INITIAL ACCIDENTAL INJURY CLAIM FORM

Thank you for trusting Aflac with your Accidental Injury needs.

- **If you are interested in filing your claim online or uploading documentation on an existing claim, register using aflac.com/myaflac.**

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

Accidental Injury (completed by Policyholder)	
Please complete and attach itemized copies of any related bills including physician, ambulance, emergency room, hospital, and/or rehabilitation unit. Bills should include diagnosis information and procedure codes from your medical provider. If surgery was performed, include operative report. An accident description is also required.	
Date the accident occurred (not when it was treated): ________ /________ /________	Accident occurred: ☐ On-job ☐ Off-job (If on-job injury, attach copy of Report of Injury document)
Have you been treated for the same or similar condition prior to this occurrence? ☐ Yes ☐ No If yes, when: ________ /________ /________	
Hospital admission: ☐ Yes ☐ No Admission: ___ /________ /________ Time: _______ ☐ AM ☐ PM Discharged: ____ /________ /________ Time: _______ ☐ AM ☐ PM	
Description of how the accident occurred (If auto accident, assault, or gunshot wound, attach a copy of the police report, if applicable.):	

Was injury a result of participating in an organized sporting activity? ☐ No ☐ Yes

Type of Event ______________________ **AND** Sporting Organization ______________________

Was this a motor vehicle accident in which the patient was the driver? ☐ No ☐ Yes (If yes, please submit a copy of the police report.)

Was death a result of this injury? ☐ No ☐ Yes (If yes, please submit the certified death certificate and the Life-Beneficiary's Statement.)

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:** | | | | | | | | |

Treating physician	Name:		
Address:	City:	State:	ZIP:
Email:	Telephone:	Fax:	
Primary physician	Name:		
Address:	City:	State:	ZIP:
Email:	Telephone:	Fax:	
Referring physician/hospital	Name:		
Address:	City:	State:	ZIP:
Email:	Telephone:	Fax:	

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

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Physician's Statement (completed by the physician)

In most cases, a completed and signed Physician's statement will be all that is required to be submitted. After review, Aflac will contact you if any additional proof of loss documentation is required.

Please submit the following with your claim: a copy of your itemized bill from your doctor which includes your diagnosis and procedure codes. If you are unable to provide an itemized billing statement(s), please have your treating physician complete and sign the section below.

Diagnosis/ICD codes: | **Was an X-ray taken?** ☐ Yes ☐ No

Is condition due to an accidental injury? ☐ Yes ☐ No | **If acute injury, please provide date:** ______ /_______ /_______

Description of acute injury: | **If re-injury, please provide date(s) and description(s):**

Physician office visit(s) related to this accident:

_______ /_______ /_______ _______ /_______ /_______ _______ /_______ /_______ _______ /_______ /_______

_______ /_______ /_______ _______ /_______ /_______ _______ /_______ /_______ _______ /_______ /_______

_______ /_______ /_______ _______ /_______ /_______ _______ /_______ /_______ _______ /_______ /_______

Appliance Treatment Date: ☐☐☐☐☐☐☐☐

- ☐ Back Brace
- ☐ Body Jacket
- ☐ Cane
- ☐ Cervical Collar
- ☐ Cervical Multiple Post Collar
- ☐ Crutches
- ☐ Halos
- ☐ Knee Scooter
- ☐ Leg Braces
- ☐ Walkers
- ☐ Walking Boot
- ☐ Wheelchairs

Therapy Treatment Date(s):

Type of Therapy:

- ☐ Occupational Therapy ____ /___ /_______ ______ /___ /_______
- ☐ Physical Therapy ____ /___ /_______ ______ /___ /_______
- ☐ Speech Therapy ____ /___ /_______ ______ /___ /_______

____ /___ /_______ ______ /___ /_______

____ /___ /_______ ______ /___ /_______

Hospital confinement:

Admission: _____ /___ /_______ Time :__________ ☐ AM ☐ PM Discharged: _____ /___ /_______ Time :__________ ☐ AM ☐ PM

Intensive Care dates From: ______ /_______ /_______ To: _______ /_______ /_______

Sub-Acute Intensive Care dates From: _______ /_______ /_______ To: _______ /_______ /_______

Hospital: | Telephone:

Address: | City: | State: | ZIP:

Surgery: ☐ Inpatient ☐ Outpatient

Was surgery performed at: ☐ Hospital ☐ Surgery Center ☐ Doctor's Office

Date: _______ /_______ /_______ CPT code : __________________

Date: _______ /_______ /_______ CPT code : __________________

Diagnostic procedures

Date: ____ /___ /_______ CPT code : __________________

Date: ____ /___ /_______ CPT code : __________________

If treated in the Emergency Room, attach a copy of the ER report/itemized bill.

If also covered under a disability policy:

Dates unable to work (full-time): From: _______ /___ /_______ To: _____ /_______ /_______ Expected return to work date: _____ /_______ /_______

Dates able to work (part-time):

From: _______ /___ /_______ To: _____ /_______ /_______ Number of hours worked:_______ Actual return to work date: _______/____ /_______

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.

PHYSICIAN SIGNATURE **TAX ID NUMBER AND NPI#** **DATE**

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