American Fidelity Assurance Company
A member of the American Fidelity Group

www.afadvantage.com
American Fidelity Assurance Company
Mail to: AFES Benefits Department
P.O. Box 25160
Oklahoma City, OK 73125-0160
Local Phone # (405) 523-5025
Toll Free Phone # 1-800-662-1113
Toll Free Fax # 1-800-818-3453

Routine Pregnancy- Do not use this form for other than routine child birth.

SECTION 1: EMPLOYEE'S DISABILITY BENEFITS APPLICATION

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.

Full Name: (last, first, middle initial) | Maiden Name | Account Number:

Social Security Number: - - | Date of Birth: / / | Telephone Number: (including area code) ( )

Mailing Address: (P.O. Box or street, city and zip code)

1. Full names and addresses of all treating physicians: (attach additional list if necessary)
_____
_____
_____

2. If hospitalized, give full name(s) and addresses of hospitals: (attach additional list if necessary)
Admit Date / Discharge Date / /
Name(s) _____
Addresses _____

3. On what date did you last work?_____
Dates of total disability:
From _____ Thru _____
On what date did you return to work?
If not returned to work, when do you anticipate returning to work?_____

4. Please complete if you desire benefits deposited directly into your bank account.
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.
Bank/Credit Union Name: _____
Signature: _____
NOTE: You must attach a voided check to begin direct deposit.

5. If your request for benefits is approved do you want us to withhold Federal Taxes from each benefit check? ❒ Yes ❒ No
If yes, amount: $ _____ (indicate amount per month $86.00 minimum)

6. Are you receiving or eligible to receive other income during this period of disability? ❒ Yes ❒ No $ _____ Month
Sick Leave or Wage Continuation: ❒ Yes ❒ No $ _____ Month
Other Disability Coverage: ❒ Yes ❒ No $ _____ Month

AUTHORIZATION TO USE OR 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 physcial 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 practicioners; 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 veneral diseases such as hepatitis, syphillis, gonorrhea, HIV/AIDS (Human Immunodeficicency 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 on the disease AIDS. Such test results shall not be discovered or published. Nothing in the 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 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 organziation 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 may request a copy from our company.

SECTION 2: EMPLOYER'S REPORT OF CLAIM

Name of Employer: | Phone No.: ( ) | Fax No.: ( )

Mailing Address: (include street, city, state and zip code)

Name of Employee: | Social Security Number:

Does employee participate in Social Security? ❑ Yes ❑ No If no, hired after 4/1/86? ❑ Yes ❑ No
Please furnish the percentage of the employee's AFA disability premium you pay: _____% Are the AFA disability premiums withheld before or after taxes? ❑ Before ❑ After

SALARY AT TIME OF DISABILITY ❑ 9 ❑ 10 ❑ 12 Month Work Schedule
Annual: $ _____ Effective Date: _____
(for educators) Number of Contract days: _____ for _____ school year.

Date employee last worked:_____ Has employee returned to work? ❑ Yes ❑ No If Yes, date returned to work: Full Time: _____

I hereby certify that the above named employee is a member of our Group Disability Program. The Information stated above is correct to the best of my knowledge and belief.
Authorized signature of employer firm or authorized official: _____
Title: _____ Date: _____

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SECTION 3: ATTENDING PHYSICIAN'S STATEMENT

Name of Patient: Date of Birth:

DIAGNOSIS

Diagnosis: ICDA Code:

Type of delivery: _____

Date pregnancy was diagnosed? ____/____/____

Date of delivery:(if delivered) ___/___/____

HISTORY

When did symptoms first appear? ____/____/____

Date patient first consulted you for this condition?____/____/____

Was the patient referred to you? ❒ Yes ❒ No If yes, full name and address of referring physician: _____

_____

_____

TREATMENT

Has the patient been confined to a hospital? ❒ Yes ❒ No

Admitted: _____/_____/_____ Discharged: _____/_____/_____

If yes, give admit and discharge dates along with name and address of hospital.

Name: _____

Address:_____

PROGNOSIS

Dates of total disability: (unable to work) From: _____ Through: _____

Attending Physician's Name: (print) | Degree: | Telephone #: ( ) - | Fax #: ( ) -

Street Address: | City: | State: | Zip Code:

Signature: | Federal Tax ID #: | Date: