SPECIFIED HEALTH EVENT CLAIM FORM

Accident Policy Number	Hospital Indemnity/Specified Health Event Policy Number	Hospital Intensive Care Policy Number

Be sure to include your policy number(s) on all documents.
Failure to complete this form in its entirety may result in a delay in processing this claim.

INSTRUCTIONS:

☐ Complete Section A: Policyholder/Patient Information and sign your claim form.
☐ Have the treating physician complete Section B: Physician's Statement and sign the claim form.
☐ If you are filing for disability, please complete the Initial Disability Claim Form (NY-S00224) as well. **Forms are available on our web site at aflacny.com.**
☐ Submit all bills related to this claim, such as hospital, surgery, etc. All bills should include the diagnosis, services rendered, and actual charges for the service.
☐ If hospitalized and/or confined to an intensive care unit, please send a copy of your hospital bill showing charges and the number of days you were confined. If confined to an intensive care unit, the bill must specify the number of days you spent in the intensive care unit.
☐ The items above can be obtained directly from your healthcare provider(s) by requesting a UB04 (hospital bill) or HCFA1500 (non-hospital bill).

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: _____

☐ Dependent Child ☐ Check here if dependant child is a full-time student (if over the age 19, please provide school name and contact information).

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.

_____ _____ _____
CLAIMANT SIGNATURE **FAMILY RELATIONSHIP, IF NOT POLICYHOLDER** **DATE**

American Family Life Assurance Company of New York (Aflac New York)
Attention: Claims Department • 1932 Wynnton Road • Columbus, GA 31999-7255
For information or help filing your claim, please call toll-free 1-800-366-3436 or visit our Web site at aflacny.com
Toll-free fax number 1-877-844-0201

SPECIFIED HEALTH EVENT CLAIM FORM - PHYSICIAN'S STATEMENT

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

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.

Policy Number: _____ Policyholder Name: _____

Patient Name: _____ Date of Birth: _____

SECTION B: PHYSICIAN'S STATEMENT

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

1. Symptoms first occurred on: _____/_____/_____ Date of initial diagnosis: _____/_____/_____

2. Patient first consulted you for this condition on: _____/_____/_____

3. Did patient undergo surgery for this diagnosis? ☐ Yes ☐ No Procedure Code: _____

Procedure Description: _____

4. Was patient hospitalized as a result of this diagnosis? ☐ Yes ☐ No

Admission: _____/_____/_____ Discharge: _____/_____/_____

Hospital Name: _____

City: _____ State: _____

5. Is there a referring physician? ☐ Yes ☐ No If yes, physician's name: _____

Referring physician's address: _____ Phone number: _____

Please indicate diagnosis below (Continued on Page 3):
All events listed may not be covered by your policy. Please check your policy for a list of covered events or call 1-800-366-3436.

☐ **Coma** **Physician's Initials**_____
Duration _____
Glasgow Coma Scale _____
- ☐ Absence of spontaneous eye movement
- ☐ Absence of response to painful stimuli
- ☐ Absence of vocalization
- ☐ Requires intubation for respiratory assistance

☐ **Major Third-Degree Burns** **Physician's Initials**_____
Percent of Total Body Area _____
- ☐ Destruction of the entire epidermis and underlying dermis
- ☐ Covers 10% or more of body surface
- ☐ Caused by heat, electricity, radiation, or chemicals

☐ **Coronary Angioplasty**
Physician's Initials_____
- ☐ Opening of narrowed or blocked blood vessels of the heart (with or without stents)

☐ **End-Stage Renal Failure** **Physician's Initials**_____
Date Dialysis Began _____
- ☐ Permanent and irreversible kidney failure
- ☐ Requires dialysis or kidney transplant to maintain life

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Policy Number: _____ Policyholder Name: _____

Patient Name: _____ Date of Birth: _____

Please indicate diagnosis below (Continued from Page 2):

☐ **Coronary Artery Bypass Surgery**

Physician's Initials_____

CPT Code _____

☐ Open-heart surgery to correct narrowing or blockage of coronary arteries by bypass graft

☐ Excludes valve replacement surgery

☐ **Paralysis**

Physician's Initials_____

Duration _____

☐ Complete and total loss of use of two or more limbs

☐ **Major Human Organ Transplant**

Physician's Initials_____

☐ Surgical transplant of the:

☐ Kidney
☐ Liver
☐ Heart
☐ Lung
☐ Pancreas

☐ Excludes mechanical or nonhuman organs

☐ **Persistent Vegetative State**

Physician's Initials_____

This condition requires a written statement from two physicians, one of whom must be the attending physician, that:

☐ Cognitive function has been substantially impaired.
☐ There is no reasonable expectation that the patient will regain significant cognitive function.

☐ **Heart Attack**

Physician's Initials_____

☐ Confirmed by electrocardiographic findings

☐ Confirmed by clinical findings

☐ Myocardial infarction, coronary thrombosis, or coronary occlusion

☐ Excludes congestive heart failure and sudden cardiac death

☐ **Stroke**

Physician's Initials_____

☐ Confirmed by neurological deficit

☐ Confirmed by neuroimaging studies

☐ Complete or partial function loss for more than 24 hours

☐ Excludes head injury, transient ischemic attack (TIA), or cerebrovascular insufficiency

PHYSICIAN'S SIGNATURE **DATE** **TAX ID NUMBER**

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Attention: Claims Department • 1932 Wynnton Road • Columbus, GA 31999-7255
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Toll-free fax number 1-877-844-0201

Claims Authorization to Obtain Information

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 1-877-844-0201 or return the form to Aflac New York, Attn: Claims Department, Worldwide Headquarters, 1932 Wynnton Road, Columbus, GA 31999-7255 as soon as possible to expedite the review of your claim.**

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

Name and Address of health care provider(s), company, or individual authorized to release the requested information:

This authorization shall be valid for a period of two years from the sign date unless a lesser time frame is indicated. Alternate Expiration Date:

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

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 New York (Aflac New York)** or any person or entity acting on its part. This could include, but is not limited to, any medical professional, medical care institution, insurer (including Aflac New York, with respect to other Aflac New York 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.
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 New York, Attn: Claims Department, Worldwide Headquarters, 1932 Wynnton Road, Columbus, GA 31999-7255**, except to the extent that:
   a. Aflac New York has taken action in reliance to this authorization, or
   b. Other law provides Aflac New York with the right to contest a claim under the policy or the policy 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.

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**