VISION NOW℠ EYE EXAM/VISION CORRECTION MATERIALS CLAIM FORM

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

Eye Exam

☐ Eye exam

Treatment Date: M M D D Y Y Y Y

Vision Correction Benefit

Bill must be attached when filing for the Vision Correction Benefit.

☐ Prescription glasses, frames or lenses

☐ Contact lenses

Purchase Date: M M D D Y Y Y Y

Provider Information

Must be an optometrist or an ophthalmologist. Applies only when filing for the Eye exam benefit.

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
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