CONTINUING DISABILITY CLAIM FORM

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

FILING CLAIM FOR:

Disability due to an Accident   Disability due to a Sickness   Disability due to Pregnancy / Complications   Disability due to Cancer

Accident Policy Number	Short-Term Disability Policy Number

INSTRUCTIONS:

- Complete **Section A: Policyholder/Patient Information**.
- Your doctor should complete and sign Section B: Physician's Disability Statement.
- Your employer should complete and sign Section C: Employer's Disability Statement.
- Be sure to sign your claim form at the bottom of Page 1.

SECTION A: POLICYHOLDER/PATIENT INFORMATION

POLICYHOLDER'S INFORMATION		
LAST	FIRST	INITIAL
SOCIAL SECURITY NUMBER (optional)	BIRTHDATE	PHONE NUMBER ( )
ADDRESS		CHECK BOX IF THIS IS A NEW PERMANENT ADDRESS }
CITY	STATE	ZIP
PLACE OF EMPLOYMENT:		PHONE NUMBER ( )
ADDRESS		
CITY	STATE	ZIP

PATIENT'S INFORMATION		
LAST	FIRST	INITIAL
SOCIAL SECURITY NUMBER (optional)	BIRTHDATE	
MALE FEMALE SINGLE MARRIED OTHER	RELATIONSHIP: SELF SPOUSE DEPENDANT -- CHECK IF CHILD IS FULL-TIME STUDENT	

Date of incident: _____/_____/_____   Describe where and how the incident occurred:____

____

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.

______________________ ______________________ ______________

CLAIMANT SIGNATURE   **FAMILY RELATIONSHIP, IF NOT POLICYHOLDER**   **DATE**

American Family Life Assurance Company of Columbus (Aflac)
Attention: Claims Department
Worldwide Headquarters: 1932 Wynnton Road, Columbus, GA 31999
For information or help filing your claim, please call toll-free 1-800-99-Aflac (1-800-992-3522) or visit our Web site at www.aflac.com
Toll-free fax number 1-877-44-Aflac (1-877-442-3522)

CONTINUING DISABILITY – PHYSICIAN'S DISABILITY STATEMENT

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

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

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

1. First date of disability: ______/______/______ First date out of work:______/______/______ Last date of treatment: ______/______/______
2. Pregnancy claims: Date of delivery: _____/_____/_____ Vaginal Cesarean If not delivered, expected delivery date: _____/_____/_____
   Please advise of any complications: ______________________________
3. Was patient hospitalized as a result of this diagnosis? Yes No Admission: ______/______/______ Discharge: ______/______/______
   Hospital Name: ______________________________ City: ________________ State: ________
4. Is patient currently working: full-time? part-time? light duty? Date patient was released to return to work: ______/______/______
5. If patient has not been released to return to work or if patient is working light duty, please provide the next appointment date: ______/______/______
6. If patient is not employed, or employed less than 30 hours, which Activities of Daily Living (ADLs) is patient unable to perform?
   Check and initial all that apply: Continence Transferring Dressing Toileting Eating Bathing

PHYSICIAN'S SIGNATURE DATE TAX ID NUMBER

SECTION C: EMPLOYER'S DISABILITY STATEMENT **Please complete if filing for disability.**

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

1. Date of Hire: _____ /_____ /_____ **First date of disability: _____ /_____ /_____**
2. Is the person still employed? Yes No If no, last date of employment: _____ /_____ /_____
3. Prior to this disability, number of hours worked per week: _________ Annual Base Salary (prior to disability): $_________________
4. Was this disability caused by an accident that occurred at the workplace? Yes No
5. Has employee returned to work? Yes No If yes, is employee working full-time? part-time? light duty?
6. Date employee began light duty: _____ /_____ /_____ Date returned (or expected to return) to Full-Time Duty: _____ /_____ /_____
7. Is the employee currently earning at least 80% of their pre-disability salary? Yes No
8. Does the employee pay Accident Disability Rider or Short-Term Disability premiums with pre-tax dollars? Rider Short-Term Disability
9. Does employer pay a portion of the disability premium for the employee? Yes No If yes, what percent?________ %
10. 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

American Family Life Assurance Company of Columbus (Aflac)
Attention: Claims Department
Worldwide Headquarters: 1932 Wynnton Road, Columbus, GA 31999
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