CONTINUING DISABILITY CLAIM FORM

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

FILING CLAIM FOR (check all that apply):

☐ Disability due to an Accident ☐ Disability due to a Sickness ☐ Disability due to Pregnancy / Complications ☐ Disability due to Cancer

INSTRUCTIONS: Be sure to include your policy number(s) on all documents.

- ☐ Complete and sign Section A: Policyholder/Patient Information.
- ☐ Your employer should complete and sign Section B: Employer's Statement.
  If you are a contract, 1099, or self-employed worker, please submit your prior-year tax return (Schedule C) and current-year estimated tax payments (1040ES).
- ☐ Your physician should complete and sign Section C: Physician's Statement.
- ☐ If hospita

_ _

CLAIMANT SIGNATURE FAMILY RELATIONSHIP, IF NOT POLICYHOLDER DATE

CONTINUING DISABILITY CLAIM FORM - EMPLOYER'S STATEMENT

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

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.

Policy Number: Policyholder's Name:

Patient Name:_____ Date of Birth:_____

SECTION B: EMPLOYER'S STATEMENT

EMPLOYER'S NAME	PHONE NUMBER ( )	FAX NUMBER ( )	
MAILING ADDRESS	CITY	STATE	ZIP

1. First date of disability: _____ /_____ /_____
2. Has the policyholder returned to work? ☐ Yes ☐ No
   If yes, is the policyholder working ☐ Full-Time ☐ Part-Time
   If the policyholder is working part-time, date he or she began part-time: _____ /_____ /_____
   Date returned (or expected to return) to full-time duty: _____ /_____ /_____
3. Is the policyholder currently earning at least 80% of his or her predisability salary? ☐ Yes ☐ No
4. Is the person still employed? ☐ Yes ☐ No If no, last date of employment: _____ /_____ /_____

Please note:
The employer is required to report disability benefits paid on pre-tax plans on Form 941 and the employee's Form W-2.

EMPLOYER'S SIGNATURE | TITLE | DATE

EMPLOYER'S PRINTED NAME | DIRECT PHONE NUMBER

American Family Life Assurance Company of Columbus (Aflac)
Attn: Claims Department • Worldwide Headquarters • 1932 Wynnton Road • Columbus, GA 31999
For information or help filing your claim, please call toll-free or visit our Web site at aflac.com.
Toll-free fax number: 1.877.44.AFLAC (1.877.442.3522)

CONTINUING DISABILITY CLAIM FORM - PHYSICIAN'S STATEMENT

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

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.

Policy Number: Policyholder Name:

Patient Name:_____ Date of Birth:_____

SECTION C: PHYSICIAN'S STATEMENT (Must be completed by physician or physician's staff. If completed by a member of the physician's staff, then physician must sign the form)

PHYSICIAN'S NAME	PHONE NUMBER ( )	FAX NUMBER ( )	
MAILING ADDRESS	CITY	STATE	ZIP

1. First date of disability:_____ /_____ /_____
   Date patient was last treated: _____ /_____ /_____
2. If this is a pregnancy claim, date of delivery: _____ /_____ /_____ ☐ Vaginal ☐ Cesarean
   If not delivered, expected delivery date: _____/_____/_____
   Please advise of any complications. _____
   _____
3. Diagnosis Description and ICD code: _____
4. Was patient hospitalized as a result of this diagnosis? • ☐ Yes • ☐ No
   Admission: _____ /_____ /_____ Discharge: _____ /_____ /_____
   Hospital Name: _____ City: _____ State: _____
5. Have you released the patient to return to work? • ☐ Yes • ☐ No
6. If patient has not been released to return to work, please provide the next appointment date: _____ /_____ /_____
   Please also provide the date of expected release: _____ /_____ /_____.
7. If the patient has been released, please provide the date released: _____ /_____ /_____.
   Patient released to work: • ☐ Full-time • ☐ Part-time
   If part-time, please provide the date the patient is expected to return to full duty: _____ /_____ /_____.
8. If patient is not employed ful-time, which Activities of Daily Living (ADLs) is the patient unable to perform?
   Check and initial all that apply: ☐ Continence ☐ Transferring ☐ Dressing
   ☐ Bathing ☐ Toileting ☐ Eating
9. Does this patient require direct personal assistance to perform these ADLs each and every time? • ☐ Yes ☐ No
   If yes, how many days will the patient require direct personal assistance? _____

PHYSICIAN'S SIGNATURE DATE TAX ID NUMBER

American Family Life Assurance Company of Columbus (Aflac)
Attn: Claims Department • Worldwide Headquarters • 1932 Wynnton Road • Columbus, GA 31999
For information or help filing your claim, please call toll-free or visit our Web site at aflac.com.
Toll-free fax number: 1.877.44.AFLAC (1.877.442.3522)