Post Office Box 84075 * Columbus, GA. 31993
Phone (800) 433-3036 * Fax (866) 849-2970
groupclaimfiling@aflac.com

**CRITICAL ILLNESS CLAIM**
**FORM INSTRUCTIONS**

To avoid delays in processing of your claim form, complete each section attaching documentation below when it applies.

Supporting Documentation Needed

- ✓ Chart Note to include admission and discharge paperwork if there was a hospital stay
- ✓ Surgical Report-if surgery took place
- ✓ Pathologist report when diagnosed with a malignant condition
- ✓ Benefit Assignment-Benefits are payable to the policy holder unless written authorization is received from you or your healthcare provider to assign benefits to the provider. If you choose to assign benefits, attach a signed and written request.
- ✓ Email form to groupclaimfiling@aflac.com or fax to 1.866.849.2970.

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# CRITICAL ILLNESS CLAIM FORM

**Please review your policy for specific benefits covered under your plan.**
**To prevent processing delays, please have claim form completed in full and return the signed HIPAA.**
**Please submit medical documentation from your healthcare provider to support your claim.**

| POLICYHOLDER/CLAIMANT INFORMATION | | | | |
|---|---|---|---|---|
| Employer's Name | Policy/Certificate No. | Social Security No. | Date of Birth | Gender |
| Policyholder's Major Medical Insurance Provider | Major Medical ID# | Policyholder's E-Mail: | | |
| Policyholder's Name: | Policyholder's Address, City, State, Zip Code<br>☐ **Check Box If This Is A Permanent Address Change** | | | Telephone Number: |
| Patient's name: | Relationship To The Policyholder: | | Date of Birth: | Gender: |

*By providing your e-mail address above, you consent to the use of electronic transactions in connection with your CAIC policies, contracts, and/or accounts to the extent available permitted by law (which may include, but not limited to: invoices, claim correspondence, contracts, surveys, and other materials that CAIC is, or may be, legally required to deliver to you).

☐ **Cancer; Carcinoma in situ; Skin Cancer:** Please submit a copy of the pathology report from which the condition was diagnosed.

☐ **Heart Attack; Sudden Cardiac Arrest:** Please submit a copy of the discharge summary, cardiology consult report, cardiac catheterization report, history & physical, and ER notes.

☐ **Coronary Artery Bypass Surgery:** Please submit a copy of the operative report for the procedure.

☐ **Major Organ Transplant; Bone Marrow Transplant:** Please submit a copy of the operative report for the procedure.

☐ **Stroke:** Please submit a copy of the discharge summary, MRI and/or CT test reports from the initial diagnosis, as well as proof of permanent neurological damage (i.e. follow up CT and/or MRI reports, office notes from neurologist or therapist, etc.)

☐ **Renal Failure:** Please submit proof of the start date for dialysis or the operative report for transplant. The End Stage Renal Disease Medical Evidence Report is preferred.

☐ **Heart Event:** Please submit a copy of the operative report for the procedure.

☐ **Loss of Sight, speech, hearing, coma, burns, paralysis**: Please submit medical documentation from the health care provider indicating the diagnosis and severity.

☐ **Other:** Please refer to your certificate for other covered events.

****Disclaimer: Some of the conditions and services listed may not be covered by your policy.**

| Dates | To and From | Round Trip Mileage |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

**Several states require that the following statement appear on the claim forms:**

Any person, who knowingly and with intent to defraud any insurance company, files a statement of claim containing any materially false, incomplete or misleading information, is guilty of a crime

I hereby certify that the answers I have provided to the foregoing questions are both complete and true to the best of my knowledge and belief. I have read the fraud notice included with this form.

**POLICYHOLDER'S SIGNATURE:**_____ **DATE:**_____

**PATIENT'S SIGNATURE:**_____ **DATE:**_____

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# CRITICAL ILLNESS CLAIM FORM (Page 1 of 2)

## ATTENDING PHYSICIAN'S STATEMENT

| PATIENT'S NAME: | | DATE OF BIRTH: |
|---|---|---|
| WHEN DID SIGNS AND/OR SYMPTOMS FIRST APPEAR? | HAS THE PATIENT EVER RECEIVED MEDICAL ADVICE OR TREATMENT FOR THIS OR A SIMILARCONDITION? ☐ No ☐ Yes, When | DIAGNOSIS (INCLUDING COMPLICATIONS) |

## CANCER/ CARCINOMA IN SITU

| DATE OF DIAGNOSIS (THE DATE THE PATHOLOGICAL SPECIMEN(S) WERE OBTAINED ONWHICH CANCER OR CARCINOMA IN SITU WERE DIAGNOSED) | WAS THE CANCER/CARCINOMA IN SITU ☐ DIAGNOSED PATHOLOGICALLY ☐ CLINICALLY DIAGNOSED |
|---|---|

IF THE CANCER/CARCINOMA IN SITU WAS PATHOLOGICALLY DIAGNOSED, ATTACH A COPY OF THE PATHOLOGY REPORT. IF THE CANCER/CARCINOMA IN SITU WAS CLINICALLY DIAGNOSED, PLEASE PROVIDE THE REASON(S) THAT PATHOLOGICAL DIAGNOSIS WAS NOT OBTAINED AND ATTACH MEDICAL EVIDENCE THAT SUPPORTS THE DIAGNOSIS OF CANCER.

## MYOCARDIAL INFARCTION (HEART ATTACK)

DOES THE PATIENT'S CONDITION MEET ALL OF THE FOLLOWING CRITERIA:

| | | |
|---|---|---|
| ☐ Yes | ☐ No | ARE NEW AND SERIAL ELECTROCARDIOGRAPHIC (EKG) FINDINGS CONSISTENT WITH MYOCARDIAL INFARCTION? ATTACH A COPY OF THE EKGs AND REPORTS |
| ☐ Yes | ☐ No | WERE CARDIAC ENZYMES ELEVATED ABOVE GENERALLY ACCEPTED LABORATORY LEVELS OF NORMAL FOR CREATINE PHYSPHOKINASE (CPK), A CPK-MB MEASUREMENT MUST BE USED? ATTACH A COPY OF THE LAB REPORT |
| ☐ Yes | ☐ No | DID DIAGNOSTIC STUDIES CONFIRM A MYOCARDIAL INFARCTION AND THE OCCLUSION OF ONE OR MORE CORONARY ARTERIES?ATTACH COPIES OF ANY APPLICABLE REPORTS. |
| ☐ Yes | ☐ No | DID THE PATIENT HAVE CHEST PAIN CONSISTENT WITH MYOCARDIAL INFARCTION? |

DATE OF DIAGNOSIS: (THE DATE THE PATIENT MET ALL OF THE ABOVE CRITERIA FOR MYOCARDIAL INFARCTION)

## CORONARY ARTERY BYPASS SURGERY

| | | |
|---|---|---|
| ☐ Yes | ☐ No | DID THE PATIENT UNDERGO OPEN HEART SURGERY TO CORRECT NARROWING OR BLOCKAGE OF ONE OR MORE CORONARYARTERIES WITH BYPASS GRAFTS? IF SO, ATTACH A COPY OF THE OPERATIVE REPORT. |

| WHAT CONDITION CAUSED THE NEED FOR CORONARY ARTERY BYPASS SURGERY? | DATE THE PATIENT WAS FIRST TREATED FOR SIGNS ORSYMPTOMS OF THIS CONDITION? |
|---|---|

## MAJOR ORGAN TRANSPLANT

| | | |
|---|---|---|
| ☐ Yes | ☐ No | DID THE PATIENT UNDERGO SURGERY TO RECEIVE A HUMAN HEART, LIVER, LUNG, KIDNEY, PANCREAS, OR BONE MARROW? IF SO, ATTACH COPY OF THE OPERATIVE REPORT. |

DATE THE PATIENT WAS FIRST TREATED FOR SIGNS ORSYMPTOMS OF THIS CONDITION?

## STROKE

| | | |
|---|---|---|
| ☐ Yes | ☐ No | DID THE PATIENT HAVE A STROKE, MEANING APOPLEXY, SECONDARY TO RUPTURE OR ACUTE OCCLUSION OF A CEREBRAL ARTERY? STROKE DOES NOT INCLUDE TRANSIENT ISCHEMIC ATTACKS AND ATTACKS OF VERTERBROBASILAR ISCHEMIA, HEAD INJURY, OR CHRONIC CEREBROVASCULAR INSUFFICIENCY. |

DATE OF DIAGNOSIS (THE DATE A STROKE OCCURRED BASED ON DOCUMENTED NEUROLOGICAL DEFICITS AND NEUROIMAGING STUDIES?

## RENAL FAILURE

| | | |
|---|---|---|
| ☐ Yes | ☐ No | DOES THE PATIENT HAVE END STAGE RENAL FAILURE PRESENTING AS CHRONIC, IRREVERSIBLE FAILURE TO FUNCTION OF BOTH KIDNEYS? |
| ☐ Yes | ☐ No | DOES THE PATIENT'S KIDNEY FAILURE NECESSITATE REGULAR RENAL DIALYSIS, HEMO-DIALYSIS OR PERITONEAL DIALYSIS (AT LEAST WEEKLY) OR WHICH RESULTS IN KIDNEY TRANSPLANTATION? |

| WHAT IS THE CAUSE FOR THE PATIENT'S RENAL DISEASE? | DATE OF DIAGNOSIS (THE DATE A DOCTOR OR PHYSICIAN RECOMMENDS THAT THE PATIENT BEGIN RENAL DIALYSIS.) | DATE THE PATIENT FIRST TREATED FOR SIGNS OR SYMPTOMSOF THIS CONDITION? |
|---|---|---|

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| ATTENDING PHYSICIAN'S STATEMENT (continued) | | | |
|---|---|---|---|
| PATIENT'S NAME: | DATE OF BIRTH: | | |
| Is the patient unable to perform job duties? ☐ No ☐ Yes If yes, please provide dates: | | | |
| What specific job duties is patient unable to perform? | | | |
| Restrictions and Limitations: (Please quantify in hours, weight, etc.) | | | |
| If retired or unemployed which activities of daily living (ADLs) is patient unable to perform? | | | |
| Is the patient:<br>☐ Ambulatory<br>☐ Bed Confined<br>☐ House Confined | Was the patient hospitalized or confined to a skilled nursing facility? ☐ No ☐ Yes<br>If yes, Hospital Address: | | |
| | Date Admitted: | Date Discharged: | |
| Date you expect patient to resume partial duties? | Date you expect patient to resume full duties? | | |
| If patient is unemployed or retired, on what date would you expect a person of like age, gender and good health to resume his/her normal and necessaryactivities? | | | |
| Was the patient treated by any other physician's for this condition? ☐ No ☐ Yes<br>If yes, provide names and addresses of other treating physicians: | | | |
| *Remember, it is unlawful to fill out this form with facts you know are false or to leave out facts you know are relevant and important. Check to be sure that all information is correct before signing. Please refer to page 3 for notice specific to your state*<br>*I hereby certify that the above described information is based upon reasonable medical probability and is true and correct to the best of myknowledge and belief.* | | | |

| ATTENDING PHYSICIAN'S SIGNATURE | | | |
|---|---|---|---|
| I hereby certify that the above described information is based upon reasonable medical probability, and is true and correct to the best of myknowledge and belief. | | | |
| Name (Attending Physician) Please Print: | Degree: | Telephone Number: | |
| Address: | City: | State: | Zip code: |
| Signature: | Date: | Medical Id#: | |

**FRAUD WARNING NOTICES**

For use with Claim Forms

**PLEASE READ THE FRAUD WARNING NOTICE FOR YOUR STATE**

| | |
|---|---|
| **ALASKA:** A person who knowingly and with intent to injury, defraud or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law. | **IDAHO:** Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony. |
| **ARIZONA:** For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties. | **INDIANA:** A person who knowingly and with intent to defraud an insurer files a statement of claim containing Any false, incomplete, or misleading information commits a felony. |
| **ARKANSAS:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. | **KENTUCKY:** Any person who knowingly and with intent to defraud any insurance company or other person files a 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. |
| **CALIFORNIA:** For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison. | **LOUISIANA:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. |
| **COLORADO:** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies. | **MAINE:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.<br><br>**MARYLAND:** Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. |
| **DELAWARE:** Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony. | **MINNESOTA:** A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilt of a crime. |
| **DISTRICT OF COLUMBIA: WARNING:** It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant. | **NEW HAMPSHIRE:** Any person who, with a purpose toinjure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, ormisleading information is subject to prosecution andpunishment for insurance fraud, as provided in RSA638:20. |
| **FLORIDA:** Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree. | **NEW JERSEY:** Any person who knowingly files astatement of claim containing any false or misleading information is subject to criminal and civil penalties. |

**FRAUD WARNING NOTICES (CONT.)**

For use with Claim Forms

**PLEASE READ THE FRAUD WARNING NOTICE FOR YOUR STATE**

**NEW MEXICO:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

**NEW YORK:** 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

**OHIO:** Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

**OKLAHOMA: WARNING:** Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

**OREGON:** Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer,submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

**PENNSYLVANIA**: Any person who knowingly and withintent 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.

**PUERTO RICO:** Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand dollars($5,000) and not more than ten thousand dollars($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances are present, the penalty thus established may be increased to a maximum of five (5) years, if extenuatingcircumstances are present, it may be reduced to a minimum of two (2) years.

**TENNESSEE:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

**TEXAS:** Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of acrime and may be subject to fines and confinement instate prison.

**VIRGINIA**: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

**WASHINGTON:** It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

**RHODE ISLAND and WEST VIRGINIA:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**ALL OTHER STATES:** 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.

# HIPAA-AUTHORIZATION TO OBTAIN INFORMATION

**Send to:**
Continental American Insurance Company
Post Offce Box 84075
Columbus, GA 31993

**Phone:** (800) 433-3036
**Fax:** (866) 849-2970
**Email:** groupclaimfiling@aflac.com

| **Primary Certificate Holder Name:** | **SSN**(optional): | **Date of Birth:** | |
|---|---|---|---|
| **Certificate Number(s):** | | | |
| **Address:** | **City:** | **State:** | **Zip:** |
| **Name of Individual Subject to Disclosure** (If not the primary Certificate Holder): | | **Date of Birth:** | |
| **Relationship to Primary Certificate Holder:** ☐ Self ☐ Spouse ☐ Domestic Partner ☐ Child ☐ Stepchild ☐ Grandchild | | | |

**I. Authorization:**
For the purpose of evaluating my *eligibility for insurance and for benefits* under an existing certificate, including checking for and resolving any issues that may arise regarding incomplete or incorrect information on my application for coverage and/or claim form, I hereby authorize the disclosure of the following information(defined below) about me and, if applicable, my dependents, from the sources listed below to Continental American Insurance Company (CAIC), or any person or entity acting on its part, to include American Family Life Assurance Company of Columbus and American Family Life Assurance Company of New York (collectively, "Aflac).

**II. Disclosure of Health Information:**
Health information may be disclosed by any health care provider, health plan (including CAIC or Aflac, with respect to other CAIC or Aflac coverages) or health care clearinghouse that has any records or knowledge about me. Health care provider includes, but is not limited to, any licensed physician, medical or nurse practitioner, nurse, pharmacist, osteopath, psychologist, physical or occupational therapist, chiropractor, dentist, audiologist or speech pathologist, podiatrist, hospital, medical clinic or laboratory, pharmacy, rehabilitation facility, nursing home or extended care facility, prescription drug database or pharmacy benefit manager, or ambulance or other medical transport service. Health information may also be disclosed by any insurance company or the Medical Information Bureau (MIB). Health information includes my entire medical record, but does not include psychotherapy notes. Some information obtained may not be protected by certain federal regulations governing the privacy of health information, but the information is protected by state privacy laws and other applicable laws. CAIC will not disclose the information unless permitted or required by those laws.

**III. Rights and Expiration:**
I understand that I may revoke this authorization at any time, except to the extent that CAIC or Aflac has taken action in reliance on this authorization. If I revoke this authorization, CAIC may not be able to evaluate my application for coverage and/or claim. To revoke this authorization, I must provide a written and signed revocation to CAIC at the address or fax number above. Unless otherwise revoked, this authorization shall remain in effect for two (2) years from the date signed or upon my death, whichever occurs first. I agree that a copy of this authorization is as valid as the original and that I or an authorized representative may request a copy of this authorization.

**IV. Notice:**
I understand that CAIC is not conditioning payment, enrollment, or eligibility for benefits on whether I sign this authorization. I understand that if the information disclosed is protected health information relating to a health plan and the person or entity receiving the information is a not a health care provider or health plan covered by federal privacy regulations, the information disclosed may be re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.

- **If records are on an adult dependent, (e.g. spouse, child over 18), the dependent must sign this form**
- **If records are on a minor child the natural parent or legal guardian must sign on their behalf.**

Signature of Individual Subject to Disclosure Date Signed

Legal Representative's Printed Name Legal Representative's Signature Legal Relationship Date

******If signed by a legal representative (e.g. Legal Guardian, Estate Administrator, Power of Attorney******

# *Electronic Funds Trans action Authorization*

**Mail To: Continental American Insurance Company**
**PO Box 84075, Columbus, GA 31993**
**Phone: 800.433.3036 Fax: 866.849.2970**
**Email: groupclaimfiling@aflac.com**

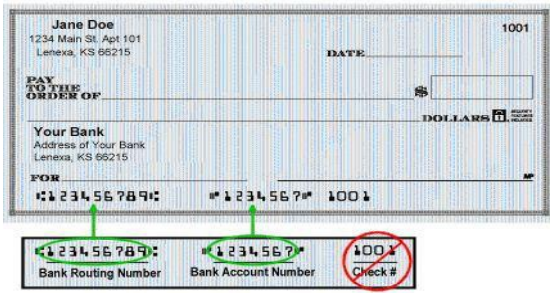
**Important:** Aflac Group (CAIC) cannot process direct deposit requests for Aflac. Electronic payments can only be made if all requested information is provided in the form below. Claim submission and direct deposit authorization may be completed by the insured creating an account via MyAflac.

I would like to: ☐ Start ☐ Stop ☐ Change direct deposit of my claim payment(s).

Account Type:

☐ Checking ☐ Savings

****** Please provide a blank voided check or direct deposit form from your financial institution. Incomplete or inaccurate information will not be processed.**




| | | |
|---|---|---|
| 9-Digit Routing Number: | | Account Number: |
| Name of Financial Institution: | | |
| Address: | | City: |
| State: | Zip: | Phone: |

I authorize Continental American Insurance Company (CAIC) to initiate credit entries, and, if errors occur, I authorize the correction of entries to my account as indicated. This authorization remains effective and in full force until CAIC receives written notification from me of its termination in such time and in such manner to afford CAIC a reasonable opportunity to act on it. Please notify CAIC immediately if your financial institution information has changed by sending notification to the address indicated above. Should you have any questions, please contact us at 1-800-433-3036.

| | |
|---|---|
| Policy/Certificate Holder's Name (*Print*): | |
| Address: | City/State/Zip: |
| Phone #: | E-mail Address: |
| Employer Name or Group #: | Certificate #: |

****By providing your e-mail address above, you consent to the use of electronic transactions in connection with your CAIC policies, contracts, and/or accounts to the extent available and permitted by law (which may include, but not limited to: invoices, claim correspondence, contracts, surveys, and other materials that CAIC is, or may be, legally required to deliver to you)*

***Note: Forms received without signature will not be processed. Electronic signatures not accepted.***

**Policy/Certificate Holder Signature *(Required)*** **Date Signed:**