

# Cancer Claim Filing Instructions

**Save Time and Paper – File Your Claim Online!**

## **How to File Online:**

1. Login to your secured Online Service Center (OSC) account at [www.americanfidelity.com/MyAccount](http://www.americanfidelity.com/MyAccount).
2. From the “My Claims” tab, click “File a Claim” to get started.
3. Conveniently upload the following documentation:
  - a. Itemized bills from each of your providers, with a complete breakdown of charges for each date of service.
  - b. If the Special Instructions (below) apply, upload copies of the Explanation of Benefits (EOB) from your primary medical coverage for each corresponding itemized bill.
  - c. If this is the first claim submitted for a new cancer diagnosis, upload the initial pathology report in which cancer was diagnosed. Your oncologist or primary treating physician can furnish a copy of this report.
4. Follow the 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 Authorization to Disclose Protected Health Information and the Statement of Insured.
2. Attach the following documentation:
  - a. Itemized bills from each of your providers, with a complete breakdown of charges for each date of service.
  - b. If the Special Instructions (below) apply, attach copies of the Explanation of Benefits (EOB) from your primary medical coverage for each corresponding itemized bill.
  - c. If this is the first claim submitted for a new cancer diagnosis, attach the initial pathology report in which cancer was diagnosed. Your oncologist or primary treating physician can furnish a copy of this report.
3. Mail the completed forms and documentation to American Fidelity at the address listed below.
4. If you wish to fax your completed forms, please fax to 800-818-3453.

Special Instructions for Customers who live in the states of GA, OK, SC or TX or who are covered under our C3, C4, C5 or C11 cancer policies (please see bottom left corner of your policy).

1. If your cancer policy is one of our C3, C4 or C5 policies, you must also attach the Explanation of Benefits (EOB) from your primary medical coverage that corresponds to each itemized bill.
2. If you live in the states of GA, OK, SC or TX and your cancer policy is one of our C3, C4, C5, C6, C7, C8 or C9 policies, you must also attach the Explanation of Benefits (EOB) from your primary medical coverage that corresponds to each itemized bill.
3. If you live in the states of GA, OK, SC or TX and you are filing for ICU benefits on any of our cancer policies, you must also attach the Explanation of Benefits (EOB) from your primary medical coverage that corresponds to each itemized bill.
4. If your cancer policy is one of our C11 policies and you are filing for chemotherapy, immunotherapy or radiation benefits, you must also attach the Explanation of Benefits (EOB) from your primary medical coverage that corresponds to each itemized bill.

Whether completing this claim online or with the below packet, all portions must be completed to avoid undue delay in processing your request for benefits. If you have any questions regarding completion of your claim, please call:

**Toll Free: 800-662-1113 | Local: 405-523-5025**



Our Family, Dedicated To Yours.®

Educational Services Division  
Benefits Department  
P.O. Box 25160  
Oklahoma City, Oklahoma 73125-0160  
[www.americanfidelity.com](http://www.americanfidelity.com)

## AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize the entities specified below to disclose any information about me or my dependents' health including my or my dependents' entire medical record and history of treatment for physical and/or emotional illness to include psychological testing, except psychotherapy notes, to individuals representing American Fidelity Assurance Company (AFAC) who are involved in determining whether I am eligible for benefits under my insurance coverage. Those so authorized are: a) licensed physicians or medical practitioners; b) hospitals, clinics or medically-related facilities; c) health plans; d) Veteran's Administration; e) past or present employers; f) pharmacy; g) insurance companies; h) the Social Security Administration; i) retirement systems; j) Department of Motor Vehicles, and k) Workers' Compensation Carrier. Colorado state law prohibits the redisclosure or reuse of information disclosed about a Colorado resident under this authorization.

**NOTICE:** Information authorized for release may include information on communicable or venereal diseases such as hepatitis, syphilis, gonorrhea, HIV/AIDS (Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome) or other conditions for which you may have been treated. For Maine residents, information authorized for release may include information on communicable or venereal diseases such as hepatitis, syphilis, gonorrhea, AIDS/ARC (Acquired Immune Deficiency Syndrome /AIDS Related Complex) or other conditions for which you may have been treated. This authorization excludes disclosure of the result of a test for HIV if you have tested HIV positive but have not developed symptoms of the disease AIDS. Such test results shall not be discovered or published. Nothing in this caveat will prohibit this authorization from including the fact that you have AIDS. For Vermont residents, this authorization does not require disclosure of prior HIV-related tests. For Wisconsin residents, results of AIDS/HIV test do not need to be reported if they were done at any anonymous counseling and testing site, if the test was not an FDA-licensed blood test, or through the use of a home test kit. For Arizona residents, release of HIV/AIDS-related information can only be disclosed for a period not to exceed 180 days from the date shown below.

**I understand that I may refuse to sign this authorization; however, if I do not sign the authorization, my failure to sign the authorization may result in a denial or a delay of benefits.** I understand that I may revoke this authorization at any time by writing to AFES Benefits Department, PO Box 25160, Oklahoma City, OK 73125-0160 or by calling, toll-free, 1-800-662-1113. I understand that my right to revoke this authorization is limited to the extent that: AFAC has taken action in reliance on the authorization; or, the law provides AFAC with the right to contest my insurance coverage or a claim under my insurance coverage. A copy of this authorization will be as valid as the original.

I understand that if protected health information is disclosed to a person or organization that is not required to comply with federal privacy regulations, the information may be redisclosed and no longer protected by the federal privacy regulations.

For health insurance coverage this authorization will expire twenty-four months from the date it is signed or upon termination of my insurance policy, whichever occurs first. For insurance coverage other than health insurance, this authorization will expire twenty-four months from the date it is signed or upon expiration of my claim for benefits, whichever occurs first.

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AFA Account#

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Printed Name of Patient

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Patient's Date of Birth

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Signature (Patient) or Personal Representative (if applicable)

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Date Signed

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Relationship of Personal Representative to Patient (If Applicable)

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*If authorization is supplied by a personal representative, a description of the authority to act on behalf of the Insured must be included.*

Warning: Any person who knowingly and with intent to injure, defraud, or deceive an insurer files a statement of claim containing any false, incomplete, or misleading information may be guilty of insurance fraud and subject to criminal and civil penalties. **California** - For your protection, California law requires the following to appear on this form: **Any person who knowingly presents 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. AR, DC, LA, NJ, NM, TX, and WV** - ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON. **DE, ID, IN, MN, OH, and OK** - **WARNING:** Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony. **Colorado** - It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies. **New Hampshire** - Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20. **Kentucky** - Any person who knowingly and with intent to defraud any insurance company or other person files a 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. **Oregon** - Any person who knowingly and with intent to defraud or solicit another to defraud an insurer: (1) by submitting an application, or (2) by filing a claim containing a false statement as to any material fact, may be guilty of insurance fraud. **Pennsylvania** - 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. **Arizona** - For your protection, Arizona law requires the following statement to appear on this form: **Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties. Florida** - Any person who knowingly, and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree. **Hawaii** - For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both. **Alabama** - Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof. **Maryland** - Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**Please retain a copy for your personal records, or you may request a copy from our Company.**

REQUEST FOR INDIVIDUAL  
CANCER, INTENSIVE  
CARE OR DREAD DISEASE  
BENEFITS



Our Family, Dedicated To Yours.®

ATTN: AFES BENEFITS DEPT.  
P.O. Box 25160  
Oklahoma City, Oklahoma 73125  
Toll Free: 1-800-662-1113  
Fax: 1-800-818-3453  
www.americanfidelity.com

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				Home Telephone # (     )
B. ABOUT THE PATIENT	If claim is for dependent, give name of dependent		Relationship:	Dependent Date of Birth:	
C. ABOUT CLAIM	Is this claim for <input type="checkbox"/> Cancer Benefits <input type="checkbox"/> Intensive Care Benefits <input type="checkbox"/> Dread Disease Benefits <input type="checkbox"/> Heart Attack/Stroke Benefits				
	Diagnosis/Condition			Date First Treated	
D. DIRECT DEPOSIT AUTH.	<p>Please complete if you desire benefits deposited directly into your bank account.</p> <p>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. <b>This authorization applies to benefits payable under all insurance policies held with AFAC.</b></p> <p>Signature: _____</p> <p><b>NOTE: You must attach a voided check to begin direct deposit.</b></p>				

Signature

Date

I verify this information is true and correct.

