

Disability Claim Form

Account Number:

Faster, Easier Online Claim Filing Instructions

Reduce your claim processing time and receive your money faster when you file online or through AFmobile®.



Two Easy Ways to Register

Online at **americanfidelity.com**

Download AFmobile from the **Apple Store** or **Google Play**



Through your online or mobile account, you can file your claim, check claim status, sign up for notifications, update personal information, enroll in direct deposit, view your detailed policy, and much more!

SB-32082-1117

! **Stop here!** If you want to receive your **money faster**, register your account and **file online** or through our mobile app.

Claim Filing Instructions for Mail or Fax:

This is not the quickest option! However, if you choose to file a paper claim by mail or fax, please complete this packet in full to avoid delays in your claim processing.

1. Complete the Statement of Insured.
2. Have your employer complete the Employer's Report of Claim and return to you.
3. Have the treating physician complete the Attending Physician's Statement and return to you.
4. Submit the completed:
 - A. Statement of Insured
 - B. Employer's Report of Claim
 - C. Attending Physician's Statement
5. Mail or fax the completed forms to American Fidelity at the address or fax number listed above.

To receive updates on the on the status of your processed or paid claims, visit **americanfidelity.com/myaccount** and select your communication preferences. Or, you may contact us at the number atop this form with questions regarding your claim.

Your Money Direct, Your Money Faster. Enroll in Direct Deposit.

To set up direct deposit with American Fidelity, provide all required information below with your submitted claim. You may also enroll in direct deposit through your online account.

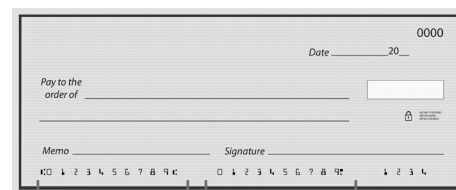
I authorize American Fidelity Assurance Company (AFA) to initiate credit entries to my account as indicated. I also authorize AFA to debit my account for any deposits made in error. This authorization remains effective and in full force until AFA receives written notification from me of its termination in such time and in such manner as to afford AFA and the Depository a reasonable opportunity to act on it. Please notify AFA immediately if your depository information has changed.

Signature: _____

You must provide the following information:

Routing Number: _____

Account Number: _____



Routing Number Account Number

STATEMENT OF INSURED

To be completed by Employee.

Full Name: (last, first, middle initial)		Date of Birth: / /
Social Security Number: / /	Account Number:	
Mailing Address: (P.O. Box or street, city and zip code)		
Telephone Number (including area code):	Email Address:	
Employer Name:		
Name and birthday of spouse and dependents:	Name:	Birthdate: / /
Name:	Birthdate: / /	

DISABILITY INFORMATION

Is the disability due to: <input type="checkbox"/> illness OR <input type="checkbox"/> accident		Date of onset / /
If accident, please describe the cause and details:		
If illness, diagnosis:		
Have you ever had the same or similar condition in the past? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, when? / /		
Provide all current treating physicians' full name(s) and contact information (attach additional list if necessary):		
Is your disability related to your employment/occupation? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, have you or do you intend to file for Worker's Compensation? <input type="checkbox"/> Yes <input type="checkbox"/> No	
On what date did you last work? / /	Dates of Total Disability: From / / Through / /	
On what date did you return to work? / /	Part Time / / Full Time / /	
If not returned to work, when do you anticipate returning to work? / /		
Has the patient been confined to a hospital? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, give admit and discharge dates along with name and address of hospital.	Admitted: / /	Discharged: / /
Name of hospital:	Address of hospital:	
If your request for benefits is approved, do you want us to withhold Federal Taxes from each benefit check? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, amount per month (minimum \$88.00): \$		

Identify other income sources and amount of income which you are receiving or may be entitled to receive during this disability.

Please check yes or no for each of the following:

Your Social Security: (disability or retirement)	<input type="checkbox"/> Yes <input type="checkbox"/> No Amount/month: \$	Unemployment:	<input type="checkbox"/> Yes <input type="checkbox"/> No Amount/month: \$
Dependent Social Security:	<input type="checkbox"/> Yes <input type="checkbox"/> No Amount/month: \$	Union:	<input type="checkbox"/> Yes <input type="checkbox"/> No Amount/month: \$
Sick Leave or Wage Cotinuation:	<input type="checkbox"/> Yes <input type="checkbox"/> No Amount/month: \$	V.A Benefits:	<input type="checkbox"/> Yes <input type="checkbox"/> No Amount/month: \$
Retirement: (normal, early, or disability)	<input type="checkbox"/> Yes <input type="checkbox"/> No Amount/month: \$	Worker's Compensation:	<input type="checkbox"/> Yes <input type="checkbox"/> No Amount/month: \$
State Disability Income:	<input type="checkbox"/> Yes <input type="checkbox"/> No Amount/month: \$	Other Disability Coverage: (list)	<input type="checkbox"/> Yes <input type="checkbox"/> No Amount/month: \$

Include a copy of your award or denial letter for any source in which one has been received.

I certify this information is true and correct. Signature:	Date:
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Attending Physicians Statement Disability Claim Form to be completed by physician

Name of Patient:	Date of Birth: / /	Social Security Number: / /	Account Number:
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DIAGNOSIS

Disabling Diagnoses (including complications):	ICD Code:
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HISTORY

When did symptoms first appear or accident happen? / /	Date patient first consulted you for this condition? / /
Has the patient ever had the same or similar condition? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, indicate when and describe:	
Was the patient referred to you? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide full name, address, and phone number of referring physician:	

TREATMENT

Frequency of treatment: <input type="checkbox"/> Monthly <input type="checkbox"/> Weekly <input type="checkbox"/> Other, describe:	Date of next appointment: / /
Please describe current treatment:	
List all dates of treatment or medical attention since the disability began:	
Is patient still under your regular care for this condition? <input type="checkbox"/> Yes <input type="checkbox"/> No	If no, please explain and provide name and phone number of the current treating physician:
Has the patient been confined to a hospital? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, give admit and discharge dates along with name and address of hospital.	Admitted: / / Discharged: / / Admitted: / / Discharged: / /
Name:	Address:

PROGNOSIS

Is patient now Disabled? For Regular occupation? <input type="checkbox"/> Yes <input type="checkbox"/> No	For any Occupation? <input type="checkbox"/> Yes <input type="checkbox"/> No
Date total disability began: / /	What is the expected return to work date? / /
Is the patient released to return to work with restrictions? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, From: / / Through: / / Please list return to work restrictions:

IMPAIRMENTS

Anticipated length of disability

What are the disabling impairments that prevent the patient from working? <input type="checkbox"/> Class 1 - No limitation of functional capacity, capable of heavy work. No Restrictions *(0-10%) <input type="checkbox"/> Class 2 - Medium manual activity *(15-30%) <input type="checkbox"/> Class 3 - Slight limitation of functional capacity; capable of light work activity *(35-55%) <input type="checkbox"/> Class 4 - Moderate limitation of functional capacity; capable of clerical/administrative sedentary activity. *(60-70%) <input type="checkbox"/> Class 5 - Severe limitation of functional capacity; Incapable of minimum sedentary activity *(75-100%)	<input type="checkbox"/> 1-2 Months <input type="checkbox"/> 2-3 Months <input type="checkbox"/> 3-6 Months <input type="checkbox"/> 6-12 Months <input type="checkbox"/> Greater than 12 Months <input type="checkbox"/> Permanent
Please list functional limitations/restrictions that render your patient temporarily totally disabled:	
Do you expect any improvement or decline in functional status? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please circle improvement or decline.	

PHYSICIAN INFORMATION

Attending Physician's Name & Title: (print)	Specialty:
Phone:	Fax:
Mailing Address: (P.O. Box or Street, City, State and Zip Code)	
Form Completed By: (Name & Title)	Signature: _____ Date: / /

If you require completion of your own authorization for the release of medical records please submit the form along with the physician statement.

Employer's Report of Claim

Name of Employer:	Phone Number:
Mailing Address: (P.O. Box or Street, City, State and Zip Code)	Fax Number:
Name of Employee:	Social Security Number: / /
Mailing Address: (P.O. Box or street, city and zip code)	
Date of Hire: / /	Occupation (please attach job description):
Employment Status at time of Disability: <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Leave of Absence <input type="checkbox"/> Terminated <input type="checkbox"/> Retired	

DISABILITY

Date employee last worked: / /	Has employee returned to work? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, date returned to work: / /	<input type="checkbox"/> Full Time <input type="checkbox"/> Part Time

PREMIUMS

Does the employee participate in Social Security? <input type="checkbox"/> Yes <input type="checkbox"/> No	If no, hired after 4/1/86? <input type="checkbox"/> Yes <input type="checkbox"/> No
Does employer pay a portion of the disability premium? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, what percent? %
Are disability premiums deducted from employee's pay on a pre-tax (section 125) basis? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Have AFA disability premiums been withheld through the last date worked? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is the last date disability premiums were deducted? / /

SALARY AT TIME OF DISABILITY FOR EDUCATION EMPLOYERS

Number of Contract Days _____ for _____ school year.	In-house days: First Day: / /
Annual Salary: \$ _____ Effective Date: / /	Last Day: / /

SALARY AT TIME OF DISABILITY FOR ALL OTHER EMPLOYERS

Hourly: \$ _____ Monthly: \$ _____
Gross salary for previous calendar year: \$ _____ Year-to-date, gross salary: \$ _____

OTHER INCOME

Did Employee's disability result from employment? Yes No Has employee made a claim for Workers' Compensation? Yes No
If yes provide the name, address, and phone number of Workers' Compensation carrier: _____

Is employee entitled to Workers' Compensation for this disability? Yes No
Is the employee receiving or eligible to receive any of the following? If yes, please complete the applicable boxes.

Other Group Disability	Begins: _____ Ends: _____	Differential/Sabbatical	Begins: _____ Ends: _____
Amount: \$ _____	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly	Amount: \$ _____	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly
Salary Continuation	Begins: _____ Ends: _____	Union Benefits	Begins: _____ Ends: _____
Amount: \$ _____	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly	Amount: \$ _____	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly
Sick Leave	Begins: _____ Ends: _____	State Disability	Begins: _____ Ends: _____
Amount: _____	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly	Amount: \$ _____	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly
PTO/PPT	Begins: _____ Ends: _____	For Union Benefits or Other Group Disability, please list provider's:	
Amount: \$ _____	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly	Name: _____	
		Phone: _____	

EMPLOYER SIGNATURE

The above named employee may qualify for benefits under the American Fidelity group disability program. The information stated above is correct to the best of my knowledge and belief. Authorized signature of employer firm or authorized official: _____

Printed Name: _____ Title: _____ Date: _____

Email Address: _____ Phone: (____) _____ Fax: (____) _____

How do you prefer to be contacted? Email Phone Fax

AUTHORIZATION TO DISCLOSE INFORMATION INCLUDING PROTECTED HEALTH INFORMATION

The purpose of this form is to allow American Fidelity Assurance Company (AFAC) to obtain data including but not limited to employment information, financial information, and protected health information about me, from any party holding that information.

I hereby authorize the entities specified below to disclose any information about me or my dependents' health or financial situation including my or my dependents' entire medical record and history of treatment for physical and/or emotional illness to include psychological testing, except psychotherapy notes, to individuals representing AFAC who are involved in determining whether I am eligible for benefits under my insurance coverage. Those so authorized are: a) licensed physicians or medical practitioners; b) hospitals, clinics or medically-related facilities; c) health plans; d) Veteran's Administration; e) past or present employers; f) pharmacy; g) insurance companies; h) the Social Security Administration; i) retirement systems; j) Department of Motor Vehicles, k) banks or financial institutions and l) Workers' Compensation Carrier. Colorado state law prohibits the redisclosure or reuse of information disclosed about a Colorado resident under this authorization.

NOTICE: Information authorized for release may include information on communicable or venereal diseases such as hepatitis, syphilis, gonorrhea, HIV/AIDS (Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome) or other conditions for which you may have been treated.

I understand that I may refuse to sign this authorization; however, if I do not sign the authorization, my failure to sign the authorization may result in a denial or a delay of benefits. I understand that I may revoke this authorization at any time by writing to American Fidelity Assurance Company, PO Box 25160, Oklahoma City, OK 73125-0160 or by calling, toll-free, 1-800-662-1113. I understand that my right to revoke this authorization is limited to the extent that: AFAC has taken action in reliance on the authorization; or, the law provides AFAC with the right to contest my insurance coverage or a claim under my insurance coverage. A copy of this authorization will be as valid as the original.

I understand that if protected health information is disclosed to a person or organization that is not required to comply with federal privacy regulations, the information may be redisclosed and no longer protected by the federal privacy regulations. In addition to the types of information described above, I also authorize American Fidelity to access any other type of information deemed necessary to investigate my claim. This information includes but is not limited to financial information, information submitted or related to insurance claim(s) or insurance coverage(s) and employment records. Any party holding this information is hereby authorized to release it to American Fidelity.

For health insurance coverage this authorization will expire twenty-four months from the date it is signed or upon termination of my insurance policy, whichever occurs first. For insurance coverage other than health insurance, this authorization will expire twenty-four months from the date it is signed or upon expiration of my claim for benefits, whichever occurs first.

AFA Account#	Printed Name of Patient	Patient's Date of Birth
Signature (Patient) or Personal Representative (if applicable)	Date Signed	

Relationship of Personal Representative to Patient (if applicable)
If authorization is supplied by a personal representative, a description of the authority to act on behalf of the Insured must be included.

Please retain a copy for your personal records, or you may request a copy from our Company.



Claim Form Fraud Statements

The following fraud language is attached to, and made part of, this claim form. **Please read and do not remove this page from this claim form.**

If you live in a jurisdiction not mentioned below, the following applies to you: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit is guilty of a crime and may be subject to fines and confinement in prison.

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, District of Columbia, Louisiana, 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.

California and Texas - For your protection California and Texas 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, Idaho and 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.

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.

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.

Maine, Tennessee, Virginia and 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 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.

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.

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.

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.

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 by 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 [be] 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.