AUTHORIZATION FOR RELEASE TO FUNERAL DIRECTORS

MAIL TO: American Family Life Assurance Company of Columbus
1932 Wynnton Road
Columbus, Georgia 31999-0001

CALL: 800.992.3522
FAX: 877.442.3522

Funeral Home Information:		
Funeral Home Name:	**Address:**	
Decedent Information:		
Decedent Name:	**SSN**(optional):	**Date of Birth:**
Address (for verification purposes):		
Policy Number(s):		

Representative Information:

You must be one of the listed relationships below in order to authorize the release of information.
Please indicate your relationship to the Decedent: (check all that apply)

☐ Policy owner (if not the decedent)	☐ Policy Beneficiary*
☐ Primary Policyholder (if decedent is a covered dependent)	☐ Trustee of a Trust Beneficiary* **(trust documents must be attached or already on file with Aflac.)**
☐ Policyholder (if making pre-death arrangements)	☐ Guardian/Conservator of a Minor Beneficiary* **(guardianship/conservatorship documents must be attached or already on file with Aflac.)**
☐ Estate Administrator, Executor of the Estate, Personal Representative **(court documents must be attached or already on file with Aflac.)**	

***Important Beneficiary Information**

If you are a beneficiary, Trustee of a Trust Beneficiary, or guardian/conservator of a minor beneficiary, you **do not** have the authority to authorize the release of other beneficiary names, if applicable. **Do not** select the Beneficiary Name(s) box below.

If multiple beneficiaries exist, the information released will be limited to only the portion of benefits you may be entitled to.

Aflac May Release the Following Information: (check all that apply)

☐ Face Value	☐ Policy Status	☐ Beneficiary Name(s) **If authorized, see note above.***

Authorization:

I, the undersigned, hereby authorize Aflac or any person or entity acting on its part to release the above listed information. I understand that the information released will be limited to only what is required for the Funeral Director to perform his/her duties. If I am one of multiple beneficiaries, the information released will be limited to the portion of benefits I may be entitled to. Additional beneficiaries will be required to complete a separate form.

Purpose, Rights, and Expiration:

- I understand that this information will be used for funeral arrangement purposes.
- This authorization shall remain in effect for one (1) year from the date hereof, unless revoked by me. I understand that I may revoke this authorization at any time, except to the extent that Aflac has taken action in reliance on this authorization. To revoke this authorization, I must provide a written and signed revocation to Aflac at the address above.
- I agree that a copy of this authorization is as valid as the original. I agree to make a copy of this signed authorization for my records; however, I may also request a copy of this authorization directly from Aflac.

Notice:

I understand that Aflac is not conditioning payment or eligibility for benefits on whether I sign this authorization. I understand that if 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. The undersigned hereby waives any restrictions on disclosure imposed by law on Aflac and releases Aflac, its officers, directors, employees and agents from any liability associated with the release of any information pursuant to this authorization.

Representative's Printed Name	Representative's Signature	Date Signed

PROOF OF DEATH - BENEFICIARY'S STATEMENT

Thank you for trusting Aflac with your Life Insurance needs.

To prevent delays, please provide documentation from your healthcare provider to support this claim. If you have additional bills or medical documentation that relates to this diagnosis other than the documentation defined, please submit them for review of additional benefits.

- **Service related items can be obtained directly from the patient's healthcare provider(s) by requesting a UB04 hospital bill or HCFA 1500 non-hospital bill.**
- **Failure to complete all sections may result in a delay in processing this claim.**
- **Disclaimer: Some of the services listed may not be covered by your policy.**

***Policy Number:** ☐☐☐☐☐☐☐☐

***Policyholder's SSN:** ☐☐☐ - ☐☐ - ☐☐☐☐
This information is required for all interest payments.

Policyholder Information: This * denotes a required field.

*Last Name | Suffix | *First Name | MI

Information on Deceased:

*Last Name | Suffix | *First Name | MI

*Date of Birth (mm/dd/yy) ☐☐ / ☐☐ / ☐☐ | *Social Security Number ☐☐☐ - ☐☐ - ☐☐☐☐ | *Maiden Name/Nickname/Alias

*Home Address

*City | *State | *Zip Code ☐☐☐☐☐ - ☐☐☐☐

*Sex: ☐ Male ☐ Female

*Relationship to policyholder: ☐ Policyholder ☐ Spouse ☐ Dependent Child ☐ Other ____________________

Proof of Death Checklist

To file a claim under Aflac's Life Insurance Policy, please complete the following information and send us:

- Proof of Death - Physician's Statement- If this is a life policy less than two years old, this statement should be completed by the regular doctor of the deceased, not necessarily the doctor who attended the deceased at death.
- Authorization to Obtain Information- This form should be completed by the deceased's next of kin.
- Certified Death Certificate

Under the following circumstances, please send the additional items listed:

- If a minor is the beneficiary - A copy of the court order appointment of the legal guardian of the property and/or estate of any minor child. (Please note: custody does not qualify as guardianship.)
- If the beneficiary has died prior to the death of insured- A copy of the certified death certificate of the beneficiary.
- If the deceased was a dependent child over the age of 19, proof of full time student status may be required.

- Date of death: _____/_____/_____
- Place of death: ______________________________
- Cause of death: ______________________________

***Policy Number:** | | | | | | | | |

***Policyholder's SSN:** | | | | - | | | - | | | | |
This information is required for all interest payments.

Policyholder Information:

*Last Name	Suffix	*First Name	MI

Information on Deceased:

*Last Name	Suffix	*First Name	MI

- If death was due to an injury, please send a copy of the police report, toxicology/BAC report and answer the following questions.
  - Date of the injury: _____/_____/_____
  - Details of the injury: _____
- If death was due to a sickness, please answer the following questions.
  - When did the deceased first experience symptoms? ____/_____/_____
  - When did the deceased first consult a physician for this illness? _____/_____/_____
- Please provide the name and addresses of all physicians who attended deceased within three years prior to death:

Name	Address	Dates of Treatment	Disease or Condition

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.

Beneficiary's Signature*
**Guardian's Signature if beneficiary is a minor.*

Beneficiary's Printed Name

Date

Beneficiary's Date of Birth

Beneficiary's Social Security Number

Beneficiary's Phone Number

Beneficiary's Mailing Address

City, State

Zip Code

Witness' Signature

Witness' Printed Name

Date

American Family Life Assurance Company of Columbus (Aflac)
ATTN: Claims Department • 1932 Wynnton Road • Columbus, GA 31999
For information or to check claim status, visit aflac.com or call 1-800-99-AFLAC (1-800-992-3522)
Claims may be faxed to 1-877-44-AFLAC (1-877-442-3522)