CANCER SCREENING BENEFIT CLAIM FORM

To file your claim online, upload documentation on an existing claim, check claim status or get paid fast by signing up for direct deposit, register on Aflac.com or download the MyAflac mobile app.

- ➢ **Benefits of filing your claim online include faster claim processing time and receiving claim communications by email.**

Please read all instructions.

Failure to follow these instructions could delay the processing of your claim.

- Do not include receipts, statements or other claim documentation with this form.
- Do not write on form except as instructed.
- Sign, date and fax or mail the completed form to the Aflac fax number/address shown below.
- Use black or blue ink only and print legibly when completing this form in its entirety.
- Mark only wellness exam boxes for test(s) and/or treatment(s) received.
- Failure to complete all sections may result in a delay in processing this claim.
- Some types of tests and/or treatment listed may not be covered by your policy.

Please keep a copy of this completed form for your records. Please print a separate form for each additional family member or call 1-800-99-AFLAC (1-800-992-3522) to request additional forms. Claims for all other benefits covered under this policy must be filed separately using the claim forms available at aflac.com or by calling 1-800-99-AFLAC (1-800-992-3522).

American Family Life Assurance Company of Columbus (Aflac)
ATTN: Claims Department • 1932 Wynnton Road • Columbus, GA 31999
For information or to check claim status, visit aflac.com or call 1-800-99-AFLAC (1-800-992-3522)
Claims may be faxed to 1-877-44-AFLAC (1-877-442-3522)

CANCER SCREENING BENEFIT CLAIM FORM

Policy Number:

All Fields are required.

Policyholder Information:

Last Name | Suffix | First Name | MI

Date of Birth (mm/dd/yy) | Telephone Number where we can reach you

Home Address

City | State | Zip Code

☐ *Check box if this is permanent address change.*

Patient Information:

Last Name | First Name | Date of Birth (mm/dd/yy)

Sex: ☐ Male ☐ Female

Relationship: ☐ Primary Policyholder ☐ Spouse ☐ Dependent Child

Treatment Date: M M D D Y Y Y Y

Mammogram Date: M M D D Y Y Y Y

Pap Smear Date: M M D D Y Y Y Y

- ☐ Genetic Testing
- ☐ Chest X-ray
- ☐ Scopes (Oscopies)
- ☐ Scans/MRI
- ☐ Pap Smear/Pap Smear-ThinPrep
- ☐ HPV Screening
- ☐ Bone Marrow Screening
- ☐ Serum Protein Electrophoresis
- ☐ Hemocult Stool Specimen
- ☐ CEA (blood test for colon cancer)
- ☐ CA125 (blood test for ovarian cancer)
- ☐ Mammogram
- ☐ Cervical Cancer Screening
- ☐ P32 Uptake Test
- ☐ CA153 (blood test for breast cancer monitoring)
- ☐ Thermography
- ☐ PSA (blood test for prostate cancer)
- ☐ Ultrasounds
- ☐ Breast Ultrasound
- ☐ Biopsy
- ☐ Cancer Vaccine

Actual Cost of Mammogram | Physician's Phone Number:

Physician's Name

Physician's Street Address

Physician's City | State: | Zip:

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.

The Physician listed above is authorized to validate the information I have provided.

POLICYHOLDER/PATIENT SIGNATURE | **FAMILY RELATIONSHIP, IF NOT POLICYHOLDER** | **DATE**

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