

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? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No \$ _____ Month Sick Leave or Wage Continuation: <input type="checkbox"/> Yes <input type="checkbox"/> No \$ _____ Month Other Disability Coverage: <input type="checkbox"/> Yes <input type="checkbox"/> 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 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 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; 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 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 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 <i>If authorization is supplied by a personal representative a description of the authority to act on behalf of the Insured must be included.</i>		Date	
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? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, hired after 4/1/86? <input type="checkbox"/> Yes <input type="checkbox"/> No Please furnish the percentage of the employee's AFA disability premium you pay: _____% Are the AFA disability premiums withheld before or after taxes? <input type="checkbox"/> Before <input type="checkbox"/> After		
SALARY AT TIME OF DISABILITY <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/> 12 Month Work Schedule		
Annual: \$ _____ (for educators)	Effective Date: _____	Number of Contract days: _____ for _____ school year.
Date employee last worked: _____ Has employee returned to work? <input type="checkbox"/> Yes <input type="checkbox"/> 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: _____	

SECTION 3: ATTENDING PHYSICIAN'S STATEMENT

Name of Patient: _____	Date of Birth: _____		
D I A G N O S I S	Diagnosis: _____ ICDA Code: _____		
	Type of delivery: _____		
	Date pregnancy was diagnosed? ____/____/____ Date of delivery:(if delivered) ____/____/____		
H I S T O R Y	When did symptoms first appear? ____/____/____ Date patient first consulted you for this condition? ____/____/____		
	Was the patient referred to you? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, full name and address of referring physician: _____ _____ _____		
T R E A T M E N T	Has the patient been confined to a hospital? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	Admitted: ____/____/____ Discharged: ____/____/____ If yes, give admit and discharge dates along with name and address of hospital. Name: _____ Address: _____		
P R O G N O S I S	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: _____	