HOSPITAL INDEMNITY CLAIM FORM

Thank you for trusting Aflac with your Hospital Indemnity needs.

- **If you are interested in filing your claim online or uploading documentation on an existing claim, register using aflac.com/smartclaim.**

To prevent delays, please provide documentation from your healthcare provider to support this claim. If you have additional bills or medical documentation that relates to this diagnosis other than the documentation defined, please submit them for review of additional benefits.

- **Service related items can be obtained directly from the patient's healthcare provider(s) by requesting a UB04 hospital bill or HCFA 1500 non-hospital bill.**
- **Failure to complete all sections may result in a delay in processing this claim.**
- **Disclaimer: Some of the services listed may not be covered by your policy.**

***Policy Number:**

Policyholder Information: This * denotes a required field.

*Last Name | Suffix | *First Name | MI

*Date of Birth (mm/dd/yy) | Telephone Number where we can reach you

*Home Address

*City | *State | *Zip Code

☐ *Check box if this is a permanent address change.*

Patient Information:

*Last Name | *First Name | *Date of Birth (mm/dd/yy)

*Sex: ☐ Male ☐ Female

*Relationship: ☐ Primary Policyholder ☐ Spouse ☐ Dependent Child

Hospital Indemnity Checklist

***If filing for a claim within the first two years of the policy, medical records may be requested for evidence of insurability.**

Is treatment due to an injury? ☐ No ☐ Yes ***If yes, please complete the following questions related to the injury:***

- Date of the injury: _____/_____/_____
- Describe how the injury occurred: _____
- Was this disability caused by an incident that occurred while performing the duties of the patient's employment? ☐ No ☐ Yes
- Was this a motor vehicle accident in which the patient was the driver? ☐ No ☐ Yes (If yes, please submit a copy of the Police Report.)

Is treatment due to a sickness? ☐ No ☐ Yes ***If yes, please complete the following questions related to the sickness:***

- Symptoms first occurred on: _____/_____/_____
- First date of treatment for this condition: _____/_____/_____
- If diagnosed with cancer, date of initial diagnosis: _____/_____/_____
- Was the patient treated by any other physicians for this sickness or a related condition? ☐ No ☐ Yes
  - If yes, physician's name(s): _____
  - Phone Number(s): _____
  - Address: _____

American Family Life Assurance Company of Columbus (Aflac)
ATTN: Claims Department • 1932 Wynnton Road • Columbus, GA 31999
For information, call 1-800-99-AFLAC (1-800-992-3522) or visit aflac.com
To check claim status Aflac's Interactive Voice Response is available 24/7 at 1-877-353-9487 or visit aflac.com/smartclaim.
Claims may be faxed to 1-877-44-AFLAC (1-877-442-3522)

If you have additional bills or medical documentation that relates to this diagnosis other than the documentation defined, please submit them for review of additional benefits.

*Policy Number:

Policyholder Information:

*Last Name | Suffix | *First Name | MI

*Date of Birth (mm/dd/yy)

Patient Information:

*Last Name | *First Name | *Date of Birth (mm/dd/yy)

Pregnancy claims:

- Date of delivery: ____/_____/_____ ☐ Vaginal ☐ Cesarean
- If not delivered, expected delivery date: _____/_____/_____
- Please advise of any complications: _____

For all claims, please complete all remaining sections.

- Please provide the name, address and phone number of the patient's primary treating physician.
  Name: _____ Phone Number: _____
  Address: _____
- Was the patient confined to the hospital as a result of this condition? ☐ No ☐ Yes (If yes, please submit the itemized hospital bill, UB04, or HCFA 1500)
  Hospital Name: _____
  City: _____ State: _____
- Was the patient confined to the intensive care unit as a result of this condition? ☐ No ☐ Yes (If yes, please submit the itemized bill, UB04, or HCFA 1500.)
- Was the patient confined to a rehabilitation unit as a result of this condition? ☐ No ☐ Yes (If yes, please submit the itemized bill, UB04, or HCFA 1500.)
- Was patient treated in an emergency room as a result of this condition? ☐ No ☐ Yes (If yes, please submit the emergency room report, UB04, or HCFA 1500.)
  Hospital name: _____ Date of treatment: _____/_____/_____
- Was the patient transported by an ambulance as a result of this condition? ☐ No ☐ Yes (If yes, please submit the ambulance bill)
- Was surgery performed as a result of this condition? ☐ No ☐ Yes (If yes, please submit a copy of the operative report, UB04, or HCFA 1500.)
- Were medical imaging services (i.e. CT Scan, MRI, EEG, etc.) provided as a result of this condition? ☐ No ☐ Yes (If yes, please submit a copy of the exam report and/or billing, UB04, or HCFA 1500.)

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/PATIENT SIGNATURE | **FAMILY RELATIONSHIP, IF NOT POLICYHOLDER** | **DATE**

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