Aflac®

American Family Life Assurance Company of New York

ACCIDENT WELLNESS BENEFIT CLAIM FORM INSTRUCTIONS

Please use black or blue ink only and print legibly when completing this form in its entirety. Keep a copy of the supporting documentation and this completed form for your records. Sign, date, and mail or fax the completed form to the address/number shown below.

Send all claims to: **Group Product Administration Accident Processing Unit**
Post Office Box 84075
Columbus, Georgia 31993

Phone -(866)849-2964 Fax– (866) 849-2974

☐ Please check this box if you are filing for a wellness benefit under multiple coverages.

CERTIFICATEHOLDER/CLAIMANT'S INFORMATION

CERTIFICATEHOLDER'S NAME	CERTIFICATE NO.	SOCIAL SECURITY NO.	DATE OF BIRTH	SEX
Colmbia, South Carolina 29202				
CERTIFICATEHOLDER'S ADDRESS			CERTIFICATEHOLDER'S TELEPHONE NO.	
CLAIMANT'S NAME	RELATIONSHIP TO THE CERTIFICATEHOLDER	CLAIMANT'S DATE OF BIRTH		

HEALTH SCREENING INFORMATION

WHICH HEALTH SCREENING TEST DID YOU HAVE PERFORMED:

- ☐ ANNUAL PHYSICAL EXAM
- ☐ EYE EXAMINATION
- ☐ IMMUNIZATION
- ☐ FLEXIBLE SIGMOIDOSCOPY
- ☐ PSA
- ☐ ULTRASOUND
- ☐ MAMMOGRAPHY (date)_____
- ☐ BLOOD SCREENING
- ☐ PAP SMEAR (date)_____

DATE THE HEALTH SCREENING TEST WAS PERFORMED (treatment date **MUST** be provided _____

Physician Information

Name	Phone Number	
Street Address		
City	State	Zip

AUTHORIZATION

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 have checked the answers given by myself and they are correct. I AUTHORIZE any physician, medical practitioner, hospital, clinic, other medical or medically related facility, insurance or reinsuring company, consumer reporting agency, or employer having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment and any non-medical information of me, to give to American Family Life Assurance Company of NY or its legal representative, any and all such information. This In formation is to include, but i s not limited to information pertaining to diagnosi s, care or treatment for psychiatric disorder, drug or alcohol abu se, treatment or pre scriptions, te sting an d/or tre atment of HIV (AIDS v irus) and/or ot her sexually transmitted di seases, in cluding case history and me dical an tecedents. I UNDERSTAND the information obtained by use of the Authorization will be used by American Family Life Assurance Company of NY to determine eligibility for benefits under an existing certificate. Any information o btained will not be released by American Famil y Life Assurance Company of NY to an y person or organiza tion EXCEPT to reinsuring companies, or o ther persons or organizations performing business or legal services in connection with my claim, or as may otherwise lawfully required or as I may further authorize. I KNOW that I may request to receive a co py of thi s Authorization. I AGREE th at a photographic copy of this Authorization shall be a s valid as t he original. I AGREE that this Authorization shall be valid for the duration of my claim.

Certificateholder's Signature: Date: Claimant's Signature: Date:

FRAUD WARNING NOTICE

For use with Claim Forms

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.