

# ACCIDENTAL INJURY 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):

Accidental Injury Only    
  Injury With Disability    
  Injury With Hospitalization    
  Deceased - Date Deceased: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Accident Policy Number	Short-Term Disability Policy Number	Hospital Indemnity Policy Number	Hospital Intensive Care Policy Number	Life Policy Number

**INSTRUCTIONS:**

- Complete **Section A: Policyholder/Patient Information.**
- Have your doctor complete Section B: Physician's Statement. If you are filing for disability, have your doctor also complete and sign Section C: Physician's Disability Statement.
- If you are filing for disability, have your employer complete and sign Section D: Employer's Disability Statement.
- Be sure to sign your claim form at the bottom of Page 1.

**ADDITIONAL NOTES:**

- Submit all bills related to this claim such as ambulance, follow-up visits, physical therapy, etc. All bills should be itemized and should include the diagnosis, services rendered and actual charges for the service.
- If you were treated in the emergency room, send us a copy of the emergency room report.
- We require a copy of the police accident report for all motor vehicle accident claims and other incidents investigated by any law enforcement agency.
- Send a copy of your hospital bill that lists the number of days confined.
- If confined to an intensive care unit, please send a copy of your hospital bill that shows charges and the number of days you spent in the intensive care unit. Your intensive care claim cannot be processed without the hospital bill.
- Please include a certified copy of the death certificate if the patient is deceased.
- **Be sure to include your policy number(s) on all documents.**

**SECTION A: POLICYHOLDER/PATIENT INFORMATION**

POLICYHOLDER'S INFORMATION		
LAST NAME	FIRST NAME	MIDDLE INITIAL
SOCIAL SECURITY NUMBER (optional)	BIRTH DATE	PHONE NUMBER (     )
MAILING ADDRESS		<input type="checkbox"/> CHECK BOX IF THIS IS A NEW PERMANENT ADDRESS
CITY	STATE	ZIP
PLACE OF EMPLOYMENT:		PHONE NUMBER (     )
MAILING ADDRESS		
CITY	STATE	ZIP

PATIENT'S INFORMATION		
LAST NAME	FIRST NAME	MIDDLE INITIAL
SOCIAL SECURITY NUMBER (optional)	BIRTH DATE	
<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> OTHER                    RELATIONSHIP: <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> DEPENDENT - CHECK IF DEPENDENT IS FULL-TIME STUDENT <input type="checkbox"/>		

Date of incident: \_\_\_\_ / \_\_\_\_ / \_\_\_\_     Describe where and how the incident occurred: \_\_\_\_\_

\*\* If the injury resulted from an auto accident, a copy of the police report is required.\*\*

**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.**

CLAIMANT SIGNATURE \_\_\_\_\_    
 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

# ACCIDENTAL INJURY 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: \_\_\_\_\_

## SECTION B: PHYSICIAN'S STATEMENT Please answer each question COMPLETELY.

PHYSICIAN'S NAME	PHONE NUMBER ( )	FAX NUMBER ( )
MAILING ADDRESS	CITY	STATE ZIP

DATES OF SERVICE	DIAGNOSIS CODE ICD	DIAGNOSIS DESCRIPTION	PROCEDURE CODE	PROCEDURE DESCRIPTION
/ /				
/ /				
/ /				
/ /				

Date of incident: \_\_\_\_/\_\_\_\_/\_\_\_\_ Describe where and how the incident occurred: \_\_\_\_\_

Was patient hospitalized as a result of this diagnosis?  Yes  No Admission: \_\_\_\_/\_\_\_\_/\_\_\_\_ Discharge: \_\_\_\_/\_\_\_\_/\_\_\_\_

Hospital Name: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

**ATTENTION PHYSICIAN: If patient is disabled, please ALSO complete SECTION C below.**

\_\_\_\_\_  
PHYSICIAN'S SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
TAX ID NUMBER

## SECTION C: PHYSICIAN'S DISABILITY STATEMENT Must be completed by physician or physician's staff.

1. First date of disability: \_\_\_\_/\_\_\_\_/\_\_\_\_ Last date of treatment: \_\_\_\_/\_\_\_\_/\_\_\_\_

2. Is patient currently working:  Full-time?  Part-time?  Light duty? Date patient was released to return to work: \_\_\_\_/\_\_\_\_/\_\_\_\_

3. If patient has not been released to return to work or if patient is working light duty, please provide the next appointment date: \_\_\_\_/\_\_\_\_/\_\_\_\_

4. If patient is not employed, or employed less than 30 hours, which Activities of Daily Living (ADLs) is the patient unable to perform?

Check and initial all that apply:  Continence  Transferring  Dressing  Toileting  Eating  Bathing (PA only)

\_\_\_\_\_  
PHYSICIAN'S SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
TAX ID NUMBER

**Please review and sign the attached authorization. Two copies are attached: return one copy to Aflac New York 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.**

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# ACCIDENTAL INJURY CLAIM FORM – EMPLOYER’S DISABILITY STATEMENT

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Policy Number: \_\_\_\_\_

Policyholder Name: \_\_\_\_\_

Patient Name: \_\_\_\_\_

## SECTION D: EMPLOYER'S DISABILITY STATEMENT Please complete if filing for disability.

EMPLOYER'S NAME	PHONE NUMBER ( )	FAX NUMBER ( )	
MAILING ADDRESS	CITY	STATE	ZIP

- Date of hire: \_\_\_\_/\_\_\_\_/\_\_\_\_ First date of disability: \_\_\_\_/\_\_\_\_/\_\_\_\_
- Date returned (or expected to return) to Full-Time Duty: \_\_\_\_/\_\_\_\_/\_\_\_\_
- Is the person still employed?  Yes  No If no, last date of employment: \_\_\_\_/\_\_\_\_/\_\_\_\_
- Prior to this disability, number of hours worked per week: \_\_\_\_\_ Annual base salary (prior to disability): \$ \_\_\_\_\_
- Was this disability caused by an incident that occurred at the workplace?  Yes  No
- Has employee returned to work?  Yes  No If yes, is employee working:  Full-time?  Part-time?  Light duty?
- Date employee began light duty: \_\_\_\_/\_\_\_\_/\_\_\_\_
- Is the employee currently earning at least 80% of his or her predisability salary?  Yes  No
- Are Sickness Disability Rider or Short-Term Disability premiums paid by the employee with pre-tax dollars?  Yes  No **(Please contact payroll and/or check the employee's SRA/PDA card for the answer to this question.)**
- Does the employer pay a portion of the disability premium for the employee?  Yes  No If yes, what percent? \_\_\_\_\_ %
- Employee is: (Check all that apply)  Exempt from Social Security  Exempt from Medicare  Subject to RRTA

### Please note:

The employer is required to report disability benefits paid on pre-tax plans on its Form 941 and the employee's Form W-2.

\_\_\_\_\_  
EMPLOYER'S SIGNATURE

\_\_\_\_\_  
TITLE

\_\_\_\_\_  
DATE

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Policy #:

Grid of 10 empty boxes for policy number entry.

**AUTHORIZATION TO OBTAIN INFORMATION**

I authorize the following to give information (as defined below) to American Family Life Assurance Company of New York (Aflac New York) or any person or entity acting on its part: 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. "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 New York deems appropriate to evaluate claims for benefits during the time this authorization is valid. I understand that any disclosure of information to Aflac New York 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 New York to evaluate claims for benefits.

I understand that I may revoke this authorization at any time, except to the extent that (1) Aflac New York has taken action in reliance on this authorization, or (2) other law provides Aflac New York with the right to contest a claim under the policy or the policy itself. My revocation must be submitted in writing to Aflac New York, Claims Department, 1932 Wynnton Road, Columbus GA 31999-7255.

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:

**RETAIN THIS COPY FOR YOUR RECORDS**