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.

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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

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
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)