

SPECIFIED-DISEASE 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

1. Has patient been diagnosed with cancer? Yes No
 Type of cancer: _____ ICD code: _____
2. Date of initial diagnosis: ____/____/____
Please provide the patient with a copy of the pathology report that diagnosed cancer, as it is required for all initial claims.
3. Patient first consulted you for this condition on: ____/____/____
4. Did any other physician previously treat the patient? Yes No If yes, physician's name: _____
 Referring physician's address: _____ Phone number: _____

Hospitalization Information:

Was patient hospitalized as a result of this diagnosis? Yes No If additional dates exist, please attach a copy of itemized billing.

Admission Date	Discharge Date	Admitting Diagnosis/ICD Code	Hospital Name (Please include city and state.)
- -	- -		
- -	- -		
- -	- -		
- -	- -		

Surgery Information:

Did patient undergo surgery for this condition? Yes No If additional dates exist, please attach a copy of itemized billing.

Date	CPT Code	Description	Charge
- -			
- -			
- -			
- -			

(PHYSICIAN'S STATEMENT CONTINUED ON PAGE 3)

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Policy Number: _____

Policyholder Name: _____

Patient Name: _____

Chemotherapy Information

Has patient received chemotherapy? Yes No

If additional dates exist, please attach a copy of itemized billing.

Date	HCPCS/CPT Code	Drug Name and Method of Administration	Drug Charge
- -			
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Radiation Therapy Information

Has patient received radiation therapy? Yes No

If additional dates exist, please attach a copy of itemized billing.

Date	CPT Code	Description	Charge
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PHYSICIAN'S SIGNATURE

DATE

TAX ID NUMBER

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

SPECIFIED-DISEASE CLAIM FORM - DISABILITY STATEMENT

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Policy Number: _____ Policyholder Name: _____
Patient Name: _____

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

- Please indicate the specific reason the insured is unable to work: _____
- First date of disability: ____/____/____ Date patient was released to return to work: ____/____/____
- Is patient currently working: Full-time? Part-time? Light duty? Last date of treatment: ____/____/____
- If patient has not been released to return to work or if patient is working light duty, please provide the next appointment date: ____/____/____
- If patient is not employed, or employed less than 30 hours, which Activities of Daily Living (ADLs) is the patient unable to perform and must have personal assistance to perform each time?
Check and initial all that apply: Contingence Transferring Dressing Toileting Eating Bathing (PA only)

PHYSICIAN'S SIGNATURE

DATE

TAX ID NUMBER

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): \$ _____
- 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 Form 941 and the employee's Form W-2.

EMPLOYER'S SIGNATURE

TITLE

DATE

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.

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



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