Hospital Indemnity Claim Filing Instructions

Save Time and Paper - File Your Claim Online!

We offer two ways to file your hospital indemnity claim: online or by mail/fax.

How to File Online:

1. Login to your secured Online Service Center (OSC) account at www.americanfidelity.com/MyAccount.
2. From the "My Claims" tab, click "File a Claim" to get started.
3. Conveniently upload an itemized hospital billing with diagnosis or itemized hospital bill with discharge summary for each hospitalization.
4. Follow step-by-step instructions to complete your online claim filing process.
5. Check the status of your claim by selecting the "My Claims" tab at the top of the screen!

How to File by Mail or Fax:

1. Complete the Statement of Insured.
2. Complete the Authorization to Disclose Protected Health Information.
3. Attach copies of the itemized hospital bill with diagnosis or itemized hospital bill with discharge summary for each hospitalization.
4. Mail the completed forms to American Fidelity at the address listed above.
5. If you wish to fax your completed forms, please fax to 800-818-3453.

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. **This authorization applies to bene□ts payable under all insurance policies held with AFAC.**

Signature: _____

NOTE: You must attach a voided check to begin direct deposit.

All portions of this form package must be completed to avoid undue delay in processing claimant's request for bene□ts. If you have any questions regarding completion of this form please call:

REQUEST FOR

STATEMENT OF INSURED

A. ABOUT YOU

Insured's Last Name	First Name	Initial	Date of Birth	Account Number
			/ /	

Mailing Address (City, State, Zip)	Insured's Social Security Number

Employer-Name/Address	Home Telephone #

B. ABOUT THE PATIENT

PATIENT INFORMATION (CHECK ONE)

FOR WHOM DO YOU MAKE THIS REQUEST?

- ☒ SELF
- ☐ WIFE
- ☐ HUSBAND
- ☐ SON
- ☐ DAUGHTER
- ☐ OTHER_____ IDENTIFY

Patient's Name	Patient's Birth Date

Patient's Social Security No.

C. ABOUT THE CLAIM