REQUEST FOR CONTINUING DISABILITY BENEFITS - SUPPLEMENTAL

Refer to the attached EOB for filling instructions
www.afadvantage.com

American Fidelity Assurance Company
A member of the American Fidelity Group

EDUCATIONAL SERVICES DIVISION
BENEFITS DEPARTMENT
Post Office Box 25160
Oklahoma City, Oklahoma 73125
Local: (405)523-5025
Toll Free: 1-800-662-1113
Fax: 1-800-818-3453

INSTRUCTIONS TO THE INSURED

1. Complete the Statement of Insured below. **2.**The attending Physician's Statement is to be completed upon request.
3. Please return this supplemental disability form to the address shown above.

STATEMENT OF INSURED

Insured's Name_____ Account Number _____
Last Name First Name Initial
Phone # ( ) _____ Social Security #_____Mailing Address_____

1. Are you still under the care of a physician?_____ If so, please give his name and address below:

_____
Physician's Name Address City State Zip Code

2. Were you hospital confined since last report?_____ If so, give dates and name and address of hospital below:
Date entered_____ Date discharged_____

_____
Hospital Address City State Zip Code

3. Give dates of treatment at Doctor's office since last report:_____
4. Are you working ?_____ If so, when and where did you begin working?_____
If not, what are your current activities?_____
_____
5. When do you expect to return to work? _____
6. Have any other illnesses or accidents occurred since the last report?_____ If so, please describe: _____
_____
7. Has your employment terminated: ❑ Yes ❑ No If so, give the effective date: / /
8. If your request for Benefits is approved do you want us to withhold amounts from each Benefit check for Federal Income Tax?
❑ Yes ❑ No If yes, amount $_____ $20.00 per week minimum. Signature_____
9. Identify other income sources and amount of income for which you are receiving or may be entitled to receive during this disability

Your Social Security: (disability or retirement)	❑ Yes	❑ No	$_____Mo.	V.A. Benefits:	❑ Yes	❑ No	$_____Mo.
Dependent Social Security:	❑ Yes	❑ No	$_____Mo.	Worker's Compensation:	❑ Yes	❑ No	$_____Mo.
Sick Leave or Wage Continuation:	❑ Yes	❑ No	$_____Mo.	Other Disability Coverage:	❑ Yes	❑ No	$_____Mo
Retirement: (normal early or disability)	❑ Yes	❑ No	$_____Mo.	(identify)_____			
State Disability Income	❑ Yes	❑ No	$_____Mo.	**Include a copy of your award or denial letter for any**			
Unemployment	❑ Yes	❑ No	$_____Mo.	**source in which one has been received.**			

Signature: _____ **Date:** _____/_____/_____
I certify this information is true and correct.

10. Please complete if you desire benefits deposited directly into your bank account.
I authorize AFAC to initiate credit entries to my account at the depository named below. This authorization is to remain in force and effect until AFAC receives written notification from me of its termination in such time and in such manner as to afford AFAC and the Depository opportunity to act on it.
Bank/Credit Union Name: _____ **Date:** _____/_____/_____
NOTE: You must attach a voided check to begin direct deposit.

Signature: _____ **Date:** _____/_____/_____

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize the entities specified below to disclose any information about my entire medical record, benefits payable, or benefit eligibility for this disability and history of treatment for physical and/or emotional illness to include psychological testing, except psychotherapy notes, to individuals representing American Fidelity Assurance Company (AFAC) who are involved in determining whether I am eligible for benefits under my insurance coverage. Those so authorized are: a) licensed physicians or medical practitioners; b) hospitals, clinics or medically-related facilities; c) health plans; d) Veteran's Administration; e) past or present employers; f) pharmacy; g) insurance companies; h) the Social Security Administration; i) retirement systems; j) Department of Motor Vehicles; and k) Workers' Compensation Carrier.

NOTICE: Information authorized for release may include information on communicable or venereal diseases such as hepatitis, syphilis, gonorrhea, HIV/AIDS (Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome) or other conditions for which you may have been treated. This authorization excludes disclosure of the result of a test for HIV if you have tested HIV positive but have not developed symptoms of the disease AIDS. Such test results shall not be discovered or published. Nothing in this caveat will prohibit this authorization from including the fact that you have AIDS.

I understand that I may refuse to sign this authorization; however, if I do not sign the authorization, my failure to sign the authorization may result in a denial or a delay of benefits. I understand that I may revoke this authorization at any time by writing to AFES Benefits Department, PO Box 25160, Oklahoma City, OK 73125-0160 or by calling, toll-free, 1-800-662-1113. I understand that my right to revoke this authorization is limited to the extent that: AFAC has taken action in reliance on the authorization; or, the law provides AFAC with the right to contest my insurance coverage or a claim under my insurance coverage. A copy of this authorization will be as valid as the original.

I understand that if protected health information is disclosed to a person or organization that is not required to comply with federal privacy regulations, the information may be redisclosed and no longer protected by the federal privacy regulations.

For health insurance coverage this authorization will expire twenty-four months from the date it is signed or upon termination of my insurance policy, whichever occurs first. For insurance coverage other than health insurance, this authorization will expire twenty-four months from the date it is signed or upon expiration of my claim for benefits, whichever occurs first.

_____ _____
Signature (Patient) or Personal Representative (if applicable) Printed Name (Patient)

_____ _____
Relationship of Personal Representative to Patient Date

If authorization is supplied by a personal representative a description of the authority to act on behalf of the Insured must be included.

Please retain a copy for your personal records, or you may request a copy from our company.

ATTENDING PHYSICIAN'S STATEMENT

Warning: Any person who knowingly and with intent to injure, defraud, or deceive an insurer files a statement of claim containing any false, incomplete, or misleading information may be guilty of insurance fraud and subject to criminal and civil penalties.

California - For your protection, California law requires the following to appear on this form. Any person who willingly presents 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.

AR, DC, LA, MD, NJ, NM, TX, and WV - ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

DE, ID, IN, MN, OH, and OK - WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

Colorado - It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

Hawaii - For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

New Hampshire - Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

Kentucky - Any person who knowingly and with intent to defraud any insurance company or other person files a 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.

Oregon - Any person who knowingly and with intent to defraud or solicit another to defraud an insurer: (1) by submitting an application, or (2) by filing a claim containing a false statement as to any material fact, may be violating state law.

Pennsylvania - 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 subjects such person to criminal and civil penalties.

Arizona - For your protection, Arizona law requires the following statement to appear on this form: Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

Florida - 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.

Name of Patient:	Date of Birth:	Social Security Number:	Account Number:

DIAGNOSIS

Diagnosis: (including complications) — ICDA Code:

Is disability due to injury or sickness arising out of or in the course of patient's employment? ❑ Yes ❑ No

TREATMENT

Frequency of treatment: ❑ Monthly ❑ Weekly ❑ Other

Date of next appointment : _____/_____/_____

Nature of treatment being rendered (including surgery and any medications being prescribed)

List all dates of treatment or medical attention since last report:

Is patient still under your regular care for this condition? ❑ Yes ❑ No If no, please explain and provide name of the current treating physician:

Has the patient been confined to a hospital? ❑ Yes ❑ No Admitted: _____/_____/_____ Discharged: _____/_____/_____

If yes, give admit and discharge dates along with name and address of hospital. Admitted: _____/_____/_____ Discharged: _____/_____/_____

Name:_____ Address: _____

EXTENT OF DISABILITY

	For any Occupation?	For Regular Occupation?
a. Is patient now totally disabled?	❑ Yes ❑ No	❑ Yes ❑ No
	From _____ To _____	From _____ To _____
b. If no, when was patient able to go to work?	Mo. _____ Day _____ 20 _____	Mo. _____ Day _____ 20 _____

PROGNOSIS

If the patient is currently disabled, what is the anticipated length of disability?

❑ 1-2 Months ❑ 2-3 Months ❑ 3-6 Months ❑ 6-12 Months ❑ More than 12 Months ❑ Permanent

When, in your opinion, will the patient recover sufficiently to return to work?

Has there been any improvement in functional status since the last report? ❑ Yes ❑ No (If yes, please clarify.)

Do you expect any improvement or decline in functional status? ❑ Yes ❑ No If so, when? _____

(If yes, please circle: improvement or decline)

IMPAIRMENTS

Functional Limitations that render your patient totally disabled:

Attending Physician's Name: (print)	Specialty:	Telephone #: ( ) -	Fax #: ( ) -
Mailing Address:	City:	State:	Zip Code:
Signature:	Federal Tax ID #:		Date: