



# ACCIDENTAL INJURY CLAIM FORM

**For associate use only:** Check to the agent for delivery

Writing # \_\_\_\_\_

Name \_\_\_\_\_

Address \_\_\_\_\_

**Filing claim for:**

- Accidental Injury Only
- Accidental Injury with Disability
- Deceased:
- Date Deceased: \_\_\_/\_\_\_/\_\_\_

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

Accident Policy Number	Short-Term Disability Policy Number	Hospital Indemnity Policy Number	Hospital Intensive Care Policy Number	Specified Health Event Policy Number

**SECTION A: PATIENT/POLICYHOLDER INFORMATION: Please print.**

PATIENT'S INFORMATION			POLICYHOLDER'S INFORMATION		
LAST	FIRST	INITIAL	LAST	FIRST	INITIAL
BIRTHDATE	<input type="checkbox"/> MALE	<input type="checkbox"/> FEMALE	ADDRESS		CHECK IF NEW ADDRESS <input type="checkbox"/>
	<input type="checkbox"/> SINGLE	<input type="checkbox"/> MARRIED	<input type="checkbox"/> OTHER	CITY	STATE ZIP
RELATIONSHIP: <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> DEPENDENT			SOCIAL SECURITY NUMBER (optional)		
CHECK IF CHILD IS FULL-TIME STUDENT: <input type="checkbox"/>			BIRTHDATE		

Date of accidental injury \_\_\_/\_\_\_/\_\_\_ Details of accident: \_\_\_\_\_

Is this claim due to an auto accident?  Yes  No If yes, a copy of the police report is required.**SECTION B: PHYSICIAN'S STATEMENT: Please print. Must be completed by physician or physician's staff.**

PHYSICIAN'S NAME	ADDRESS	PHONE NUMBER
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DATES OF SERVICE	DIAGNOSIS CODE ICD	DIAGNOSIS DESCRIPTION	PROCEDURE CODE	PROCEDURE DESCRIPTION	ACTUAL CHARGES

- Is this patient covered by Medicaid / State Aid?  Yes  No
- Date of accidental injury \_\_\_/\_\_\_/\_\_\_ Details of accident: \_\_\_\_\_

3. Was patient hospitalized?  Yes  No If yes: Admission \_\_\_/\_\_\_/\_\_\_ Discharge \_\_\_/\_\_\_/\_\_\_  
 Hospital Name \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

**ATTENTION PHYSICIAN: If patient is disabled, please ALSO complete SECTION C ON PAGE 2 OF THIS FORM.**

PHYSICIAN'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_ TAX ID NUMBER \_\_\_\_\_

**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 subjects such person to criminal and civil penalties.**

AMERICAN FAMILY LIFE ASSURANCE COMPANY OF COLUMBUS (AFLAC)  
 MAIL COMPLETED CLAIM FORMS TO: ATTN: CLAIMS DEPT., WORLDWIDE HEADQUARTERS, 1932 WYNNTON ROAD, COLUMBUS, GA 31999  
 or FAX COMPLETED CLAIMS TO: TOLL FREE FAX NUMBER 1-877-44-AFLAC (1-877-442-3522)  
 VISIT OUR WEB SITE AT [www.aflac.com](http://www.aflac.com) or CALL TOLL-FREE 1-800-99-AFLAC (1-800-992-3522)



# ACCIDENTAL INJURY DISABILITY SECTION

Patient Name \_\_\_\_\_

Policy Number \_\_\_\_\_

**Failure to complete this form in its entirety may result in a delay in processing this claim.  
Complete only if claiming disability benefits under an AFLAC policy.**

## SECTION C: PHYSICIAN'S DISABILITY STATEMENT

• **Please print. Must be completed by physician or physician's staff.**

1. First date of disability: \_\_\_/\_\_\_/\_\_\_ Last date of treatment: \_\_\_/\_\_\_/\_\_\_
2. Date released to return to work: \_\_\_/\_\_\_/\_\_\_ If not released, next appointment date: \_\_\_/\_\_\_/\_\_\_
3. Is patient:  ambulatory?  bed-confined?  house-confined?  hospital-confined?
4. If not employed, or employed less than 30 hours per week, which **Activities of Daily Living (ADLs)** is patient unable to perform?  
Check all that apply:  Contingence  Transferring  Dressing  Toileting  Eating  Bathing

\_\_\_\_\_  
PHYSICIAN'S SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
TAX ID NUMBER

## SECTION D: EMPLOYER'S DISABILITY STATEMENT

- **Please print. This section to be completed by employer if filing for disability.**
- **If self-employed complete this section and submit a copy of business license and previous year's tax return.**

EMPLOYER'S NAME	ADDRESS	PHONE NUMBER

### WORK STATUS

1. Is this disability caused by an accident that occurred at the workplace?  Yes  No
2. Is the employee currently earning at least 80% of their salary prior to disability?  Yes  No
3. Prior to this disability, number of hours worked per week: \_\_\_\_\_ Annual Base Salary: \$ \_\_\_\_\_
4. Is the person still employed?  Yes  No If No, date left employment? \_\_\_/\_\_\_/\_\_\_
5. First date employee unable to work: \_\_\_/\_\_\_/\_\_\_
6. Last date employee unable to work: \_\_\_/\_\_\_/\_\_\_
7. Is employee currently working?  Yes  No If yes, is employee working:  full time?  part time?  light duty?
8. Date to return to Full Time Duty: \_\_\_/\_\_\_/\_\_\_

### PREMIUM / TAX INFORMATION

**Please note:**

The employer is required to report disability benefits paid on pre-tax plans on its Form 941 and the employee's Form W-2.

1. Does the employee pay disability premiums with pre-tax dollars?  Yes  No
2. Does employer pay a portion of the disability premium for the employee?  Yes  No If yes, what percent? \_\_\_\_\_%
3. Employee is: (Check all that apply)  exempt from Social Security?  exempt from Medicare?  subject to RRTA?

\_\_\_\_\_  
EMPLOYER'S SIGNATURE

\_\_\_\_\_  
TITLE

\_\_\_\_\_  
DATE

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