HOSPITAL INDEMNITY PLAN WELLNESS BENEFIT CLAIM FORM

Some of the tests listed may not be covered under the Wellness Benefit of your policy. Please check your policy for a list of covered wellness procedures or call 1-800-99-AFLAC (1-800-992-3522) for a Wellness Form specifically tailored for your policy.

Please use black or blue ink only and print legibly when completing this form in its entirety. Keep a copy of the supporting documentation and this completed form for your records. Sign, date, and mail the completed form to the Aflac address shown below.

Policyholder Information

Policyholder First Name: | Middle Initial: | Policyholder Last Name:

Policyholder Birth Date: M M D D Y Y Y Y | ZIP of mailing address:

Policy Number

Patient Information

First Name: | Middle Initial: | Last Name:

Relationship:
- ☐ Primary Policyholder
- ☐ Spouse
- ☐ Dependent Child

Sex:
- ☐ Male
- ☐ Female

Patient Birth Date: M M D D Y Y Y Y

Wellness Exam

Treatment Date: M M D D Y Y Y Y

Treatment date must be provided.

- ☐ Annual physical
- ☐ Ultrasound
- ☐ PSA (blood test for prostate cancer)
- ☐ Pap smear
- ☐ Blood screening
- ☐ Immunizations
- ☐ Eye exam
- ☐ Dental exam
- ☐ Flexible sigmoidoscopy

Pap Smear Date: M M D D Y Y Y Y

Mammogram Date: M M D D Y Y Y Y

Physician Information

Phone Number: - -

Name:

Street Address:

City: | State: | ZIP:

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.

I certify that the information provided is true and correct:

POLICYHOLDER SIGNATURE | **DATE**

American Family Life Assurance Company of Columbus (Aflac)
Attn: Claims Department • 1932 Wynnton Road • Columbus, GA 31999-7251
1-800-99-AFLAC (1-800-992-3522) • aflac.com • 1-800-SI-AFLAC (1-800-742-3522) en español