PROOF OF DEATH - BENEFICIARY'S STATEMENT

FOR AGENT USE ONLY:

☐ Send the insured's check to the agent for delivery. Writing No.: _____ Name:_____	Address: _____ _____

TO FILE A CLAIM UNDER AFLAC'S LIFE INSURANCE POLICY, PLEASE SEND US:

- **Certified Death Certificate**
- **Life Insurance Policy**, if available - If the claim is on a dependant, do not send the policy.

UNDER THE FOLLOWING CIRCUMSTANCES, PLEASE SEND THE ADDITIONAL ITEMS LISTED:

- **If this is a Life Policy Less Than 2 Years Old** - Please send us a **Proof of Death - Physician's Statement** (Form A-2575). This statement should be completed by the regular doctor of the deceased, not necessarily the doctor who attended the deceased at death.
- **If the Estate is the Beneficiary** - Please send us a copy of the court order appointment of the Administrator/Executor of the insured's estate.
- **If a Minor is the Beneficiary** - Please send us a copy of the court order appointment of the legal guardian of the property and/or estate of any minor child.
- **If the Beneficiary Has Died Prior to the Death of the Insured** - Please send us a copy of the certified death certificate of the beneficiary.
- **If the Death was Investigated by Any Law Enforcement Agency** - A copy of the police report, including the toxicology results.
- **If the Deceased was a Dependent Child** - Proof that the child was a full-time student if the child is over the age of 18.

TO FILE A CLAIM FOR ADVANCED LIFE BENEFITS, PLEASE HAVE FORM S-2029 COMPLETED AND SEND US ONE OF THE FOLLOWING:

- **Classic EKG (Electrocardiogram)** - EKG report with evidence of a heart attack;
- **Elevated Cardiac Enzyme** - Laboratory report in which the CPK (creatine phosphokinase) is at least two times the normal value for the evaluating institution (hospital); or
- **MBCPK** (MB creatine phosphokinase) - Laboratory report indicating a MBCPK of 3% or greater.

Provide all policy numbers under which the deceased may be covered as the primary policyholder, spouse, or dependent:

Policy Number(s)	Policy Effective Date	Insurance Amount

DECEDENT INFORMATION

LAST NAME	FIRST NAME	MIDDLE INITIAL	Maiden Name / Alias
ADDRESS			
CITY	STATE	ZIP	
SOCIAL SECURITY NUMBER (optional)		BIRTH DATE	
☐ MALE ☐ FEMALE ☐ SINGLE ☐ MARRIED ☐ OTHER	RELATIONSHIP: ☐ SELF	☐ SPOUSE	☐ DEPENDENT
OCCUPATION AT TIME OF DEATH:		DATE OF DEATH	
PLACE OF DEATH:			
CAUSE OF DEATH			

American Family Life Assurance Company of Columbus (Aflac)
Attention: Claims Department
Worldwide Headquarters • 1932 Wynnton Road • Columbus, GA 31999
For information or help filing your claim, please call toll-free 1-800-99-AFLAC (1-800-992-3522) or visit our Web site at aflac.com
Toll-free fax number 1-877-44-AFLAC (1-877-442-3522)

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

Policyowner's name: _____ Policy Number: _____

Decedent's name: _____

If death was due to an accident, send us a copy of the police or coroner's report.

When was the accident? ____/____/____ Please give us details of accident _____

_____

If death was due to an illness, when did the deceased first complain of, or give indication of, this illness?

When did the deceased first consult a physician for this illness? _____

_____

Complete this section only if the policy is two years old or less.

Names and addresses of all physicians who attended deceased during his last illness and during the three years before death:

NAME	ADDRESS	DATES OF ATTENDANCE	DISEASE OR CONDITION

The undersigned hereby applies to Aflac for 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, shall constitute and they are hereby made a part of these Proofs of Death and further agrees that the furnishing of this form, or of any other forms supplemental thereto, by said company shall 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 subjects such person to criminal and civil penalties.

Signed at _____ this _____ day of _____, 20____
City, State

_____ _____ ____/____/____
Beneficiary's Signature | Social Security # of Beneficiary | Date of Birth

_____ _____
Please ***Print*** Beneficiary's Name | Witnessed by:

_____ _____
Beneficiary's Address: Street City/State | Telephone #

Please review and sign the attached authorization. Two copies are attached: return one copy to Aflac and keep one for your records. By returning the signed authorization with your claim, you will help us process your claim as quickly and efficiently as possible.

American Family Life Assurance Company of Columbus (Aflac)
Attention: Claims Department
Worldwide Headquarters • 1932 Wynnton Road • Columbus, GA 31999
For information or help filing your claim, please call toll-free 1-800-99-AFLAC (1-800-992-3522) or visit our Web site at aflac.com
Toll-free fax number 1-877-44-AFLAC (1-877-442-3522)

Policy #: | | | | | | | | |

AU

AUTHORIZATION TO OBTAIN INFORMATION

I authorize the following to give information (as defined below) to American Family Life Assurance Company of Columbus (Aflac) or any person or entity acting on its part: any medical professional, medical care institution, insurer (including Aflac, with respect to other Aflac coverages), reinsurer, government agency (including departments of public safety and motor vehicle departments), consumer reporting agency or employer. "Information" means facts or opinions relating to the deceased's past, present, or future physical or mental health or condition (excluding psychotherapy notes), employment, other insurance coverage, or any other non-medical facts that Aflac deems appropriate to evaluate claims for benefits during the time this authorization is valid. I understand that any disclosure of information to Aflac for the purpose of evaluating claims for benefits for coverage other than health plan coverage means the information may no longer be protected by federal privacy regulations. I further understand, however, that such information may be re-disclosed only in accordance with other applicable laws or regulations.

I understand that this information will be used by Aflac to evaluate claims for benefits.

I understand that I may revoke this authorization at any time, except to the extent that (1) Aflac has taken action in reliance on this authorization, or (2) other law provides Aflac with the right to contest a claim under the policy or the policy itself. My revocation must be submitted in writing to Aflac, Claims Department, 1932 Wynnton Road, Columbus, GA 31999.

Unless otherwise revoked, I agree that this authorization will expire two years from the date indicated below.

I agree that a copy of this authorization is as valid as the original.

Signature Date Printed Name

Individual/Guardian/Personal Representative

Printed Name

If this authorization has been signed by a personal representative on behalf of an individual, his/her authority to act on behalf of the individual must be set forth here:

Policy #: | | | | | | | | |

AU

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I agree that a copy of this authorization is as valid as the original.

_____ _____

Signature Date Printed Name

Individual/Guardian/Personal Representative

_____

Printed Name

If this authorization has been signed by a personal representative on behalf of an individual, his/her authority to act on behalf of the individual must be set forth here:

RETAIN THIS COPY FOR YOUR RECORDS