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

STATEMENT OF INSURED To be completed by Employee.

Full Name: (last, first, middle initial)	Account Number:
Mailing Address: (P.O. Box or street, city and zip code)	
Employer:	Date of Birth:
Email Address:	
Telephone Number: (including area code)	Social Security Number:
For whom do you make this request? (check one) ☐ Self ☐ Spouse ☐ Child ☐ Other	
Patient Name:	Patient Birth Date: Patient Social Security Number:

Select the benefit for which claim is being made (refer to policy for available coverage):

☐ Coma	☐ End Stage Renal Failure	☐ Major Burns	☐ Stroke
☐ Coronary Angioplasty	☐ Heart Attack (Myocardial Infarction)	☐ Major Organ Failure	☐ Paralysis
☐ Coronary Bypass Surgery		☐ Occupational HIV or Hepatitis B,C,D	

Optional Rider Benefits:

☐ Cancer ☐ Sudden death due to cardiac arrest ☐ Hospital Confinement

Date first treated:	
Have you ever had a similar condition? ☐ Yes ☐ No	If yes, when?

STATEMENT OF ATTENDING PHYSICIAN To be completed by Physician.

Please complete the appropriate section for each condition that the patient has been diagnosed.

CANCER

Does the patient have cancer? ☐ Yes ☐ No	Type of cancer: Date cancer diagnosed:
Stage of Cancer:	Is this an In Situ Cancer? ☐ Yes ☐ No

COMA

Is the patient in a comatose state? ☐ Yes ☐ No	Was the coma medically induced? ☐ Yes ☐ No
Date the coma was diagnosed based on documented neurological dysfunction and prolonged unresponsiveness:	
What caused the coma:	
Did the patient's coma produce severe neurological dysfunction and unresponsiveness persisting for more than 14 days? ☐ Yes ☐ No	

CORONARY ANGIOPLASTY

Does the patient have coronary artery disease? ☐ Yes ☐ No	Date Coronary Artery Disease was diagnosed:
Date Coronary Angioplasty was recommended:	Date Coronary Angioplasty occurred:

CORONARY BYPASS SURGERY

Does the patient have coronary artery disease? ☐ Yes ☐ No	Date Coronary Artery Disease was diagnosed:
Date Coronary Bypass Surgery was recommended:	Date surgery occurred:

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

STATEMENT OF ATTENDING PHYSICIAN, CONTINUED

END STAGE RENAL FAILURE

Does the patient have End Stage Renal Failure presenting as chronic, irreversible failure to function of both kidneys? ☐ Yes ☐ No	Does the patient's kidney failure necessitate regular peritoneal or hemodialysis (at least weekly) or kidney transplantation? ☐ Yes ☐ No
Date of recommendation for patient to begin renal dialysis or kidney transplant:	
What is the cause for patient's End Stage Renal Disease:	
Date patient was first treated for signs or symptoms of this condition:	

HEART ATTACK (MYOCARDIAL INFARCTION)

Are new and serial electrocardiographic (EKG) findings consistent with Myocardial Infarction? ☐ Yes ☐ No If yes, attach a copy of the EKG.	
Were cardiac enzymes elevated above generally accepted laboratory levels of normal for creatine physphokinase (CPK)? ☐ Yes ☐ No	Did diagnostic studies confirm a Myocardial Infarction and the occlusion of one or more coronary arteries? ☐ Yes ☐ No
Did the patient have symptoms consistent with Myocardial Infarction? ☐ Yes ☐ No	What symptoms?
Date the patient was diagnosed with a Myocardial Infarction:	

MAJOR BURNS

Date the burns occurred:	Percentage of body surface covered by the burns: %
Degree of the burns: ☐ 1st degree ☐ 2nd degree ☐ 3rd degree ☐ 4th degree	

MAJOR ORGAN FAILURE

Has the patient been placed on the UNOS (United Network for Organ Sharing) list, requiring transplantation of any of the following: ☐ heart ☐ liver ☐ lung ☐ entire pancreas	
Date patient was placed on UNOS list:	
What condition caused the need for transplant?	Date patient first treated for signs or symptoms of this condition:

OCCUPATIONAL HIV or OCCUPATIONAL HEPATITIS B, C, D

Is the claim for: ☐ Occupational HIV – or – Hepatitis ☐ B ☐ C ☐ D	
Date patient positively diagnosed:	
Date the of accidental exposure to HIV or Hepatitis B/C/D-contaminated body fluids:	
Did the accidental exposure occur during the normal course of duties of the occupation? ☐ Yes ☐ No	
Has the patient previously tested positive for HIV or Hepatitis B/C/D? ☐ Yes ☐ No	If yes, give date:
What event caused the HIV or Hepatitis B/C/D?	
Was a preliminary screening test performed within 14 days of the accidental exposure? ☐ Yes ☐ No	Date of the test:
Was a subsequent screening test performed within 26 weeks of the accidental exposure? ☐ Yes ☐ No	Date of the test:
Were all HIV or Hepatitis B/C/D tests blood tests approved by the FDA? ☐ Yes ☐ No	If Yes, provide name of test:
Were all HIV or Hepatitis B/C/D tests performed by a state certified, licensed laboratory? ☐ Yes ☐ No	

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

STATEMENT OF ATTENDING PHYSICIAN, CONTINUED

PERMANENT DAMAGE DUE TO A STROKE

Did the patient have a stroke? ☐ Yes ☐ No
For how many days did the patient's stroke produce persisting neurological deficits?
Date stroke occurred based on documented neurological deficits and neuroimaging or other neurodiagnostic study:

PERMANENT PARALYSIS DUE TO A COVERED ACCIDENT

Has the patient experienced permanent paralysis due to injuries to the spinal cord resulting in paraplegia or quadriplegia persist-ing for a period of 90 consecutive days or more? ☐ Yes ☐ No
Is paralysis expected to be permanent in nature? ☐ Yes ☐ No
Date patient first diagnosed with permanent paralysis:
What event resulted in paralysis:
Date patient first treated for signs or symptoms of this condition:

SUDDEN DEATH DUE TO CARDIAC ARREST

Date the Cardiac Arrest occurred:	Date of the patient's Death:
What condition resulted in the Cardiac Arrest:	

HOSPITAL CONFINEMENT

Was the patient or is the patient currently hospitalized? ☐ Yes ☐ No	Diagnosis:
Dates the patient was hospitalized: From: To:	
Name and address of the hospital:	

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 and title):	Signature:
Date:	