AMERICAN FAMILY LIFE ASSURANCE COMPANY OF COLUMBUS (AFLAC)

ATTN: CLAIMS DEPT., WORLDWIDE HEADQUARTERS: 1932 WYNNTON ROAD, COLUMBUS, GA 31999-7251
FOR INFORMATION, CALL TOLL-FREE 1-800-99-AFLAC (1-800-992-3522) or visit our web site at www.aflac.com
TOLL FREE FAX NUMBER 1-877-44AFLAC (1-877-442-3522)

LONG-TERM CARE/CONVALESCENT CARE CLAIM FORM

FOR ASSOCIATE USE ONLY:

Check the appropriate box:	
☐ Send the insured's check to the agent for delivery.	Writing #: ______ Name: ______
☐ Contact the associate only if additional information is needed to complete processing of this claim.	Address: ______

PART ONE (To be completed by the policyowner)

PATIENT'S INFORMATION		CONTACT PERSON (IF OTHER THAN POLICYOWNER)	
LAST FIRST MIDDLE		LAST FIRST MIDDLE	
ADDRESS - STREET & NUMBER		ADDRESS - STREET & NUMBER	
CITY	STATE/ZIP CODE	CITY	STATE/ZIP CODE
POLICY NUMBER		RELATIONSHIP TO POLICYHOLDER	PHONE
POLICYOWNER'S NAME (IF OTHER THAN PATIENT)		**POLICYOWNER'S SOCIAL SECURITY NUMBER**	

Name and address of family physician ______

Please review and sign the attached authorization. Two copies are attached: return one copy to AFLAC and keep one for your records. By returning the signed authorization with your claim, you will help us process your claim as quickly and efficiently as possible.

PART TWO (To be completed by the admitting physician)

Admitting Diagnosis	ICD-9	Onset Date	First Consulted You On
1.			
2.			

Other Diagnoses Treated In The Past Two Years		List ADLs Patient Is Unable To Perform Without Assistance	
1.	DATE	☐ Continence	☐ Toileting
2.	DATE	☐ Transferring	☐ Eating
3.	DATE	☐ Dressing	☐ Other

1. Is patient expected to need assistance with ADLs or supervision for cognitive impairment for more than 90 days?
   ☐ Yes ☐ No If **YES,** expected period of illness: ______
2. Does patient require continual medical supervision? ☐ Yes ☐ No If **NO,** explain: ______
3. Was patient referred to you by another physician? ☐ Yes ☐ No If **YES,** give name and address of referring physician:

______
(Name of referring physician) *(Address* *(Area Code/Phone Number)*

Date: ______ Signed: ______

______
Name of attending physician (Please print) **(Federal Tax ID Number)**

______
(Street Address) **(State/Zip Code)** **(Area Code/Phone Number)**

LONG-TERM CARE/CONVALESCENT CARE CLAIM FORM

A copy of the facility billing must accompany this form.

PART THREE (To be completed by the Director of Nursing)

Policyowner's name: ____________________ **Policy Number:** ____________________

Social Security Number: ____________________

1. Date of admission to this facility: __________ Date of discharge from this facility: __________
2. Was any portion of this confinement covered by Medicare? ☐ Yes ☐ No
   If Yes, list dates and attach billing or EOMB: ____________________
3. Is this patient a Medicaid recipient? ☐ Yes ☐ No If yes, list eligibility dates: ____________________
4. What type of care are you licensed to provide? License number ____________________
   ☐ Skilled ☐ Intermediate ☐ Custodial ☐ Personal ☐ Assisted Living ☐ Residential ☐ Respite ☐ Other __________
5. Describe the type of care administered: ____________________
6. Indicate dates and section(s) to which patient was confined:

☐ Skilled Nursing	from ______	to ______		☐ Residential Facility	from ______	to ______	
☐ Intermediate Nursing	from ______	to ______		☐ Domiciliary Care	from ______	to ______	
☐ Custodial Care	from ______	to ______		☐ Retirement Home	from ______	to ______	
☐ Assisted Living	from ______	to ______		☐ Sheltered Care	from ______	to ______	
☐ Personal Care	from ______	to ______		☐ Respite	from ______	to ______	
☐ Alzheimer's Unit	from ______	to ______		☐ Other	from ______	to ______	

Admitting Diagnosis	ICD-9	List ADLs Patient is unable to perform without assistance:	
a)		☐ Continence	☐ Toileting
b)		☐ Transferring	☐ Eating
c)		☐ Dressing	☐ Other

7. Is patient expected to need assistance with ADLs or supervision for cognitive impairment for more than 90 days?
   ☐ Yes ☐ No If YES, expected period of illness: ____________________
8. Does this patient require continual medical supervision? ☐Yes ☐ No If NO, explain: ____________________
9. Was patient confined to the hospital during this period of care? ☐ Yes ☐ No If YES, list dates: __________
10. Were there bed hold days during this period of care? ☐ Yes ☐ No If YES, list dates: __________
11. Was patient confined to another facility or hospital prior to this admission? ☐ Yes ☐ No If YES, give name and address of facility and dates of confinement:
    Facility ____________________ Dates: __________
    Facility ____________________ Dates: __________

Signature of Director of Nursing ____________________ Date: __________

Name of Institution ____________________ Tax ID #: __________

Address: ____________________

Phone #: __________

Policy #: ______________________________

AUTHORIZATION TO OBTAIN INFORMATION

I authorize the following to give information (as defined below) to American Family Life Assurance Company of Columbus (AFLAC) or any person or entity acting on its part: any medical professional, medical care institution, insurer (including AFLAC, with respect to other AFLAC coverages), reinsurer, government agency (including departments of public safety and motor vehicle departments), consumer reporting agency or employer. "Information" means facts or opinions relating to my past, present, or future physical or mental health or condition (excluding psychotherapy notes), employment, other insurance coverage, or any other non-medical facts that AFLAC deems appropriate to evaluate claims for benefits during the time this authorization is valid. I understand that any disclosure of information to AFLAC for the purpose of evaluating claims for benefits for coverage other than health plan coverage means the information may no longer be protected by federal privacy regulations. I further understand, however, that such information may be re-disclosed only in accordance with other applicable laws or regulations.

I understand that this information will be used by AFLAC to evaluate claims for benefits.

I understand that I may revoke this authorization at any time, except to the extent that (1) AFLAC has taken action in reliance on this authorization, or (2) other law provides AFLAC with the right to contest a claim under the policy or the policy itself. My revocation must be submitted in writing to AFLAC, Claims Department, Worldwide Headquarters, 1932 Wynnton Road, Columbus, GA 31999.

Unless otherwise revoked, I agree that this authorization will expire two years from the date indicated below.

I agree that a copy of this authorization is as valid as the original.

______________________________ ______________________________

Signature Date Printed Name

Individual/Guardian/Personal Representative

____

Printed Name

If this authorization has been signed by a personal representative on behalf of an individual, his/her authority to act on behalf of the individual must be set forth here:

Policy #: ___________________________________

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RETAIN THIS COPY FOR YOUR RECORDS