LONG TERM CARE CONTINUING CLAIM FORM

Thank you for trusting Aflac with your Long Term Care needs.

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.**
- **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.**

*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

*Social Security Number - -

Institution Information:

*Phone Number - -

*Fax Number - -

*Name of the Institution

*Address

*City | *State | *Zip Code -

Long Term Care Continuing Checklist

In addition to this form, we must receive a bill from your provider verifying services were rendered.

- Confinement date range for this period of care*: ____/_____/_____ to : _____/_____/_____

  ***Benefits cannot be determined for future dates of treatment or for dates of treatment older than date of signature**.

- Initial Date of Admission to this facility: _____/_____/_____

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)

***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) / /

- Is the patient deceased?* ☐ No ☐ Yes (If yes, date of death: _____/_____/_____)
  ***If yes, please submit a copy of the death certificate and legal documents verifying the person authorized to handle the affairs of the deceased.**
- Indicate type of care patient received while confined:

  ☐ Skilled Nursing ☐ Personal ☐ Alzheimer's Unit ☐ Sheltered Care

  ☐ Intermediate ☐ Assisted Living ☐ Domiciliary Care ☐ Respite Care

  ☐ Custodial ☐ Residential ☐ Retirement Home ☐ Other

  If other, please describe: _____
- Was patient confined to hospital during this period of care? ☐ No ☐ Yes
  - If yes, list date of admission: _____/_____/_____ and date of discharge: _____/_____/_____
- Were there bed hold days during this period of care? ☐ No ☐ Yes (If yes, list dates: _____)

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.

NURSING HOME PERSONNEL SIGNATURE **TAX ID NUMBER** **DATE**

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