox"/> Open-heart surgery to correct narrowing or blockage of coronary arteries by bypass graft <input type="checkbox"/> Excludes valve replacement surgery	<input type="checkbox"/> <b>Paralysis</b> <b>Physician's Initials</b> _____ <i>Duration</i> _____ <input type="checkbox"/> Complete and total loss of use of two or more limbs
<input type="checkbox"/> <b>Major Human Organ Transplant</b> <b>Physician's Initials</b> _____ <input type="checkbox"/> Surgical transplant of the: <input type="checkbox"/> Kidney <input type="checkbox"/> Liver <input type="checkbox"/> Heart <input type="checkbox"/> Lung <input type="checkbox"/> Pancreas <input type="checkbox"/> Excludes mechanical or nonhuman organs	<input type="checkbox"/> <b>Persistent Vegetative State</b> <b>Physician's Initials</b> _____ This condition requires a written statement from two physicians, one of whom must be the attending physician, that: <input type="checkbox"/> Cognitive function has been substantially impaired. <input type="checkbox"/> There is no reasonable expectation that the patient will regain significant cognitive function.
<input type="checkbox"/> <b>Heart Attack</b> <b>Physician's Initials</b> _____ <input type="checkbox"/> Confirmed by electrocardiographic findings <input type="checkbox"/> Confirmed by clinical findings <input type="checkbox"/> Myocardial infarction, coronary thrombosis, or coronary occlusion <input type="checkbox"/> Excludes congestive heart failure and sudden cardiac death	<input type="checkbox"/> <b>Stroke</b> <b>Physician's Initials</b> _____ <input type="checkbox"/> Confirmed by neurological deficit <input type="checkbox"/> Confirmed by neuroimaging studies <input type="checkbox"/> Complete or partial function loss for more than 24 hours <input type="checkbox"/> Excludes head injury, transient ischemic attack (TIA), or cerebrovascular insufficiency

\_\_\_\_\_  
**PHYSICIAN'S SIGNATURE**

\_\_\_\_\_  
**DATE**

\_\_\_\_\_  
**TAX ID NUMBER**

## Claims Authorization to Obtain Information

Instructions for completing this Health Insurance Portability and Accountability Act of 1996 (HIPAA) compliant form:

1. All areas of this form should be completed.
2. This form must be signed and dated by the claimant/patient below.
3. **IMPORTANT:** If you are filing a claim on behalf of a deceased, please check here
4. If you are the Authorized Representative, please sign below and indicate your relationship to the claimant/patient/deceased. In addition, include a copy of the legal document(s) authorizing you to act on their behalf.
5. Fax this form to 1-877-442-3522 or return the form to Aflac, Claims Department, Worldwide Headquarters, 1932 Wynnton Road, Columbus, GA 31999 as soon as possible to expedite the review of your claim.

Policyholder Name:	Policy Number(s):	Date of Birth:
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Policyholder Address:

Claimant/Patient Name (if different from named policyholder listed above):	Date of Birth:
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Name and Address of health care provider(s), company, or individual authorized to release the requested information:

This authorization shall be valid for a period of two years from the sign date unless a lesser time frame is indicated. Alternate Expiration Date:

**Purpose of Disclosure:** Evaluate claims for benefits during the time this authorization is valid.

I, or my authorized representative, request that information regarding my past, present, or future physical or mental health condition (excluding psychotherapy notes), employment, other insurance coverage, or any other nonmedical facts be released to **American Family Life Assurance Company of Columbus (Aflac)** or any person or entity acting on its part. This could include, but is not limited to, any medical professional, medical care institution, insurer (including Aflac, with respect to other Aflac coverages), reinsurer, government agency (including departments of public safety and motor vehicle departments), consumer reporting agency or employer.

**I understand that:**

1. Protected health information may include information and records protected under Federal and State Law such as: alcohol, drug abuse, mental health, AIDS or HIV testing or treatment.
2. My treatment, payment or eligibility for benefits may not be conditioned on signing this authorization.
3. I understand that I may revoke this authorization at any time by writing to **Aflac, Claims Department, Worldwide Headquarters, 1932 Wynnton Road, Columbus, GA 31999**, except to the extent that:
  - a. Aflac has taken action in reliance to this authorization, or
  - b. Other law provides Aflac with the right to contest a claim under the policy or the policy itself.
4. If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.

It is recommended I retain a copy of this signed form for my records, understanding that a copy is as valid as the original.

Signature of claimant/patient, guardian or authorized representative

Date

Printed name of claimant/patient, guardian or authorized representative

Relationship