PHYSICIAN'S VISIT BENEFIT CLAIM FORM

Your Aflac Personal Sickness Indemnity policy pays a Physician's Visit Benefit for services rendered under the supervision of a physician, after the effective date of your policy (see policy schedule).

- **Please complete all sections of the form, sign, date, and mail form to the address shown below.**
- **Submit only one treatment date per claim form.**
- **Each additional treatment date should be on a separate claim form.**
- **Claims for all other benefits covered under this policy should be filed separately.**
- **Do not fax or photocopy this document.**
- **Incomplete forms will be returned for completion.**
- **Do not attach receipts, statements or other documentation to this form.**
- **Use blue or black ink only**

Policyholder Information:

Policy Number:

First Name:

Last Name:

Policyholder Birth Date: M M D D Y Y Y Y

Patient Information:

Patient First Name:

Middle Initial:

Patient Last Name:

Sex:
- Male
- Female

Patient Birth Date: M M D D Y Y Y Y

Relationship:
- Primary Policyholder
- Spouse
- Dependent Child
- Check if dependent is full-time student

Date of Physician's Visit: M M D D Y Y Y Y

Physician's Phone Number: - -

Physician's Name:

Physician's Street Address:

Physician's City:

State:

ZIP:

For your protection California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Policyholder Signature | **Printed Name** | **Date**

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1-800-SI-AFLAC (1-800-742-3522) en español