AMERICAN FIDELITY
a different opinion

American Fidelity Assurance Company | Mail to: Worksite Group Benefits Department
P.O. Box 25160 | Oklahoma City, Oklahoma | 73125-0160
Toll Free Phone # 1-800-662-1113
Toll Free Fax # 1-800-818-3453
americanfidelity.com

Life Benefit Department Waiver of Premium Benefit

Attending Physicians Statement

Name of Patient:	SSN:	Account Number:
Date of Birth:	ICD Code:	
Diagnosis: (including complications)		
Subjective Symptoms:		
Objective Findings: (Give report of x-rays, E.K.G.s, or any other special tests)		
Is Insured: ❒ Ambulatory ❒ Bed Confined ❒ House Confined ❒ Hospital Confined		
Frequency of treatment: ❒ Monthly ❒Weekly ❒ Other	If not under your regular care and attendance please explain.	
Nature of treatment being rendered (including surgery and any medications being prescribed) and the current treatment plan:		
Has the patient been confined to a hospital? ❒ Yes ❒ No If yes, give admit and discharge dates along with name and address of hospital.	Admitted: / / Discharged: / / Admitted: / / Discharged: / /	
Name:	Address:	
Date total disability began.	From: / /	Through: / /
Disabled from: Patient's Job ❒ Yes ❒ No	Any other work ❒ Yes ❒ No	
What duties of patient's job is he/she incapable of performing?		
If the patient if currently disabled what is the anticipated length of disability: ❒ 1-2 Months ❒ 2-3 Months ❒ 3-6 Months ❒ 6-12 Months ❒ More than 12 Months ❒ Permanent		
When, in your opinion will the patient recover sufficiently to return to work?		

IMPAIRMENTS

What are the disabling impairments that prevent the patient from working?	❒ 1-2 Months
❒ Class 1 - No limitation of functional capacity, capable of heavy work. No Restrictions *(0-10%)	❒ 2-3 Months
❒ Class 2 - Medium manual activity *(15-30%)	❒ 3-6 Months
❒ Class 3 - Slight limitation of functional capacity; capable of light work activity *(35-55%)	❒ 6-12 Months
❒ Class 4 - Moderate limitation of functional capacity; capable of clerical/administrative sedentary activity. *(60-70%)	❒ Greater than 12 Months
❒ Class 5 - Severe limitation of functional capacity: Incapable of minimum sedentary activity *(75-100%)	❒ Permanent

PHYSICIAN INFORMATION

Attending Physician's Name & Title: (print)	Specialty:	
Phone:	Fax:	
Mailing Address: (P.O. Box or Street, City, State and Zip Code)		
Form Completed By: (Name & Title)	Signature:	Date: / /

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Statement of Insured

Full Name: (last, first, middle initial)	Date of Birth: / /
Social Security Number: / /	Account Number:
Mailing Address: (P.O. Box or street, city and zip code)	
Telephone Number (including area code):	Email Address:
Occupation:	
Date illness or accident began:	
If accident, explain how and where it happened:	
Have you ever had the same or similar condition in the past? ❒ Yes ❒ No If yes, list names and addresses of treating physicians?	
Nature and cause of disability (please be as detailed as possible):	
Provide all current treating physicians' full name(s) and contact information (attach additional list if necessary): Physician's Full Name(s): _____ Physician's Phone Number(s):_____ Physician's Full Name(s): _____ Physician's Phone Number(s):_____	
If hospital confined, please provide: Hospital(s): _____ Admitted: _____ Discharged: _____ Hospital(s): _____ Admitted: _____ Discharged: _____	
Are you currently receiving Social Security disability? ❒ Yes ❒ No If not, have you applied? ❒ Yes ❒ No If benefits were denied, please advise date of last denial: / / Are you receiving benefits from any other source due to disability? ❒ Yes ❒ No	
I certify this information is true and correct. Signature:	Date:

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AUTHORIZATION TO DISCLOSE INFORMATION INCLUDING PROTECTED HEALTH INFORMATION

The purpose of this form is to allow American Fidelity Assurance Company (AF) to obtain data including but not limited to employment information, financial information, and protected health information about me, from any party holding that information. Once obtained, AF may use this data to review or process benefits, confirm policy information, or otherwise review or process information related to my Customer relationship with them.

I hereby authorize the entities specified below to disclose any information about me or my dependents' health or financial situation 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 AF 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, k) banks or financial institutions and l) 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.

I understand that AF may not condition payment of claims, enrollment, or eligibility for benefits on whether I sign this authorization. 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 an inability to pay benefits under my policy if my failure to sign results in AF not having enough information to process my benefits. I understand that I may revoke this authorization at any time by writing to American Fidelity Assurance Company, 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: AF has taken action in reliance on the authorization; or, the law provides AF 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. In addition to the types of information described above, I also authorize American Fidelity to access any other type of information deemed necessary to investigate my claim. This information includes but is not limited to financial information, information submitted or related to insurance claim(s) or insurance coverage(s) and employment records. Any party holding this information is hereby authorized to release it to American Fidelity.

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.

AF Account# _____ Printed Name of Patient _____ Patient's Date of Birth _____

Signature (Patient) or Personal Representative (if applicable) _____ Date Signed _____

Relationship of Personal Representative to Patient (if applicable) _____

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

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