# Accident/Hospital Indemnity Wellness 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 and complete the form, failure to do so could delay the processing of your claim.**

Please check your policy for specific details on this benefit.

- 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)**

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**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 and Physician Information**

**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

☐ Annual Physical
☐ Ultrasound
☐ PSA (blood test for prostate cancer)
☐ Pap Smear
☐ Blood Screening
☐ Immunizations
☐ Eye Exam
☐ Mammogram
☐ Dental Exam
☐ Flexible Sigmoidoscopy

Physician's Phone Number:

Physician's Name

Physician's Street Address

Physician's City | State: | Zip:

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

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

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



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