

# 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

Failure to complete this form in its entirety may result in a delay in processing this claim.

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.

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	

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 - PHYSICIAN'S STATEMENT

Failure to complete this form in its entirety may result in a delay in processing this claim.

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.

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 full-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

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)