INSTRUCTIONS FOR FILING DENTAL CLAIMS

PLEASE DO NOT SUBMIT THIS FORM FOR PRECERTIFICATION. AFLAC NEW YORK DOES NOT REQUIRE PRECERTIFICATIONS AND WILL NOT COMPLETE THE FORM FOR PRECERTIFICATION.

1. All claims must be submitted on a typed ADA claim form; a copy is on the back of these instructions. Your dentist may prefer to file your claims electronically.

2. Only dental claims may be filed with this claim form. If you need to file a claim under another Aflac New York policy, please submit the appropriate claim form.

3. Please ask your dentist's office to complete the entire form. Blank fields will cause the form to be returned and the claim processing to be delayed. We must have the following information:
   - The policyholder’s dental policy number (Please leave the Group Field blank).
   - The policyholder’s complete name as it is printed on the Dental Plan ID card.
   - The patient’s full name, sex, date of birth and relationship to the insured.
   - The treatment date, tooth or surface, oral cavity and if initial placement, ADA code and charge for each procedure.
   - The patient's Social Security number. (This will speed up claim processing.)

4. If the patient is a full-time student and over age 19, please indicate this on the form.

5. If you are filing for the initial benefit under the Orthodontic Rider or a cosmetic rider benefit, there is a two-year waiting period before benefits are payable under these riders.

6. Your dentist may submit the claim electronically. Make sure that Aflac New York’s payer number (52080) is included on each claim submitted.

Submit the typed claim form directly to Aflac New York at:
American Family Life Assurance Company of New York (Aflac New York)
Attention: Claims Department
1932 Wynnton Road
Columbus, GA 31999-7254
Fax: 1-877-844-0201  Attn: Dental Claims
### Patient Information

<table>
<thead>
<tr>
<th>Field</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Name (Last, First, Middle)</td>
<td></td>
</tr>
<tr>
<td>Address</td>
<td></td>
</tr>
<tr>
<td>City</td>
<td></td>
</tr>
<tr>
<td>State</td>
<td></td>
</tr>
<tr>
<td>Date of Birth (MM/DD/YYYY)</td>
<td></td>
</tr>
<tr>
<td>Sex</td>
<td>M</td>
</tr>
<tr>
<td>Phone Number ( )</td>
<td></td>
</tr>
<tr>
<td>Zip Code</td>
<td></td>
</tr>
</tbody>
</table>

### Relationship to Subscriber / Employee:

- Self
- Spouse
- Child
- Other

### Employment Information

- Employer Name: ____________________________
- Address: ____________________________

### Coverage Information

- Is patient covered by another plan? Yes
- Dental or Medical
- Policy #: ____________________________
- Other Subscriber's Name: ____________________________
- Date of Birth (MM/DD/YYYY): _______/_____/_____
- Sex: M
- Plan/Program Name: ____________________________

### Employment Status

- Employer / School Name: ____________________________
- Address: ____________________________
- Subscriber / Employee Status: Employed

### Billing Information

- Name of Billing Dentist or Dental Entity: ____________________________
- Address: ____________________________
- Date of Birth (MM/DD/YYYY): _______/_____/_____
- Examination and treatment plans: List teeth in order.
- Examination and treatment plans: List teeth in order.
- Identification all missing teeth with X

### Payment Information

- Carrier Name: Aflac New York
- Carrier Address: 1932 Wynnton Road Columbus, GA 31999-7254
- Carrier Name: Medicaid
- Carrier Address: Claims Department
- Carrier Name: EPSDT
- Carrier Address: Claims Department
- Carrier Name: Medicaid
- Carrier Address: Claims Department

### Other Policies

- Is treatment result of occupational illness or injury? No
- Date of Birth (MM/DD/YYYY): _______/_____/_____
- Address: ____________________________
- City: ____________________________
- State: ____________________________
- Zip Code: ____________________________

### Signature

Signed (Patient/Guardian) Date (MM/DD/YYYY)
Instructions for completing this Health Insurance Portability and Accountability Act of 1996 (HIPAA) compliant form:

1. All areas of this form should be completed.
2. This form must be signed and dated by the claimant/patient below.
3. IMPORTANT: If you are filing a claim on behalf of a deceased, please check here
4. If you are the Authorized Representative, please sign below and indicate your relationship to the claimant/patient/deceased. In addition, include a copy of the legal document(s) authorizing you to act on their behalf.
5. Fax this form to 1-877-844-0201 or return the form to Aflac New York, Attn: Claims Department, Worldwide Headquarters, 1932 Wynnton Road, Columbus, GA 31999-7255, as soon as possible in order to expedite claim review.

<table>
<thead>
<tr>
<th>Policyholder Name:</th>
<th>Policy Number(s):</th>
<th>Date of Birth:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policyholder Address:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Claimant/Patient Name (if different from named policyholder listed above):</td>
<td>Date of Birth:</td>
<td></td>
</tr>
</tbody>
</table>

This authorization shall be valid for a period of two years from the sign date unless a lesser time frame is indicated. Alternate Expiration Date:  
Name and Address of health care provider(s), company, or individual authorized to release the requested information: 
(this section will be completed by Aflac New York):

Purpose of Disclosure: Evaluate claims for benefits during the time this authorization is valid.

I, or my authorized representative, request that information regarding my past, present, or future physical or mental health condition (excluding psychotherapy notes), employment, other insurance coverage, or any other nonmedical facts be released to American Family Life Assurance Company of New York (Aflac New York) or any person or entity acting on its part. This could include, but is not limited to, any medical professional, medical care institution, insurer (including Aflac New York, with respect to other Aflac New York coverages), reinsurer, government agency (including departments of public safety and motor vehicle departments), consumer reporting agency or employer.

I understand that:

1. Protected health information may include information and records protected under Federal and State Law such as: alcohol, drug abuse, mental health, AIDS or HIV testing or treatment, or the presence of a communicable or noncommunicable disease.
2. My treatment, payment or eligibility for benefits may not be conditioned on signing this authorization.
3. I understand that I may revoke this authorization at any time by writing to Aflac New York, Claims Department, Worldwide Headquarters, 1932 Wynnton Road, Columbus, GA 31999-7255, except to the extent that:
   a. Aflac New York has taken action in reliance to this authorization, or
   b. Other law provides Aflac New York with the right to contest a claim under the policy or the policy itself.
4. If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. It is recommended I retain a copy of this signed form for my records, understanding that a copy is as valid as the original.

Signature of claimant/patient, guardian or authorized representative

Printed name of claimant/patient, guardian or authorized representative

Relationship

American Family Life Assurance Company of New York (Aflac New York)
Home Office • 22 Corporate Woods Boulevard Suite 2 • Albany, NY 12211
1-800-366-3436 • aflacny.com

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