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

INSTRUCTIONS: **Be sure to include your policy number(s) on all documents.**

- ☐ Complete and sign **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 estimated 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.

SECTION A: 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 Date of Birth: _____/_____/_____

Have you returned to work at any job? ☐ Yes ☐ No

Date of Incident: _____/_____/_____ Describe where and how the incident occurred: _____

For your protection California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

CLAIMANT SIGNATURE **FAMILY RELATIONSHIP, IF NOT POLICYHOLDER** **DATE**

American Family Life Assurance Company of Columbus (Aflac)
Attn: Claims Department • Worldwide Headquarters • 1932 Wynnton Road • Columbus, GA 31999
For information or help filing your claim, please call toll-free or visit our Web site at aflac.com.
Toll-free fax number: 1.877.44.AFLAC (1.877.442.3522)

CONTINUING DISABILITY CLAIM FORM - EMPLOYER'S STATEMENT

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Policy Number: Policyholder's Name:

Patient Name:_____ Date of Birth:_____

SECTION B: EMPLOYER'S STATEMENT

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

1. First date of disability: _____ /_____ /_____
2. Has the policyholder returned to work? ☐ Yes ☐ No
   If yes, is the policyholder working ☐ Full-Time ☐ Part-Time
   If the policyholder is working part-time, date he or she began part-time: _____ /_____ /_____
   Date returned (or expected to return) to full-time duty: _____ /_____ /_____
3. Is the policyholder currently earning at least 80% of his or her predisability salary? ☐ Yes ☐ No
4. Is the person still employed? ☐ Yes ☐ No 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.

EMPLOYER'S SIGNATURE | TITLE | DATE

EMPLOYER'S PRINTED NAME | DIRECT PHONE NUMBER

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CONTINUING DISABILITY CLAIM FORM - PHYSICIAN'S STATEMENT

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Policy Number: Policyholder Name:

Patient Name:_____ Date of Birth:_____

SECTION C: PHYSICIAN'S STATEMENT (Must be completed by physician or physician's staff. If completed by a member of the physician's staff, then physician must sign the form)

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

1. First date of disability:_____ /_____ /_____
   Date patient was last treated: _____ /_____ /_____
2. If this is a pregnancy claim, 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. Have you released the patient to return to work? ☐ Yes ☐ No
6. If patient has not been released to return to work, please provide the next appointment date: _____ /_____ /_____
   Please also provide the date of expected release: _____ /_____ /_____.
7. If the patient has been released, please provide the date released: _____ /_____ /_____.
   Patient released to work: ☐ Full-time ☐ Part-time
   If part-time, please provide the date the patient is expected to return to full duty: _____ /_____ /_____.
8. If patient is not employed ful-time, which Activities of Daily Living (ADLs) is the patient unable to perform?
   Check and **initial** all that apply: ☐ Continence ☐ Transferring ☐ Dressing
   ☐ Bathing ☐ Toileting ☐ Eating
9. Does this patient require direct personal assistance to perform these ADLs **each and every time**? ☐ Yes ☐ No
   If yes, how many days will the patient require direct personal assistance? _____

PHYSICIAN'S SIGNATURE DATE TAX ID NUMBER

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