

CONTINUING DISABILITY – PHYSICIAN'S DISABILITY 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: _____

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

PHYSICIAN'S NAME	PHONE NUMBER ()	FAX NUMBER ()
MAILING 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. Diagnosis description and ICD code: _____

4. Was patient hospitalized as a result of this diagnosis? Yes No Admission: ____/____/____ Discharge: ____/____/____

Hospital Name: _____ City: _____ State: _____

5. Is patient currently working: full-time? part-time? light duty? Date patient was released to return to work: ____/____/____

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

7. 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 (PA only)

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 ()
MAILING 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 (Please contact payroll and/or check the employee's SRA/PDA card for the answer to this question.)

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 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