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

Critical Illness Claim Filing Instructions

Account Number:

Faster, Easier Online Claim Filing Instructions

Reduce your claim processing time and receive your money faster when you file online or through AFmobile®.

Two Easy Ways to Register

Online at **americanfidelity.com**

Download AFmobile from the **Apple App Store** or **Google Play**

Through your online or mobile account, you can file your claim, check claim status, sign up for notifications, update personal information, enroll in direct deposit, view your detailed policy, and much more!

SB-32082-1117

Stop here! If you want to receive your **money faster**, register your account and **file online** or through our mobile app.

Claim Filing Instructions for Mail or Fax:

This is not the quickest option! However, if you choose to file a paper claim by mail or fax, please complete this packet in full to avoid delays in your claim processing.

1. **Complete the Statement of Insured.**
2. **Complete the Authorization to Disclose Protected Health Information.**
3. **Have your treating physician complete the Attending Physician Statement.**
4. **Please attach copies of all office notes or medical records from the date you were first treated for symptoms associated with the condition up to the present. Please refer to your policy for available coverage.**
5. **Mail or fax the completed forms to American Fidelity at the address or fax number listed above.**

To receive updates on the on the status of your processed or paid claims, visit **americanfidelity.com/myaccount** and select your communication preferences. Or, you may contact us at the number atop this form with questions regarding your claim.

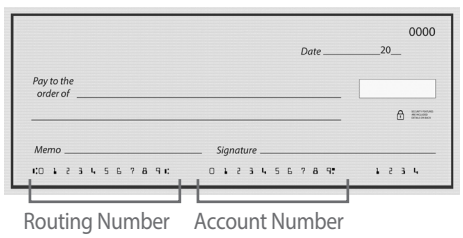
Your Money Direct, Your Money Faster. Enroll in Direct Deposit.

To set up direct deposit with American Fidelity, provide all required information below with your submitted claim. You may also enroll in direct deposit through your online account.

I authorize American Fidelity Assurance Company (AFA) to initiate credit entries to my account as indicated. I also authorize AFA to debit my account for any deposits made in error. This authorization remains effective and in full force until AFA receives written notification from me of its termination in such time and in such manner as to afford AFA and the Depository a reasonable opportunity to act on it. Please notify AFA immediately if your depository information has changed.

Signature: _____

You must provide the following information:
Routing Number: _____
Account Number: _____



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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:

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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	

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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:	

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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.

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Claim Form Fraud Statements

The following fraud language is attached to, and made part of, this claim form. **Please read and do not remove this page from this claim form.**

If you live in a jurisdiction not mentioned below, the following applies to you: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit is guilty of a crime and may be subject to fines and confinement in prison.

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.

Alaska - A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

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.

Arkansas, District of Columbia, Louisiana, Rhode Island and West Virginia - 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.

California and Texas - For your protection California and Texas 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.

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.

Delaware, Idaho and Oklahoma - WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

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.

Indiana - A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

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.

Maine, Tennessee, Virginia and Washington - It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

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.

Minnesota - A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

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.

New Jersey - Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New Mexico - 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 CIVIL FINES AND CRIMINAL PENALTIES.

Ohio - Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is 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.

Puerto Rico - Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances [be] present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.