CANCER ANNUAL CARE BENEFIT CLAIM FORM

Please read all instructions.

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

Your Aflac Cancer policy pays one Cancer Annual Care Benefit per year, up to five years following the anniversary of the diagnosis of internal Cancer for any Covered Person surviving Cancer.

- Do not include receipts, statements or other claim documentation with this form.
- Do not write on form except as instructed.
- Please sign, date and mail or fax the completed form to the Aflac address/fax number shown below.
- Please use black or blue ink only and print legibly when completing this form in its entirety.
- Failure to complete all sections may result in a delay in processing this claim.

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 ANNUAL CARE 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

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Physician Information:

Physician's Name

Physician's Street Address

Physician's City | State: | Zip:

Tax ID Number:

Physician's Phone Number:

I verify the above mentioned patient is currently under my care as of the date I have signed this form.

Date:

Physician Signature

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.

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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