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a different opinion

Worksite Group Benefits Department | P.O. Box 25160 | Oklahoma City, Oklahoma 73125-0160
American Fidelity Assurance Company | 1-800-662-1113 | Fax: 1-800-818-3453 | **americanfidelity.com**

Disability Claim Form

Faster, Easier Online Claim Filing

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-32082-0219

Two Easy Ways to Register

Online at **americanfidelity.com**

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

Stop here! Paper claim filing is not the fastest option. Receive your money faster when you file online or through AFmobile.

Claim Filing Instructions for Mail or Fax:

Please complete this packet in full to avoid delays in your claim processing.

1. **Complete the Statement of Insured.**
2. **Have your employer complete the Employer's Report of Claim and return to you.**
3. **Have the treating physician complete the Attending Physician's Statement and return to you.**
4. **Submit the completed:**
   - **A. Statement of Insured**
   - **B. Employer's Report of Claim**
   - **C. Attending Physician's Statement**
5. **Mail or fax the completed forms to American Fidelity at the address or fax number listed above.**

To receive updates on the status of your claims, log in or register for an account at **americanfidelity.com** and select your communication preferences.

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. This authorization applies to benefits payable under all benefit plans with AFA.

Signature: _____

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

Routing Number Account Number

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STATEMENT OF INSURED To be completed by Employee.

Full Name: (last, first, middle initial)	Date of Birth: / /
Social Security Number: / /	Account Number: / /
Mailing Address: (P.O. Box or street, city and zip code)	
Telephone Number (including area code):	Email Address:
Employer Name:	
Name and birthday of spouse and dependents: Name: Birthdate: / / Name: Birthdate: / /	

DISABILITY INFORMATION

Is the disability due to: ☐ illness OR ☐ accident Date of onset: / / If accident, please describe the cause and details: If illness, diagnosis:	
Have you ever had the same or similar condition in the past? ☐ Yes ☐ No If so, when? / /	
Provide all current treating physicians' full name(s) and contact information (attach additional list if necessary):	
Is your disability related to your employment/occupation? ☐ Yes ☐ No	If yes, have you or do you intend to file for Workers' Compensation? ☐ Yes ☐ No
On what date did you last work? / /	Dates of Total Disability: From / / Through / /
On what date did you return to work? / /	Part Time / / Full Time / /
If not returned to work, when do you anticipate returning to work? / /	
Has the patient been confined to a hospital? ☐ Yes ☐ No If yes, give admit and discharge dates along with name and address of hospital.	Admitted: / / Discharged: / / Admitted: / / Discharged: / /
Name of hospital:	Address of hospital:
If your request for benefits is approved, do you want us to withhold Federal Taxes from each benefit check? ☐ Yes ☐ No If yes, amount per month (minimum $88.00): $	

Identify other income sources and amount of income which you are receiving or may be entitled to receive during this disability.
Please check yes or no for each of the following:

Your Social Security: (disability or retirement)	☐ Yes ☐ No Amount/month: $	Unemployment:	☐ Yes ☐ No Amount/month: $
Dependent Social Security:	☐ Yes ☐ No Amount/month: $	Union:	☐ Yes ☐ No Amount/month: $
Sick Leave or Wage Continuation:	☐ Yes ☐ No Amount/month: $	V.A. Benefits:	☐ Yes ☐ No Amount/month: $
Retirement: (normal, early, or disability)	☐ Yes ☐ No Amount/month: $	Workers' Compensation:	☐ Yes ☐ No Amount/month: $
State Disability Income:	☐ Yes ☐ No Amount/month: $	Other Disability Coverage: (list)	☐ Yes ☐ No Amount/month: $
Include a copy of your award or denial letter for any source in which one has been received.			
I certify this information is true and correct. Signature:		Date:	

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Attending Physicians Statement Disability Claim Form to be completed by physician

Name of Patient:	Date of Birth: / /	Social Security Number: / /	Account Number:

DIAGNOSIS

Disabling Diagnoses (including complications):	ICD code:

HISTORY

When did symptoms first appear or accident happen? / /	Date patient first consulted you for this condition? / /
Has the patient ever had the same or similar condition? ☐ Yes ☐ No	If yes, indicate when and describe:
Was the patient referred to you? ☐ Yes ☐ No	If yes, provide full name, address, and phone number of referring physician:
Is the disability work related? ☐ Yes ☐ No	

TREATMENT

Frequency of treatment: ☐ Monthly ☐ Weekly ☐ Other, describe:	Date of next appointment : / /
Please describe current treatment:	
List all dates of treatment or medical attention since the disability began:	
Is patient still under your regular care for this condition? ☐ Yes ☐ No	If no, please explain and provide name and phone number of the current treating physician:
Has the patient been confined to a hospital? ☐ Yes ☐ No If yes, give admit and discharge dates along with name and address of hospital.	Admitted: / / Discharged: / / Admitted: / / Discharged: / /
Name:	Address:

PROGNOSIS

Is patient now Disabled? For Regular occupation? ☐ Yes ☐ No	For any Occupation? ☐ Yes ☐ No
Date total disability began: / /	What is the expected return to work date? / /
Is the patient released to return to work with restrictions? ☐ Yes ☐ No	If yes, From: / / Through: / / Please list return to work restrictions:
Anticipated length of disability: ☐ 1-2 Months ☐ 2-3 Months ☐ 3-6 Months ☐ 6-12 Months ☐ Greater than 12 Months ☐ Permanent	

IMPAIRMENTS

Please list functional limitations/restrictions that render your patient temporarily totally disabled:
Do you expect any improvement or decline in functional status? ☐ Yes ☐ No If yes, please circle improvement or decline.

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 & Title)	Signature:	Date: / /

If you require completion of your own authorization for the release of medical records please submit the form along with the physician statement.

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Employer's Report of Claim

Name of Employer:	Phone Number:
Mailing Address: (P.O. Box or Street, City, State and Zip Code)	Fax Number:
Name of Employee:	Social Security Number: / /
Mailing Address: (P.O. Box or street, city and zip code)	
Date of Hire: / /	Occupation (please attach job description):
Employment Status at time of Disability: ☐ Full-Time ☐ Part-Time ☐ Leave of Absence ☐ Terminated ☐ Retired	

DISABILITY

Date employee last worked: / /	Has employee returned to work? ☐ Yes ☐ No
If yes, date returned to work: / /	☐ Full Time ☐ Part Time

PREMIUMS

Does the employee participate in Social Security? ☐ Yes ☐ No	If no, hired after 4/1/86? ☐ Yes ☐ No
Does employer pay a portion of the disability premium? ☐ Yes ☐ No	If yes, what percent? %
Are disability premiums deducted from employee's pay on a pre-tax (section 125) basis? ☐ Yes ☐ No	
Have AFA disability premiums been withheld through the last date worked? ☐ Yes ☐ No	If not, what is the last date disability premiums were deducted? / /

SALARY AT TIME OF DISABILITY FOR EDUCATION EMPLOYERS

Number of Contract Days _____ for _____ school year. In-house days: First Day: / /
Annual Salary: $ Effective Date: / / Last Day: / /

SALARY AT TIME OF DISABILITY FOR ALL OTHER EMPLOYERS

Hourly: $ _____ Monthly: $ _____
Gross salary for previous calendar year: $ _____ Year-to-date, gross salary: $ _____

OTHER INCOME

Did Employee's disability result from employment? ☐ Yes ☐ No Has employee made a claim for Workers' Compensation? ☐ Yes ☐ No
If yes provide the name, address, and phone number of Workers' Compensation carrier: _____
Is the employee entitled to Workers' Compensation for this disability? ☐ Yes ☐ No

Please indicate if the employee is receiving or eligible to receive any of the following:
Other Group Disability: ☐ Yes ☐ No Amount: $_____ Start Date: _____ End Date: _____ ☐ Daily ☐ Weekly ☐ Monthly
Salary Continuation/Other Paid Leave: ☐ Yes ☐ No Amount: $_____ Start Date: _____ End Date: _____ ☐ Daily ☐ Weekly ☐ Monthly
Sick Leave: ☐ Yes ☐ No Amount: $_____ Start Date: _____ End Date: _____ ☐ Daily ☐ Weekly ☐ Monthly
Differential/Sabbatical: ☐ Yes ☐ No Amount: $_____ Start Date: _____ End Date: _____ ☐ Daily ☐ Weekly ☐ Monthly
Union Benefits: ☐ Yes ☐ No Amount: $_____ Start Date: _____ End Date: _____ ☐ Daily ☐ Weekly ☐ Monthly
State Disability: ☐ Yes ☐ No Amount: $_____ Start Date: _____ End Date: _____ ☐ Daily ☐ Weekly ☐ Monthly
For Union Benefits or Other Group Disability, please list provider's: Name: _____
Phone: _____

EMPLOYER SIGNATURE

The above named employee may qualify for benefits under the American Fidelity 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: _____
Printed Name: _____ Title: _____ Date: _____
Email Address: _____ Phone: (____)_____ Fax: (____)_____
How do you prefer to be contacted? ☐ Email ☐ Phone ☐ Fax

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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), or business partners acting on behalf of AF in the administration of AF products and services 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 or their business associates; 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. AF will only disclose any data collected pursuant to this authorization as necessary for our legitimate business purposes, and only to the extent allowed by law.

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.

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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.