PROOF OF DEATH - BENEFICIARY'S STATEMENT

TO FILE A CLAIM UNDER AN AFLAC NEW YORK LIFE INSURANCE OR ACCIDENT POLICY, PLEASE MAIL YOUR COMPLETED BENEFICIARY'S STATEMENT ALONG WITH VERIFIABLE PROOF OF DEATH. PLEASE NOTE, ADDITIONAL INFORMATION MAY BE REQUESTED FROM THE INSURED'S ESTATE, NEXT OF KIN OR PERSONAL REPRESENTATIVE.

INFORMATION ON DECEASED			
LAST NAME	FIRST NAME	MIDDLE INITIAL	MAIDEN/ALIAS/NICKNAME
ADDRESS			
CITY	COUNTY	STATE	ZIP
SOCIAL SECURITY NUMBER			DATE OF BIRTH
RELATIONSHIP TO POLICYHOLDER: ❒ SPOUSE ❒ DEPENDENT ❒ OTHER _____			

The undersigned hereby applies to Aflac New York or payment of said insurance and agrees that the written statements and affidavits of all the physicians who attended or treated the insured, and all other papers called for by the instructions hereon, will constitute, and they are hereby made a part of these verifiable Proofs of Death and further agrees that the furnishing of this form, or of any other forms supplemental thereto, by said company will not constitute nor be considered an admission by it that there was any insurance in force on the life in question, nor a waiver of any of its rights or defense.

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.

Signed at _____ Dated _____
City, County, State

_____ _____ ____/____/____
Beneficiary's Signature Beneficiary's SSN Beneficiary's DOB

_____ _____
Print Beneficiary's Name Witnessed by

_____ (____)_____
Beneficiary's Mailing Address City County State/Zip Home Telephone

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

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

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

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