SPECIFIED-DISEASE CLAIM FORM

Failure to complete this form in its entirety may result in a delay in processing this claim. FILING CLAIM FOR (check all that apply): ☐ Cancer With Disability □ Cancer ☐ Cancer With Hospitalization ☐ Deceased - Date Deceased:_ Short-Term Disability/Sickness Life Specified-Disease Hospital Indemnity Hospital Intensive Care Disability Rider Policy Number Policy Number Policy Number Policy Number Policy Number INSTRUCTIONS: ☐ Complete and sign **Section A: Policyholder/Patient Information**. Your physician should complete and sign Section B: Physician's Statement (Pages 2 and 3). This Cancer Claim Form should be completed on or after the initial date of your hospitalization and/or surgery. Forms completed prior to the initial date of your hospitalization and/or surgery, may result in a delay in processing this claim. A pathology report diagnosing cancer must accompany your first claim. (The hospital or doctor will furnish this report to you at your request.) If the diagnosis of cancer was made clinically instead of pathologically, please submit the clinical evidence that established the diagnosis of cancer. Submit all bills related to this claim, such as ambulance, radiation treatments, chemotherapy treatments, etc. All bills should be itemized and should include the diagnosis, services rendered, and actual charges for the service. If filing for chemotherapy, itemized billing should also include drug names. Please include a certified copy of the death certificate if the patient is deceased. If surgery was performed, please submit a copy of the surgeon's bill or operative report. The items above can be obtained directly from your health care provider(s) by requesting a UB04 (hospital bill) or HCFA1500 (nonhospital bill). Be sure to include your policy number(s) on all documents. Policyholder Information (Please print.) First Name Initial Last Name Mailing Address City State ZIP Check box if this is a new permanent address: Social Security Number Phone Number **Patient Information** (Please print.) First Name Initial Last Name Relationship: Sex: Primary Policyholder Female Spouse Male Patient Birth Date: Dependent Child Check here if dependent child is a full-time student (if over the age 19, please provide school name and contact information). 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.

FAMILY RELATIONSHIP, IF NOT POLICYHOLDER DATE

American Family Life Assurance Company of New York (Aflac New York)
Attention: Claims Department • 1932 Wynnton Road • Columbus, GA 31999-7255
For information or help filing your claim, please call toll-free 1-800-366-3436 or visit our Web site at aflacny.com.
Toll-free fax number: 1-877-844-0201

CLAIMANT SIGNATURE

SPECIFIED-DISEASE CLAIM FORM - PHYSICIAN'S STATEMENT

Failure to complete this form in its entirety may result in a delay in processing this claim.

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.

Policy Number:		Policyholder	Name:		
Patient Name:			Date of Birth:		
SECTION B: PHY	SICIAN'S STATEM	ENT Please answer each questi	on COMPLETELY.		
PHYSICIAN'S NAME			PHONE NUMBER	FAX NUMBER	
MAILING ADDRESS	3		CITY	STATE	ZIP
Has patient bee	en diagnosed with ca	incer?			
Type of cancer:				CD code:	
2. Date of initial di	agnosis:/_	/			
Please provide th	e patient with a co	py of the pathology report that d	iagnosed cancer, as it	is required for all init	ial claims.
3. Patient first con	sulted you for this c	ondition on:/			
4. Was the patient	t referred to you by a	another physician? Yes I	No		
If yes, physician's i	name:				
Referring physiciar	n's address:		Ph	one number:	
Hospitalization	Information				
Was patient hospit	alized as a result of	this diagnosis? ☐ Yes ☐ No If ac	dditional dates exist, plea	se attach a copy of ite	mized billing.
Admission Date Discharge Date Adr		Admitting Diagnosis/ICD Code	(Please include city and state.)		
		│ (PHYSICIAN'S STATEMENT CON	TINUED ON PAGE 3)		
			·		
PHYSICIAN'S SIG	SNATURE	DATE		TAX ID NUMBER	

American Family Life Assurance Company of New York (Aflac New York)

Attention: Claims Department • 1932 Wynnton Road • Columbus, GA 31999-7255

For information or help filing your claim, please call toll-free 1-800-366-3436 or visit our Web site at aflacny.com

Toll-free fax number 1-877-844-0201

SPECIFIED-DISEASE CLAIM FORM - PHYSICIAN'S STATEMENT

Failure to complete this form in its entirety may result in a delay in processing this claim.

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.

Policyholder Name:

Policy Numbe	r:	Policyholder Name:						
Patient Name:	e: Date of Birth:							
Surgery Info	ormation: Where	e was the	surgery	y performed? □C	Office Surgical Cent	er □Outpatient Hospita	I ☐ Inpatient Hospita	
Name of facilit	ty:							
Did patient und	dergo surgery for	this condit	tion? [☐ Yes ☐ No	If additional dates	exist, please attach a co	py of itemized billing	
Date of Service	Diagnosis/ICD Code		Surgery/CPT Description Code		ption of Surgery	Facility Nar	ne Charges	
Chemothera	apy Information	L						
Has patient re	ceived chemother	ару? 🏻	Yes	□ No If a	additional dates exist,	olease attach a copy of i	temized billing.	
Date HCPCS/CPT Code		ΓCode	Drug Name and Method of Administration			inistration	Drug Charge	
D - 1'-1' T	L L - C	4						
	herapy Informa							
Has patient re Date	ceived radiation th	· · ·	☐ Yes	s 🗆 No	If additional dates exis	st, please attach a copy of	Charge	
		oue			Description		Charge	
Date								
Date								
Date								
Date								
Date								

American Family Life Assurance Company of New York (Aflac New York)

Attention: Claims Department • 1932 Wynnton Road • Columbus, GA 31999-7255

For information or help filing your claim, please call toll-free 1-800-366-3436 or visit our Web site at aflacny.com

Toll-free fax number 1-877-844-0201

DATE

TAX ID NUMBER

PHYSICIAN'S SIGNATURE

Claims Authorization to Obtain Information

Instructions for completing this Health Insurance Portability and Accountability Act of 1996 (HIPAA) compliant form:



- 1. All areas of this form should be completed.
- 2. This form must be signed and dated by the claimant/patient below.
- IMPORTANT: If you are filing a claim on behalf of a deceased, please check here
- 4. If you are the Authorized Representative, please sign below and indicate your relationship to the claimant/patient/deceased. In addition, include a copy of the legal document(s) authorizing you to act on their behalf.
- 5. Fax this form to 1-877-844-0201 or return the form to Aflac New York, Attn: Claims Department, Worldwide Headquarters, 1932 Wynnton Road, Columbus, GA 31999-7255, as soon as possible in order to expedite claim review.

Policyholder Name:	Policy Number(s):		Date of Birth:
Policyholder Address:			
Claimant/Patient Name (if different fr	rom named policyh	older listed above):	Date of Birth:
This authorization shall be valid for years from the sign date unless a les indicated. Alternate Expiration Date:	sser time frame is	Name and Address of health care provider(s), company, or individual authorized to release the requested information: (this section will be completed by Aflac New York)	
Purpose of Disclosure: Evaluate claiduring the time this authorization is valid			

I, or my authorized representative, request that information regarding my past, present, or future physical or mental health condition (excluding psychotherapy notes), employment, other insurance coverage, or any other nonmedical facts be released to **American Family Life Assurance Company of New York (Aflac New York)** or any person or entity acting on its part. This could include, but is not limited to, any medical professional, medical care institution, insurer (including Aflac New York, with respect to other Aflac New York coverages), reinsurer, government agency (including departments of public safety and motor vehicle departments), consumer reporting agency or employer.

I understand that:

- 1. Protected health information may include information and records protected under Federal and State Law such as: alcohol, drug abuse, mental health, AIDS or HIV testing or treatment, or the presence of a communicable or noncommunicable disease.
- 2. My treatment, payment or eligibility for benefits may not be conditioned on signing this authorization.
- 3. I understand that I may revoke this authorization at any time by writing to Aflac New York, Claims Department, Worldwide Headquarters, 1932 Wynnton Road, Columbus, GA 31999-7255, except to the extent that:
 - a. Aflac New York has taken action in reliance to this authorization, or
 - b. Other law provides Aflac New York with the right to contest a claim under the policy or the policy itself.
- 4. If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
- 5. It is recommended I retain a copy of this signed form for my records, understanding that a copy is as valid as the original.

Signature of claimant/patient, guardian or authorized representative	Date
Printed name of claimant/patient, guardian or authorized representative	Relationship