VISION CLAIM FORM

Thank you for trusting Aflac with your Vision needs.

- **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.**

To prevent delays, please provide documentation from your healthcare provider to support this claim. If you have additional bills or medical documentation that relates to this diagnosis other than the documentation defined, please submit them for review of additional benefits.

- **Service related items can be obtained directly from the patient's healthcare provider(s) by requesting a UB04 hospital bill or HCFA 1500 non-hospital bill.**
- **Failure to complete all sections may result in a delay in processing this claim.**
- **Disclaimer: Some of the services listed may not be covered by your policy.**

***Policy Number:**

Policyholder Information: This * denotes a required field.

*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 a permanent address change.*

Patient Information:

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

*Sex: ☐ Male ☐ Female

*Relationship: ☐ Primary Policyholder ☐ Spouse ☐ Dependent Child

Vision Checklist

- Filing claim for: ☐ Injury ☐ Sickness
- Date of the injury: _____/_____/_____
- Details of the injury: _____
- Symptoms first occurred on: _____/_____/_____ First date of treatment for this condition: _____/_____/_____
- Please indicate the condition the patient is filing for below and submit medical documentation showing diagnosis and first date of treatment

  ☐ Macular Degeneration

  ☐ Retinal Detachment

  ☐ Proliferative Diabetic Retinopathy

  ☐ Retinitis Pigmentosa

  ☐ Glaucoma (excluding preglaucoma and/or borderline glaucoma)

  ☐ Was surgery performed as a result of this condition? (If yes, please submit a copy of the operative report or the surgeon's bill.)

  If yes, please list surgery type(s):_____

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)

If you have additional bills or medical documentation that relates to this diagnosis other than the documentation defined, please submit them for review of additional benefits.

*Policy Number:

Policyholder Information:

*Last Name | Suffix | *First Name | MI

*Date of Birth (mm/dd/yy)

Patient Information:

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

- Please provide the name, address and phone number of the patient's primary treating physician.

  Name: _____ Phone Number: _____

  Address: _____

- Was the patient treated by any other physicians for this condition? ☐ No ☐ Yes

  If yes, physician's name(s): _____

  Phone Number(s): _____

  Address: _____

- Was permanent visual impairment a result of this condition? ☐ No ☐ Yes (If yes, please submit the physician's office notes or medical documentation showing the level of impairment.)
  - If yes, please indicate which eye: ☐ Right ☐ Left
    - Level 1- Severe Visual Impairment: maximum visual acuity, after correction, of 20/200 or less, or a total diameter of the visual field in that eye of 20 degrees or less.
    - Level 2- Profound Visual Impairment: maximum visual acuity, after correction, of 20/500 or less, or a total diameter of the visual field in that eye of 10 degrees or less.
    - Level 3- Near-Total Visual Impairment: maximum visual acuity, after correction, of less than 20/1000, or a total diameter of the visual field in that eye of 5 degrees or less.
    - Level 4- Total Visual Impairment: complete loss of vision with no remaining perception of light, or loss of the natural eye.
- Was the patient confined to the hospital as a result of this condition? ☐ No ☐ Yes (If yes, please submit the itemized hospital bill, UB04, or HCFA 1500.)

  Hospital Name: _____

  City: _____ State: _____

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.

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

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