AMERICAN FIDELITY
a different opinion

Life & Annuity - Worksite
P.O. Box 25160
Oklahoma City, OK 73125-0160
Toll Free Phone 1-800-662-1113
Toll Free Fax 1-800-818-3453
www.americanfidelity.com

Accelerated Benefit for Critical Illness

Claim Filing Instructions

How to File an Accelerated Benefit for Critical Illness Claim By Mail or Fax:

1. Complete the Authorization to Disclose Protected Health Information and the Statement of Insured.
2. Have your attending physician complete the Statement of the Attending Physician.
3. Mail the completed forms to American Fidelity and the Pathologist's report if claim is for Invasive Cancer.
4. If you wish to fax your completed forms, please fax to 800-818-3453.

IF THE POLICY IS LESS THAN TWO YEARS OLD - AS A PART OF OUR NORMAL PROCESS, ADDITIONAL INFORMATION AND DOCUMENTATION WILL BE REQUIRED WITH THE CLAIM. FOR ALL CLAIMS, 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 SCHEDULE FOR AVAILABLE COVERAGE.

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize the entities specified below to disclose any information about the Insured's health including their 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 (AFA) who are involved in determining whether the Insured is eligible for benefits under this insurance coverage. Specified entities include: licensed physicians or medical practitioners; hospitals, clinics or medically-related facilities; health plans; Veteran's Administration; or other government healthcare payers or providers; past or present employers; pharmacies; insurance companies; the Social Security Administration; retirement systems; Department of Motor Vehicles, and Workers' Compensation Carriers.

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 the Insured may have been treated. This authorization excludes disclosure of the result of a test for HIV if the Insured had tested HIV positive but had 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 the Insured had 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 the Life 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: AFA has taken action in reliance on the authorization; or, the law provides AFA with the right to contest my insurance coverage or a claim under the Insured's 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.

This authorization will expire twenty-four months from the date it is signed or upon expiration of the claim for benefits, whichever occurs first.

_____ _____

Signature (Patient) or Personal Representative (if applicable) Printed Name (Patient)

_____ _____ _____

Relationship of Personal Representative to Patient Date Account #

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.

REQUEST FOR
ACCELERATED BENEFITS
FOR CRITICAL ILLNESS

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See page 4 for fraud statements.

STATEMENT OF INSURED

In furnishing this form, the Company reserves all of its rights under the Policy and waives none of the conditions of the Policy.

A. About the Insured	Insured's Last Name	First Name	Initial	Date of Birth	Account Number
	Mailing Address (City, State, Zip)			Insured's Social Security #	
	Telephone Number		Email Address		
B. About the Owner (if different than Insured)	Owner's Last Name	First Name	Initial	Owner's Social Security #	
	Mailing Address (City, State, Zip)				
	Telephone Number		Email Address		
C. About the Claim	Benefit for which claim is being made: ☐ Invasive Cancer ☐ End Stage Renal Failure ☐ Heart Attack ☐ Major Organ Failure ☐ Permanent Damage Due to a Stroke				
	Date first treated:	Have you ever had a similar condition? ☐ Yes ☐ No		If Yes, when?	
	Provide names, addresses and telephone numbers for all attending physicians for the Critical Illness (Attach additional sheet of paper, if necessary):				

We may require additional information in order to quickly adjudicate your claim. Please gather the following supporting documentation when requesting an Accelerated Benefit for Critical Illness:

- A completed Attending Physician Statement as shown on page 3 signed by your doctor
- Medical records from the date you were first treated for the Critical Illness to the present
- Medical records or office notes from each provider treating the Critical Illness

Tip! You may obtain these items from the attending physician's office or hospital, wherever treatment was provided.

SIGNATURE AND ACKNOWLEDGMENT

I certify the above statements are true and complete to the best of my knowledge. I acknowledge that benefits will be paid to the Owner.

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. Refer to **"Fraud Warning Notices"** for your state.

Signed _____ Date: _____
(Insured)

Signed _____ Date: _____
(Owner, if different than the Insured)

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A. About the Patient	Patient's Name	Patient's Date of Birth	Patient's Social Security #

STATEMENT OF THE ATTENDING PHYSICIAN

Please complete the appropriate Section for each condition for which the patient has been diagnosed.

SECTION 1 INVASIVE CANCER (Attach Pathology Report)

Does the patient have cancer? ☐ Yes ☐ No Type of cancer diagnosed: _____

Stage of cancer: _____ Date of Diagnosis: _____

SECTION 2 END STAGE RENAL FAILURE

Does the patient have End Stage Renal Failure presenting as irreversible failure to function of both kidneys? ☐ Yes ☐ No

Does the patient's kidney failure necessitate regular dialysis or kidney transplantation? ☐ Yes ☐ No

Date of recommendation for patient to begin regular dialysis or kidney transplant: _____

What is the cause for patient's End Stage Renal Failure: _____

Date patient was first treated for signs or symptoms of this condition: _____

SECTION 3 HEART ATTACK (ACUTE MYOCARDIAL INFARCTION)

Are new and serial electrocardiographic (EKG) findings consistent with a myocardial infarction? ☐ Yes ☐ No If YES, attach a copy of the EKG

Were cardiac biochemical markers elevated and consistent with a myocardial infarction? ☐ Yes ☐ No

Did diagnostic studies confirm a myocardial infarction resulting in death of a portion of the heart muscle? ☐ Yes ☐ No

Did the patient have symptoms consistent with a myocardial infarction? ☐ Yes ☐ No What symptoms? _____

Date the patient was diagnosed with a myocardial infarction: _____

SECTION 4 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: _____

SECTION 5 PERMANENT DAMAGE DUE TO A STROKE

Does the patient have Permanent Damage Due To A Stroke meaning permanent neurological damage to the brain which results from an acute or sub-acute interruption of blood flow to brain tissue, including infarction of brain tissue due to embolism, thrombus or bleeding? (Permanent Damage Due To A Stroke does not include Transient Ischemic Attacks.) ☐ Yes ☐ No

For how many days did the patient's stroke produce persisting neurological deficits? _____

Do you expect the patient's neurological damage to be permanent? ☐ Yes ☐ No

Date neurological deficits from the stroke were first diagnosed as permanent based on neuroimaging or other neurodiagnostic study: _____

SIGNATURE OF ATTENDING PHYSICIAN

Attending Physician's Printed Name	Specialty	Telephone	Fax #
Signature of Attending Physician	Date Signed	Email Address	Federal Tax ID #

Address

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

Kentucky (continued) – 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.