Aflac Contacts & Claims Guide

Susan Schulz – Agent

(All Inquiries)
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Colt Riggs – Regional Claims Administrator

(Claims, Policyholder Service – Back-up)
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Aflac Group Headquarters

(Claims, Policyholder Service - Backup)
PO Box 427
Columbia, SC 29202
(800) 433-3036
www.aflacgroupinsurance.com
(note: there is no online access for policy information or claims)

FAX ALL CLAIM FORMS AND SUPPORTING DOCUMENTS TO: (970) 313-4359 Attn: Susan

Aflac Group Claims: Quick Facts & Reminders

Please note that 'Aflac' and 'Aflac Group' are two separate companies. ***The city of Greeley has AFLAC GROUP.*** *If you visit aflac.com or try and call Aflac Corporate in Columbus Georgia, they will not be able to find you in the system. Please utilize the information provided on the cover sheet of this guidebook if you wish to follow up with Aflac Group directly.*

General Information

- Fill out claim forms as completely as possible. If there is something you don't know or have, that is usually ok – you can call or email (email is best) your agent if you have a question, or send the information in as-is and your agent will review and let you know if the information is needed.
- The number you are faxing to goes to your AGENT who will work with the Regional Claims Specialist to review, file, and track your claim with Aflac. *You can also do this yourself if desired by using the contact information on the claim form.
- Be sure to **set up direct deposit (form below)** if you'd like your claim money to be directly deposited into the bank account of your choice. If not set up, Aflac will mail a check to you from their Columbia, SC location upon claim payout.
- "Policy Number" on your claim form is not needed as long as you have either your DOB or SSN on the claim form.

Accident Plan - Tips & Reminders

- **The Aflac Group Accident plan does NOT pay the follow up visit or physical therapy visit benefits for accidents in which the insured does not receive care for the accident within 72 hours**** (Other benefits may still apply).
- Be sure to review your brochure for your policy upon claim so you are aware of all of the benefits you should be paid upon claim – this will help you obtain the appropriate paperwork
- Accidents are covered 24 hours whether it occurs on or off the job on both plans.
- The Accident plan offers a Wellness benefits of $50 per year, per person *beginning AFTER the policy has been in force for 12 months.*

Hospital Plan - Tips & Reminders

- The hospital plan will not pay for hospitalization due to a pre-existing condition (see brochure for definition of pre-existing condition) for 6 months from the effective date of the policy.
- The hospital plan will not pay for the delivery of a baby if the delivery occurs within 10 months of the effective date of the policy.

Following this page, you will find the instructions and claim forms for each policy offered. Please contact your agent if you have further questions.

Group Accident Insurance Claims

Please provide a date and complete description of your accident. You can provide this information in the designated space on the claim form.

If the accident resulted from the use of a motor vehicle(s), a copy of the police or accident report is required. If your injury occurred on the job, a first report of injury filed with your employer must be attached to the completed claim form.

If you were first treated in an emergency room, a copy of the hospital discharge papers is required to verify the first date of treatment, diagnosis, and procedure.

Please include all dates of treatment and charges incurred due to the accident.

Please date and sign all required forms where indicated.

Group Hospital Insurance Claims

A hospital indemnity claim requires supporting documentation for review of benefits, itemized bills showing medical treatment dates and diagnosed conditions, hospital admission and discharge papers for inpatient hospital admission and confinement benefits, pharmacy receipts for prescription drug reimbursement, and a signed and dated Authorization for Disclosure of Health Information (HIPAA form). Also, if you are filing during the first year of your coverage effective date, we'll need you to provide the information requested on the Pre-Existing Investigation Statement.

Please date and sign all required forms where indicated.

Electronic Funds Transaction Authorization

Send to: **Continental American Insurance Company**
Mail: Post Office Box 427 Columbia, South Carolina 29202
Phone: (800) 433-3036 Fax (866) 849-2970
Email: groupclaimfiling@aflac.com

I would like to:

☐ Start ☐ Stop ☐ Change direct deposit of my claim payment(s).

Account Type:

☐ Checking ☐ Savings ☐ Other

9-Digit Routing Number:	Account Number:

Remember: The 9-digit number on a deposit slip is not a routing number.
You can obtain the routing number from a check or from your financial institution. *See example above.*

Name of Financial Institution:

Address:		City:
State:	Zip:	Phone:

Authorization Agreement for Direct Deposit

I authorize Continental American Insurance Company (CAIC) to initiate credit entries, and, if errors occur, I authorize the correction of entries to my account as indicated. This authorization remains effective and in full force until CAIC receives written notification from me of its termination in such time and in such manner to afford CAIC a reasonable opportunity to act on it. Please notify CAIC immediately if your financial institution information has changed by sending notification to the address indicated above. Should you have any questions, please contact us at 1-800-433-3036.

Certificateholder's Name (*Print)*:

Address:	City/State:
Zip:	Phone #:
Employer Name or Group #:	Certificate #:
Signature:	Date:

CONTINENTAL AMERICAN INSURANCE COMPANY
Post Office Box 427* Columbia, South Carolina 29202
Phone (800) 433-3036 Fax (866) 849-2970

ACCIDENT CLAIM FORM

Failure to complete all sections may result in a delay in processing this claim.
To prevent delays, please provide documentation from your healthcare provider to support this claim.
Please review your policy for specific benefits covered under your plan.

- ✓ **Benefits are payable to you unless we receive written authorization from your provider to assign benefits to them or from you to pay your benefits elsewhere. This is called an assignment. If you wish to assign your benefits, please send a signed written request.**
- ✓ **If this claim is for an individual covered by Medicaid or a state variation of Medicaid, most non-disability benefits are automatically assigned according to state regulations. This means we must pay the benefits to Medicaid or to the medical provider to reduce the charges billed to Medicaid.**

AUTHORIZATION

Several states require that the following statement appear on the claim forms:
Any person who knowingly and with intent to defraud any insurance company, files a statement of claim containing any materially false, incomplete or misleading information, is guilty of a crime.

I hereby certify that the answers I have made to the foregoing questions are both complete and true to the best of my knowledge and belief. I have read the fraud notice included in this form.

Policyholder's Signature: _____ Date: _____

Patient's Signature: _____ Date: _____

PART A — POLICYHOLDER/PATIENT'S INFORMATION

1	EMPLOYER'S NAME			POLICYHOLDER'S EMAIL ADDRESS	
2	POLICYHOLDER'S NAME	POLICY NO.	SOCIAL SECURITY NO.	DATE OF BIRTH	GENDER
3	POLICYHOLDER'S ADDRESS	STREET	CITY	STATE	ZIP CODE
	☐ CHECK BOX IF THIS IS A PERMANENT ADDRESS CHANGE.				
4	PATIENT'S NAME (PERSON WHO IS SICK OR INJURED)	DATE OF BIRTH	GENDER	POLICYHOLDER'S TELEPHONE NO. (INCLUDE AREA CODE)	
5	RELATIONSHIP TO POLICYHOLDER				

[redacted]

- Date of the Injury: _____
- Describe how the injury occurred: _____
  _____
- Location of the injury? ☐ On the job ☐ Off the job
  - Has a Worker's Compensation claim been filed? ☐ No ☐ Yes
    - If yes, status of the claim: ☐ Approved ☐ Pending ☐ Denied
- Was the patient injured in a motor vehicle accident? ☐ No ☐ Yes (If yes, please submit the Police Report)

ACCIDENT CLAIM FORM

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

- Was the patient confined to the hospital as a result of this injury? ☐ No ☐ Yes (If yes, please submit the itemized hospital bill, UB04, or HCFA 1500)
  Admission date: _____Discharge Date: _____

  Hospital name: _____

  City: _____ State: _____

- Was the patient transported by an ambulance as a result of this injury? ☐ No ☐ Yes (If yes, please submit the ambulance bill)

- If any of the following were the result of your injury, please provide medical records or physician's office notes:
  - Coma
  - Paralysis
  - Degree of Burn
  - Injury to the Eye
  - Laceration (including length and method of repair)
  - Dislocation (X-ray reports or major diagnostic exam reports are needed)
  - Concussion (Major diagnostic exam reports are needed)
  - Fractures (X-ray reports or major diagnostic exam reports are needed)

- Was an aid in locomotion (mobility) prescribed as a result of this injury? (i.e. Crutches, Wheelchairs, Leg Braces, Walking Boots, Back Braces, Walkers, Cervical Collars) ☐ No ☐ Yes (If yes, please submit documentation from the prescribing provider.)

- Your policy covers the following surgeries:*
  - Open Reduction, Internal Fixation (Fractures or Dislocations)
  - Ruptured Disc Repair
  - Knee Cartilage Repair
  - Tendon or Ligament Repair
  - Open Abdominal/Thoracic Surgery
  - Eye Surgery
  - Were any of these surgical procedures performed as a result of this injury? ☐ No ☐ Yes (If yes, please submit a copy of the operative report.)

- Was a major diagnostic exam (i.e. CT Scan, MRI, MRA, EEG) performed as a result of this condition?
  ☐ No ☐ Yes (If yes, please submit a copy of the exam report or billing.)

- Provide all dates of treatment related to injury on the lines below (please submit supporting medical documentation for each visit indicated below):*
  - Initial date of treatment:_____
  - Follow ups:_____
  - Physical Therapy:_____

**See policy for time limit provisions.*

FRAUD WARNING NOTICES

For use with Claim Forms

PLEASE READ THE FRAUD WARNING NOTICE FOR YOUR STATE

ALABAMA: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

ALASKA: A person who knowingly and with intent to injure, defraud or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

ARIZONA: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

ARKANSAS: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

CALIFORNIA: For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

COLORADO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

DELAWARE: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

DISTRICT OF COLUMBIA: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

FLORIDA: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

IDAHO: Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement containing any false, incomplete, or misleading information is guilty of a felony.

INDIANA: A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

KANSAS: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud as determined by a court of law.

KENTUCKY: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.

LOUISIANA: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

MAINE: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

MARYLAND: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

MINNESOTA: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

FRAUD WARNING NOTICES (CONT.)

For use with Claim Forms

PLEASE READ THE FRAUD WARNING NOTICE FOR YOUR STATE

NEW MEXICO: any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

NEW YORK: 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

OHIO: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

OKLAHOMA: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

OREGON: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

PENNSYLVANIA: 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.

PUERTO RICO: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances are present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

TENNESSEE: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

TEXAS: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

VIRGINIA: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

WASHINGTON: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

RHODE ISLAND and WEST VIRGINIA: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

ALL OTHER STATES: 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.

CONTINENTAL AMERICAN INSURANCE COMPANY
Post Office Box 427* Columbia, South Carolina 29202
Phone (800) 433-3036 Fax (866) 849-2970

INSURED_____ POLICY NUMBER_____

AUTHORIZATION TO OBTAIN INFORMATION
CONTINENTAL AMERICAN INSURANCE COMPANY

For the purpose of evaluating my *eligibility for insurance and eligibility for benefits* under an existing policy/certificate, including checking for and resolving any issues that may arise regarding incomplete or incorrect information on my application for coverage and/or claim form, I hereby authorize the disclosure of the following information about me and, if applicable, my dependents, from the sources listed below to Continental American Insurance Company (CAIC) and its duly authorized representatives.

Disclosure of Health Information

Health information may be disclosed by any health care provider, health plan (including CAIC or Aflac, with respect to other CAIC or Aflac coverages) or health care clearinghouse that has any records or knowledge about me. Health care provider includes, but is not limited to, any licensed physician, medical or nurse practitioner, nurse, pharmacist, osteopath, psychologist, physical or occupational therapist, chiropractor, dentist, audiologist or speech pathologist, podiatrist, hospital, medical clinic or laboratory, pharmacy, rehabilitation facility, nursing home or extended care facility, prescription drug database or pharmacy benefit manager, or ambulance or other medical transport service. Health information may also be disclosed by any insurance company or the Medical Information Bureau (MIB). Health information includes my entire medical record, but does not include psychotherapy notes.

Financial or credit history, earnings, or employment history may be disclosed by any entity, person, or organization that has these records about me, including but not limited to my employer, employer representative and compensation sources, insurance company, financial institution, or any consumer reporting agency.

Federal, state, and local government organizations including but not limited to the Veteran's Administration, Internal Revenue Service, Social Security Administration, and Medicare or Medicaid agencies, may disclose health or financial information or records about me.

Any information CAIC obtains pursuant to this authorization will be used for the purpose of evaluating and administering my application for coverage and/or claim for benefits. Some information obtained may not be protected by certain federal regulations governing the privacy of health information, but the information is protected by state privacy laws and other applicable laws. CAIC will not disclose the information unless permitted or required by those laws.

I understand that if the information disclosed is protected health information relating to a health plan and the person or entity receiving the information is a not a health care provider or health plan covered by federal privacy regulations, the information disclosed may be redisclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.

This authorization may be revoked by me or my authorized representative at any time except to the extent CAIC has relied on the authorization prior to notice of revocation or has a legal right to contest coverage under the contract or the contract itself. If I revoke this authorization, CAIC may not be able to evaluate my application for coverage and/or claim. I may revoke this authorization by sending written notice to: Continental American Insurance Company, ATTN: New Business Department (for applications) or ATTN: Claims Department (for claims), P.O. Box 427, Columbia, SC 29202.

You may refuse to sign this form; however, CAIC may not be able to evaluate and administer your application for coverage and/or your claim without this authorization.

This authorization is valid for two (2) years from its execution or for the duration of my claim, whichever is later. A copy of this authorization is as valid as the original. I know that I or my authorized representative may request a copy of this authorization and access to this information.

I am the individual to whom this authorization applies or that person's legal Guardian, Power of Attorney Designee, Conservator, Beneficiary or personal representative.

_____ _____
(Printed Name of Individual Subject to Disclosure) (Date of Birth)

_____ _____
(Signature) (Date Signed)

If applicable, I signed on behalf of the insured as _____.
(Indicate relationship, legal Guardian, Power of Attorney Designee, Conservator, Beneficiary or personal representative.)

_____
(Printed Name of Legal Representative)

_____ _____
(Signature of Legal Representative) (Date Signed)

Electronic Funds Transaction Authorization

Send to: **Continental American Insurance Company**
Mail: Post Office Box 427 Columbia, South Carolina 29202
Phone: (800) 433-3036 Fax (866) 849-2970
Email: groupclaimfiling@aflac.com

I would like to:

☐ Start ☐ Stop ☐ Change direct deposit of my claim payment(s).

Account Type:

☐ Checking ☐ Savings ☐ Other

9-Digit Routing Number:	Account Number:

Remember: The 9-digit number on a deposit slip is not a routing number.
You can obtain the routing number from a check or from your financial institution. *See example above.*

Name of Financial Institution:

Address:		City:
State:	Zip:	Phone:

Authorization Agreement for Direct Deposit

I authorize Continental American Insurance Company (CAIC) to initiate credit entries, and, if errors occur, I authorize the correction of entries to my account as indicated. This authorization remains effective and in full force until CAIC receives written notification from me of its termination in such time and in such manner to afford CAIC a reasonable opportunity to act on it. Please notify CAIC immediately if your financial institution information has changed by sending notification to the address indicated above. Should you have any questions, please contact us at 1-800-433-3036.

Certificateholder's Name (*Print)*:

Address:	City/State:
Zip:	Phone #:
Employer Name or Group #:	Certificate #:
Certificateholder's Signature:	Date:

CONTINENTAL AMERICAN INSURANCE COMPANY
Post Office Box 427* Columbia, South Carolina 29202
Phone (800) 433-3036 Fax (866) 849-2970

HOSPITAL INDEMNITY CLAIM FORM

Failure to complete all sections may result in a delay in processing this claim.
To prevent delays, please provide documentation from your healthcare provider to support this claim.
Please review your policy for specific benefits covered under your plan.

- ✓ **Benefits are payable to you unless we receive written authorization from your provider to assign benefits to them or from you to pay your benefits elsewhere. This is called an assignment. If you wish to assign your benefits, please send a signed written request.**
- ✓ **If this claim is for an individual covered by Medicaid or a state variation of Medicaid, most non-disability benefits are automatically assigned according to state regulations. This means we must pay the benefits to Medicaid or to the medical provider to reduce the charges billed to Medicaid.**

Authorization

Several states require that the following statement appear on claim forms: **Any person who knowingly attempts to defraud any insurance company, files a statement of claim containing any materially false, incomplete or misleading information, is guilty of a crime.**

I hereby certify that the answers I have made to the foregoing questions are both complete and true to the best of my knowledge and belief. I have read the fraud notice included in this form.

Policyholder's signature: _____ Date: _____

Patient's Signature: _____ Date: _____

POLICYHOLDER'S / PATIENT INFORMATION

Employer's Name		Policyholder's Email Address		
Policyholder's Name	Policy No	Social Security No	Date of Birth	Gender
Policyholder's Address City State Zip Code		Policyholder's Telephone No. (with area code)		
Patient's Name (Person who is sick or injured)	Patient's Date of Birth	Patient's Gender	Relationship to Policyholder	

*By providing your e-mail address above, you consent to the use of electronic transactions in connection with your CAIC policies, contracts, and/or accounts to the extent available permitted by law (which may include, but not limited to: invoices, claim correspondence, contracts, surveys, and other materials that CAIC is, or may be, legally required to deliver to you).

Please sign the attached HIPAA Form and return it with the completed claim form.

*****If filing a claim within the first policy year for benefits, medical records may be requested*****

Is medical treatment due to an injury? No _____ Yes _____

- If yes, please complete the following questions related to the injury:
- Date of the injury: _____
- Describe how the injury occurred:

  _____
  _____
  _____
  _____
  _____

- Location of the injury: _____ On the job _____Off the job

- Was the patient injured in a motor vehicle accident? _____ No _____Yes - (If yes, please submit the Police Report)

Is treatment due to a sickness? _____ No _____ Yes

If Yes, please complete the following questions related to the sickness

- What is your sickness diagnosis: _____
- Symptoms first occurred on what date: _____
- First date of treatment for this condition: _____
- If diagnosed with Cancer, on what date was the initial diagnosis? _____
  (Please submit pathology report with your claim submission if diagnosed with Cancer)
  - Was the patient treated by any other physicians for this sickness or a related condition?
    - _____ No _____ Yes
    - If yes, please provide the physician's name(s), address(es) and phone number(s) inside the box below.

Treatment Date	Physician Name	Address	City,State,Zip	Phone Number

Pregnancy claims:

- Date of delivery: _____
- Type of Delivery: _____ Vaginal _____ Cesarean
- If not delivered, expected delivery date: _____
- What was the date of your last menstrual period? _____

- Please list any complications due to your pregnancy:

  _____
  _____
  _____
  _____

Please complete the remaining sections for all claims:

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

Name: _____ Phone Number: _____

Address: _____ City/State/Zip: _____

- Was the patient confined to the hospital as a result of this condition? _____ No _____ Yes

  (If confined, please submit copy of patient's admission and discharge papers or a copy of a UB-04 billing invoice from the hospital)

  Hospital (Facility) name: _____ Phone Number: _____

  Admission date: _____ Discharge Date: _____

If yes, please complete the below:

Employer Facility Benefit Provision

(for insureds who have employer facility benefits)

Name of Hospital (Facility) name where patient was admitted, confinement or received treatment: _____ Phone Number: _____

Address: _____ City/State/ZIP: _____

Is this facility also your place of employment? _____ No _____ Yes

If no, does this facility partner with your employer's healthcare system? _____ No _____ Yes

- Was the patient confined to the intensive care unit as a result of this condition? _____ No _____ Yes

  (If yes, please submit copy of a UB-04 billing invoice from the hospital facility to identify the days spent in the intensive care unit)

- Was the patient confined to a rehabilitation unit as a result of this condition? _____No _____Yes

  (If yes, please submit copy of patient's admission and discharge papers or a copy of a UB-04 billing invoice from the hospital)

- Was the patient treated in an emergency room as a result of this condition? _____No _____Yes

  (If yes, please submit emergency room admission and discharge papers)

- Was surgery performed as a result of the medical condition? _____ No _____ Yes

  (If yes, please submit a copy of the operative report.)

**For outpatient prescription drug benefits, please submit pharmacy receipts showing the name of the prescription, the physician name prescribing it and the date prescribed.

FRAUD WARNING NOTICES

For use with Claim Forms

PLEASE READ THE FRAUD WARNING NOTICE FOR YOUR STATE

ALASKA: A person who knowingly and with intent to injury, defraud or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

ARIZONA: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

ARKANSAS: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

CALIFORNIA: For your protection California law requires the following to appear on this form:
Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

COLORADO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

DELAWARE: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

DISTRICT OF COLUMBIA: **WARNING:** It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

FLORIDA: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

IDAHO: Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

INDIANA: A person who knowingly and with intent to defraud an insurer files a statement of claim containing Any false, incomplete, or misleading information commits a felony.

KENTUCKY: Any person who knowingly and with intent to defraud any insurance company or other person files a 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.

LOUISIANA: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

MAINE: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

MARYLAND: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

MINNESOTA: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

NEW HAMPSHIRE: Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

NEW JERSEY: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

FRAUD WARNING NOTICES (CONT.)

For use with Claim Forms

PLEASE READ THE FRAUD WARNING NOTICE FOR YOUR STATE

NEW MEXICO: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

NEW YORK: 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

OHIO: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

OKLAHOMA: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

OREGON: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

PENNSYLVANIA: 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.

PUERTO RICO: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances are present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

TENNESSEE: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

TEXAS: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

VIRGINIA: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

WASHINGTON: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

RHODE ISLAND and WEST VIRGINIA: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

ALL OTHER STATES: 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.

CONTINENTAL AMERICAN INSURANCE COMPANY
Post Office Box 427* Columbia, South Carolina 29202
Phone (800) 433-3036 Fax (866) 849-2970

AUTHORIZATION TO OBTAIN INFORMATION

MAIL TO: Continental American Insurance Company
P.O. Box 427
Columbia, South Carolina 29202

CALL: 1.800.433.3036 (toll-free)
CLAIM FAX: 1.866.849.2970

Primary Certificateholder's Name:	**SSN**(optional):	**Date of Birth:**
Certificate Number(s):		
Address:		
Name of Individual Subject to Disclosure (If not the primary Certificateholder):		**Date of Birth:**
Relationship to Primary Certificateholder: □Self □ Spouse □ Domestic Partner □ Child □ Stepchild □ Grandchild		

I. Authorization:
For the purpose of evaluating my *eligibility for insurance and for benefits* under an existing certificate, including checking for and resolving any issues that may arise regarding incomplete or incorrect information on my application for coverage and/or claim form, I hereby authorize the disclosure of the following information(defined below) about me and, if applicable, my dependents, from the sources listed below to Continental American Insurance Company (CAIC), or any person or entity acting on its part, to include American Family Life Assurance Company of Columbus and American Family Life Assurance Company of New York (collectively, "Aflac).

II. Disclosure of Health Information:
Health information may be disclosed by any health care provider, health plan (including CAIC or Aflac, with respect to other CAIC or Aflac coverages) or health care clearinghouse that has any records or knowledge about me. Health care provider includes, but is not limited to, any licensed physician, medical or nurse practitioner, nurse, pharmacist, osteopath, psychologist, physical or occupational therapist, chiropractor, dentist, audiologist or speech pathologist, podiatrist, hospital, medical clinic or laboratory, pharmacy, rehabilitation facility, nursing home or extended care facility, prescription drug database or pharmacy benefit manager, or ambulance or other medical transport service. Health information may also be disclosed by any insurance company or the Medical Information Bureau (MIB). Health information includes my entire medical record, but does not include psychotherapy notes. Some information obtained may not be protected by certain federal regulations governing the privacy of health information, but the information is protected by state privacy laws and other applicable laws. CAIC will not disclose the information unless permitted or required by those laws.

III. Rights and Expiration:
I understand that I may revoke this authorization at any time, except to the extent that CAIC or Aflac has taken action in reliance on this authorization. If I revoke this authorization, CAIC may not be able to evaluate my application for coverage and/or claim. To revoke this authorization, I must provide a written and signed revocation to CAIC at the address or fax number above. Unless otherwise revoked, this authorization shall remain in effect for two (2) years from the date signed or upon my death, whichever occurs first. I agree that a copy of this authorization is as valid as the original and that I or an authorized representative may request a copy of this authorization.

IV. Notice:
I understand that CAIC is not conditioning payment, enrollment, or eligibility for benefits on whether I sign this authorization. I understand that if the information disclosed is protected health information relating to a health plan and the person or entity receiving the information is a not a health care provider or health plan covered by federal privacy regulations, the information disclosed may be redisclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.

- **If records are on an adult dependent, (e.g. spouse, child over 18), the dependent must sign this form**
- **If records are on a minor child the natural parent or legal guardian must sign on their behalf.**

_____ _____
Signature of Individual Subject to Disclosure Date Signed

_____ _____ _____ _____
Legal Representative's Printed Name Legal Representative's Signature Legal Relationship Date Signed

If signed by a legal representative (e.g. Legal Guardian, Estate Administrator, Power of Attorney)

Electronic Funds Transaction Authorization

Send to: **Continental American Insurance Company**
Post Office Box 427
Columbia, South Carolina 29202

Phone: (800) 433-3036 Fax (866) 849-2970
Email: groupclaimfiling@aflac.com

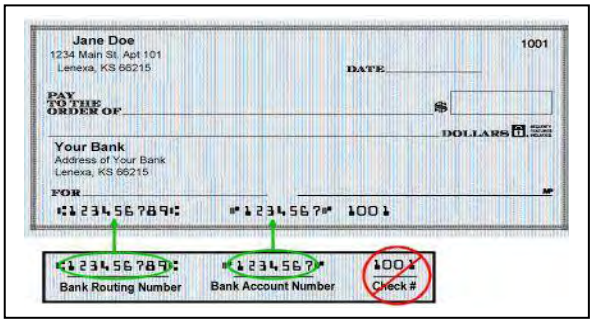
I would like to:

☐ Start ☐ Stop ☐ Change direct deposit of my claim payment(s).

Account Type:

☐ Checking ☐ Savings

****** Please provide a blank voided check or direct deposit form from your financial institution. Incomplete or inaccurate information will not be processed.**



9-Digit Routing Number:	Account Number:
Name of Financial Institution:	
Address:	City:
State: / Zip:	Phone:

Authorization Agreement for Direct Deposit

I authorize Continental American Insurance Company (CAIC) to initiate credit entries, and, if errors occur, I authorize the correction of entries to my account as indicated. This authorization remains effective and in full force until CAIC receives written notification from me of its termination in such time and in such manner to afford CAIC a reasonable opportunity to act on it. Please notify CAIC immediately if your financial institution information has changed by sending notification to the address indicated above. Should you have any questions, please contact us at 1-800-433-3036.

Policy/Certificate Holder's Name (*Print*):

Address:	City/State/Zip:
Phone #:	E-mail Address:
Employer Name or Group #:	Certificate #:

By providing your e-mail address above, you consent to the use of electronic transactions in connection with your CAIC policies, contracts, and/or accounts to the extent available and permitted by law (which may include, but not limited to: invoices, claim correspondence, contracts, surveys, and other materials that CAIC is, or may be, legally required to deliver to you)

_____ _____
Policy/Certificate Holder Signature ***(Required)*** Date

Note: Forms received without signature will **not** be processed.