

CONTINUING DISABILITY CLAIM FORM

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

FILING CLAIM FOR:

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

| | |
|-----------------------------------|--|
| Accident Policy Number | Short-Term Disability Policy Number |
| | |

INSTRUCTIONS:

- ◆ Complete **Section A: Policyholder/Patient Information**.
- ◆ Your doctor should complete and sign Section B: Physician's Disability Statement.
- ◆ Your employer should complete and sign Section C: Employer's Disability Statement.
- ◆ Be sure to sign your claim form at the bottom of Page 1.

SECTION A: POLICYHOLDER/PATIENT INFORMATION

| POLICYHOLDER'S INFORMATION | | |
|---|--|--|
| LAST | FIRST | INITIAL |
| SOCIAL SECURITY NUMBER (optional) | BIRTHDATE | PHONE NUMBER () |
| ADDRESS | | CHECK BOX IF THIS IS A NEW PERMANENT ADDRESS } <input type="checkbox"/> |
| CITY | STATE | ZIP |
| PLACE OF EMPLOYMENT: | | PHONE NUMBER () |
| ADDRESS | | |
| CITY | STATE | ZIP |
| PATIENT'S INFORMATION | | |
| LAST | FIRST | INITIAL |
| SOCIAL SECURITY NUMBER (optional) | BIRTHDATE | |
| <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> OTHER | RELATIONSHIP: <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> DEPENDANT – CHECK IF CHILD IS FULL-TIME STUDENT <input type="checkbox"/> | |

Date of incident: ____/____/____ Describe where and how the incident occurred: _____

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.

CLAIMANT SIGNATURE

FAMILY RELATIONSHIP, IF NOT POLICYHOLDER

DATE

American Family Life Assurance Company of Columbus (Aflac)

Attention: Claims Department

Worldwide Headquarters: 1932 Wynnton Road, Columbus, GA 31999

For information or help filing your claim, please call toll-free 1-800-99-Aflac (1-800-992-3522) or visit our Web site at www.aflac.com

Toll-free fax number 1-877-44-Aflac (1-877-442-3522)

CONTINUING DISABILITY – PHYSICIAN'S DISABILITY STATEMENT

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

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SECTION B: PHYSICIAN'S DISABILITY STATEMENT Must be completed by physician or physician's staff.

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

1. First date of disability: ____/____/____ First date out of work: ____/____/____ Last date of treatment: ____/____/____
2. Pregnancy claims: Date of delivery: ____/____/____ Vaginal Cesarean If not delivered, expected delivery date: ____/____/____
Please advise of any complications: _____
3. Was patient hospitalized as a result of this diagnosis? Yes No Admission: ____/____/____ Discharge: ____/____/____
Hospital Name: _____ City: _____ State: _____
4. Is patient currently working: full-time? part-time? light duty? Date patient was released to return to work: ____/____/____
5. If patient has not been released to return to work or if patient is working light duty, please provide the next appointment date: ____/____/____
6. If patient is not employed, or employed less than 30 hours, which Activities of Daily Living (ADLs) is patient unable to perform?
Check and initial all that apply: Continence Transferring Dressing Toileting Eating Bathing

PHYSICIAN'S SIGNATURE

DATE

TAX ID NUMBER

SECTION C: EMPLOYER'S DISABILITY STATEMENT Please complete if filing for disability.

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

1. Date of Hire: ____/____/____ First date of disability: ____/____/____
2. Is the person still employed? Yes No If no, last date of employment: ____/____/____
3. Prior to this disability, number of hours worked per week: _____ Annual Base Salary (prior to disability): \$ _____
4. Was this disability caused by an accident that occurred at the workplace? Yes No
5. Has employee returned to work? Yes No If yes, is employee working full-time? part-time? light duty?
6. Date employee began light duty: ____/____/____ Date returned (or expected to return) to Full-Time Duty: ____/____/____
7. Is the employee currently earning at least 80% of their pre-disability salary? Yes No
8. Does the employee pay Accident Disability Rider or Short-Term Disability premiums with pre-tax dollars? Rider Short-Term Disability
9. Does employer pay a portion of the disability premium for the employee? Yes No If yes, what percent? _____ %
10. Employee is: (Check all that apply) exempt from Social Security exempt from Medicare subject to RRTA

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

EMPLOYER'S SIGNATURE

TITLE

DATE

American Family Life Assurance Company of Columbus (Aflac)
Attention: Claims Department

Worldwide Headquarters: 1932 Wynnton Road, Columbus, GA 31999

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