Claims Authorization to Obtain Information

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Instructions for completing this Health Insurance Portability and Accountability Act of 1996 (HIPAA) compliant form:

1. **All areas of this form should be completed.**
2. **This form must be signed and dated by the claimant/patient below.**
3. **IMPORTANT: If you are filing a claim on behalf of a deceased, please check here**
4. **If you are the Authorized Representative, please sign below and indicate your relationship to the claimant/patient/deceased. In addition, include a copy of the legal document(s) authorizing you to act on their behalf.**
5. **Fax this form to 1-877-442-3522 or return the form to Aflac, Attn: Claims Department, Worldwide Headquarters, 1932 Wynnton Road, Columbus, GA 31999, as soon as possible in order to expedite claim review.**

Policyholder/Certificate Holder Name:	**Policy/Certificate Number(s):**	**Date of Birth:**
Policyholder/Certificate Holder Address:		
Claimant/Patient Name (if different from named policyholder/certificate holder listed above):		**Date of Birth:**

For residents of AZ, CA, CT, GA, IL, ME, MA, MN, NV, NJ, NM, NC, OH, and VA, this authorization will be valid for a period of two years from the sign date or until the termination of the policy/certificate coverage, whichever is less, unless a lesser alternate expiration date is provided below.

For residents of all other States, this authorization will be valid for a period of two years from the sign date, unless a lesser alternate expiration date is provided below.

Alternate Expiration Date:

Purpose of Disclosure: Evaluate claims for benefits during the time this authorization is valid.

Name and Address of health care provider(s), company, or individual authorized to release the requested information:
(this section will be completed by Aflac):

I, or my authorized representative, request that information regarding my past, present, or future physical or mental health condition (excluding psychotherapy notes), employment, other insurance coverage, or any other nonmedical facts be released to **American Family Life Assurance Company of Columbus (Aflac)** or any person or entity acting on its part. This could include, but is not limited to, any medical professional, medical care institution, medical clearinghouse, insurer (including Aflac, with respect to other Aflac coverages), reinsurer, government agency (including departments of public safety and motor vehicle departments), consumer reporting agency or employer.

I understand that:

1. Protected health information may include information and records protected under Federal and State Law such as: alcohol, drug abuse, mental health, AIDS or HIV testing or treatment, or the presence of a communicable or noncommunicable disease.
2. My treatment, payment or eligibility for benefits may not be conditioned on signing this authorization.
3. I understand that I may revoke this authorization at any time by writing to **Aflac, Claims Department, Worldwide Headquarters, 1932 Wynnton Road, Columbus, GA 31999**, except to the extent that:
   a. Aflac has taken action in reliance to this authorization, or
   b. Other law provides Aflac with the right to contest a claim under the policy/certificate or the policy/certificate itself.
4. If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. It is recommended I retain a copy of this signed form for my records, understanding that a copy is as valid as the original.

Signature of claimant/patient, guardian or authorized representative **Date**

Printed name of claimant/patient, guardian or authorized representative **Relationship**