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 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.

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)