REQUEST FOR ACCIDENT ONLY POLICY BENEFITS

American Fidelity Assurance Company
A member of the American Fidelity Group

ATTN: AFES BENEFITS DEPT.
P.O. Box 25160
Oklahoma City, Oklahoma 73125
1-800-662-1113 Local 523-5025
Fax No: 1-800-818-3453
www.afadvantage.com

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 may be guilty of insurance fraud and subject to criminal and civil penalties.

CLAIM FILING INSTRUCTIONS

CLAIM PROCESSING:
FOR MEDICAL EXPENSE BENEFITS:
1. Complete all questions on the front of this form.
2. Include a copy of the itemized bill.

FOR DISABILITY BENEFITS
1. Complete the Statement of Insured section on the front and back of this form, answering all questions in full.
2. Have your Employer complete the Statement of Employer section on the back of this form, answering all questions in full.
3. Have your physician complete the Attending Physician's Statement on the back of this form.
4. Fax or mail the completed claim form.

STATEMENT OF INSURED

A. ABOUT YOU

INSURED'S LAST NAME	First Name	Initial	Date of Birth	ACCOUNT NUMBER

Address (City, State, Zip)	Insured's Social Security Number
Employer - Name	**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.

If Claim is for a Dependent Child Under 21, is Such Child Living in Your Household? ☐ Yes ☐ No

If Dependent Child is between age 21 and 25 years old is (s)he a full-time student? ☐ Yes ☐ No

C. ABOUT THE ACCIDENT

Did the accident result from employment?_____Yes _____No

If yes, are you filing or will you be filing for Workers' Compensation?_____Yes _____No

How, when, and where did the accident occur?

Were you transported to an emergency center or hospital by ambulance? _____Yes _____No

Were you hospital confined due to this accident? _____Yes _____No

If yes, give admit and discharge dates, and name and address of hospital. admitted___/___/___ discharged___/___/___.

Are you making a claim under your Disability benefit? _____Yes _____No **IF YES, COMPLETE THE BACK OF THIS FORM.**

E. ABOUT THE INFORMATION RELEASE

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize the entities specified below to disclose any information about my 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 medic 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.

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. 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.

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.

Signature (Patient) or Personal Representative (if applicable)

Printed Name (Patient)

Relationship of Personal Representative to Patient

Date

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 MY REQUEST A COPY FROM OUR COMPANY.

ONLY COMPLETE FOR DISABILITY BENEFITS

INSURED STATEMENT

1. Last date worked: _____
2. Dates you were totally disabled: From_____ Thru _____
3. On what date did you return to work? Part time_____ Full Time _____
4. If you have not yet returned to work, when do you anticipate returning to work? _____

ATTENDING PHYSICIAN'S STATEMENT

1. Diagnosis and concurrent condition ICDA Code_____
   (If diagnosis code other then ICDA* used, give name)

2. Is condition due to injury arising out of patient's employment? _____Yes _____No

3. Date of services since disability commenced, not previously reported: _____ _____ _____	4. If patient hospitalized, give name and address of hospital and dates: Name of hospital: _____ Address of hospital: _____ Admitted _____/_____/_____ Discharged _____/_____/_____
5. Date accident happened:	6. Date patient first consulted you for this condition:
7. Has patient ever had same or similar condition? _____ Yes _____No If yes, when and describe.	8. Is patient still under your care for this condition? _____Yes _____No
9. Patient was continuously and totally disabled? (unable to work) From Through	10. Patient was partially disabled? From Through
11. If still disabled, date patient should be able to return to work.	12. Was there a referring physician? _____ Yes _____ No If so, what is his name and address?

Date	Physician's Name (Print)	Signature	Degree	Fax	Telephone

Street	City and State	Zip Code	Tax Identification #

STATEMENT OF EMPLOYER

Company Name	Phone No.
Name of Employee	What percentage of the employees premium is paid by the employer? ___%
Employee's Title ☐ Weekly Salary $ _____ ☐ Monthly Salary $ _____ ☐ Annual Salary (if commissioned) $_____	Are the employee paid premiums for this policy withheld before or after taxes? Before ☐ After ☐
Is this loss a result of employment? ____Yes ____No	Has the employee made claim for or is he entitled to Workers' Compensation? _____Yes _____No
Date employee last worked / /	Date returned to work / /
Give final date of paid sick leave to which employee is entitled / /	

At the time of this disability was the employee ☐ Full Time ☐ Part Time ☐ On Leave ☐ Retired ☐ No Longer Employed (Check One)?
Is employee eligible for any other paid compensation? ___Yes ___No If yes, explain what type of benefit this is: Monthly Benefit _____
Period eligible _____

_____ _____
(Signature of Employer Representative) (Date Signed)