

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

**INSTRUCTIONS:**

- Complete **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 estimates 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.

**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 Birth Date: \_\_\_\_\_

If unemployed, date unemployment began: \_\_\_\_\_

Date of incident: \_\_\_\_/\_\_\_\_/\_\_\_\_ Describe where and how the incident occurred: \_\_\_\_\_

**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.**

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 1-800-99-AFLAC (1-800-992-3522) or visit our Web site at aflac.com.  
Toll-free fax number: 1.877.44.AFLAC (1.877.442.3522)

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Policy Number:

Policyholder Name:

## SECTION B: EMPLOYER'S STATEMENT

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

1. First date of disability: \_\_\_\_ / \_\_\_\_ / \_\_\_\_
2. Prior to this disability, number of hours worked per week: \_\_\_\_\_ .
3. Gross annual income (without overtime, unless contractual, bonuses, or other incentives) [prior to disability] \$ \_\_\_\_\_. If you are self-employed, your gross annual income is your net earnings.
4. Was this disability caused by an incident that occurred while performing the duties of his/her employment? Yes No
5. Has policyholder returned to work? Yes No If yes, is policyholder working full-time? part-time? light duty?
6. Date policyholder began light duty: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Date returned (or expected to return) to Full-Time Duty: \_\_\_\_ / \_\_\_\_ / \_\_\_\_
7. Is the policyholder currently earning at least 80% of their pre-disability salary? Yes No  
If yes, is the policyholder currently using paid leave (sick or vacation) days? Yes No  
(If the policyholder is not currently on disability, please complete question 7 as it pertains to the disability period.)

### Please complete this section only for W-2 Employees.

8. Are Accident/Sickness Disability Rider or Short-Term Disability premiums deducted from the policyholder's paycheck on a pre-tax basis? Yes No **(Please contact payroll and/or check the policyholder's Salary Redirection Agreement/Premium Deduction Authorization card for the answer to this question.)**
9. Does employer pay a portion of the disability premium for the policyholder? Yes No If yes, what percent? \_\_\_\_%
10. Date of Hire: \_\_\_\_ / \_\_\_\_ / \_\_\_\_
11. Is the person still employed? Yes No If no, last date of employment: \_\_\_\_ / \_\_\_\_ / \_\_\_\_
12. Policyholder is: (Check all that apply) exempt from Social Security exempt from Medicare subject to RRTA

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

EMPLOYER'S SIGNATURE	TITLE	DATE
EMPLOYER'S PRINTED NAME	DIRECT PHONE NUMBER	

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Policy Number:

Policyholder Name:

## SECTION C: PHYSICIAN'S STATEMENT Must be completed by physician or physician's staff.

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

1. First date of disability: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Date patient was last treated: \_\_\_\_ / \_\_\_\_ / \_\_\_\_
2. Pregnancy claims: 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. Is patient currently working:    full-time?    part-time?    light duty?  
Date patient was released to return to work: \_\_\_\_ / \_\_\_\_ / \_\_\_\_
6. If patient has not been released to return to work or if patient is working light duty, please provide the next appointment date or estimated return to work date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_
7. If patient is not employed, or employed less than 30 hours, which Activities of Daily Living (ADLs) is patient unable to perform? (Please note this does not apply to all policies)  
Check and **initial** all that apply:    Continenence    Transferring    Dressing    Toileting    Eating  
 Bathing (applicable only to certain Pennsylvania policies.)
8. Does patient require direct personal assistance to perform ADLs?    Yes    No    If yes, for how many days will the patient require direct personal assistance? \_\_\_\_\_

PHYSICIAN'S SIGNATURE

DATE

TAX ID NUMBER

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