ACCIDENTAL INJURY CLAIM FORM

Thank you for trusting Aflac with your Accidental Injury 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

Accidental Injury Checklist

- Date of the injury: _____/_____/_____
- Describe how the injury occurred: _____
- Was this injury caused by an incident that occurred while performing the duties of his/her employment? ☐ No ☐ Yes
- Was injury a result of participating in an organized sporting activity? ☐ No ☐ Yes
  Type of Event_____ Sporting Organization_____
- 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.)
- Was death a result of this injury? ☐ No ☐ Yes (If yes, please submit the certified death certificate and the Life-Beneficiary's Statement.)
- Was the patient confined to the hospital as a result of this injury? ☐ No ☐ Yes (If yes, please submit the UB04 (Universal Billing 2004), itemized hospital bill, or HCFA 1500.)
- Hospital Name: _____
- City _____ State _____

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)

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)

- Was the patient transported by an ambulance as a result of this injury? ☐ No ☐ Yes (If yes, please submit the ambulance bill.)
- Was an aid in locomotion (mobility) prescribed as a result of this injury? (I.e. crutches, wheelchairs, leg braces, back braces, walkers, cervical collars, etc.) ☐ No ☐ Yes (If yes, please submit documentation from the prescribing provider, UB04 or HCFA 1500.)
- If any of the following were the result of your injury, please provide medical records, physician's office notes, or any bills received for these conditions that describe the diagnosis or type of treatment received:
  - Coma
  - Paralysis
  - Burn
  - Injury to the Eye
  - Laceration
  - Dislocation
  - Concussion (major diagnostic exam reports are acceptable)
  - Fractures (x-ray reports or major diagnostic exam reports are acceptable)
- Was surgery performed as a result of this injury? ☐ No ☐ Yes (If yes, please submit a copy of the operative report or detailed billing from the surgeon's office, such as UB04 or HCFA 1500.)
- Was a major diagnostic exam (i.e. CT Scan, MRI, MRA, EEG) performed as a result of this condition? ☐ No ☐ Yes (If yes, please submit a copy of the exam report, billing information, UB04 or HCFA 1500.)
- Dates of treatment related to injury (please submit supporting medical documentation for each visit indicated below):

Date	Provider Name	Provider Address	Provider Phone Number	Type of Treatment
				☐ Follow up ☐ Therapy *
				☐ Follow up ☐ Therapy *

* Some policies provide benefits for therapy including physical, speech, and occupational therapy. Not all types are available on all policies. Please submit information indicating date of treatment, treatment type, and who provided it to determine benefit.

- Transportation/Lodging Information: Please complete if you are filing a claim for transportation or lodging and please submit the hotel receipts and mileage information. For additional information, please refer to your policy language.

Date	To/From	Round-Trip Mileage

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.

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

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