Accident/Hospital Indemnity Wellness Benefit Claim Form

Policy Number:

All Fields are required.

Policyholder Information:

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 permanent address change.*

Patient Information:

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

Sex: ☐ Male ☐ Female

Relationship: ☐ Primary Policyholder ☐ Spouse ☐ Dependent Child

Treatment and Physician Information

Treatment Date: M M D D Y Y Y Y

Mammogram Date: M M D D Y Y Y Y

Pap Smear Date: M M D D Y Y Y Y

☐ Annual Physical
☐ Ultrasound
☐ PSA (blood test for prostate cancer)
☐ Pap Smear
☐ Blood Screening
☐ Immunizations
☐ Eye Exam
☐ Mammogram
☐ Dental Exam
☐ Flexible Sigmoidoscopy

Physician's Phone Number:

Physician's Name

Physician's Street Address

Physician's City | State: | Zip:

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.

The Provider listed above is authorized to validate the information I have provided.

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

American Family Life Assurance Company of Columbus (Aflac)
ATTN: Claims Department • 1932 Wynnton Road • Columbus, GA 31999
For information or to check claim status, visit aflac.com or call 1-800-99-AFLAC (1-800-992-3522)
Claims may be faxed to 1-877-44-AFLAC (1-877-442-3522)