SPECIFIED-DISEASE CLAIM FORM

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

FILING CLAIM FOR (check all that apply)**:**

☐ Cancer ☐ Cancer With Disability ☐ Cancer With Hospitalization ☐ Deceased - Date Deceased:_____/_____/_____

Specified-Disease Policy Number	Short-Term Disability/Sickness Disability Rider Policy Number	Hospital Indemnity Policy Number	Hospital Intensive Care Policy Number	Life Policy Number

INSTRUCTIONS:

☐ Complete and sign **Section A: Policyholder/Patient Information**.

☐ Your physician should complete and sign Section B: Physician's Statement (Pages 2 and 3).

☐ This Cancer Claim Form should be completed on or after the initial date of your hospitalization, and/or surgery. Forms completed prior to the initial date of your hospitalization and/or surgery, may result in a delay in processing this claim.

☐ A pathology report diagnosing cancer **must** accompany your first claim. (The hospital or doctor will furnish this report to you at your request.) If the diagnosis of cancer was made clinically instead of pathologically, please submit the clinical evidence that established the diagnosis of cancer.

☐ Submit all bills related to this claim, such as ambulance, radiation treatments, chemotherapy treatments, etc. All bills should be itemized and should include the diagnosis, services rendered, and actual charges for the service. If filing for chemotherapy, itemized billing should also include drug names.

☐ Please include a certified copy of the death certificate if the patient is deceased.

☐ If surgery was performed, please submit a copy of the surgeon's bill or operative report.

☐ The items above can be obtained directly from your healthcare provider(s) by requesting a UB04 (hospital bill) or HCFA1500 (non-hospital bill).

☐ **Be sure to include your policy number(s) on all documents.**

Policyholder Information
(Please print.)

First Name _____ Initial ____ Last Name _____

Mailing Address _____

City _____ State _____ ZIP _____

Check box if this is a new permanent address: ☐

Patient Information
(Please print.)

Social Security Number _____ Phone Number _____

First Name _____ Initial ____ Last Name _____

Relationship:

☐ Primary Policyholder ☐ Spouse

Sex:

☐ Male ☐ Female

Patient Birth Date: _____

☐ Dependent Child ☐ Check here if dependant child is a full-time student (if over the age 19, please provide school name and contact information).

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.

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

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: _____ Date of Birth: _____

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. Was the patient referred to you by another physician? ☐ 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.)

(PHYSICIAN'S STATEMENT CONTINUED ON PAGE 3)

PHYSICIAN'S SIGNATURE **DATE** **TAX ID NUMBER**

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SPECIFIED-DISEASE CLAIM FORM - PHYSICIAN'S STATEMENT

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

Policy Number: _____ Policyholder Name: _____

Patient Name: _____ Date of Birth: _____

Surgery Information: Where was the surgery performed? ☐ Office ☐ Surgical Center ☐ Outpatient Hospital ☐ Inpatient Hospital

Name of facility: _____

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

Date of Service	Diagnosis/ICD Code	Surgery/CPT Code	Description of Surgery	Facility Name	Charges

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

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

PHYSICIAN'S SIGNATURE **DATE** **TAX ID NUMBER**

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Claims Authorization to Obtain Information

Instructions for completing this Health Insurance Portability and Accountability Act of 1996 (HIPAA) compliant form:

1. **All areas of this form should be completed.**
2. **This form must be signed and dated by the claimant/patient below.**
3. **IMPORTANT: If you are filing a claim on behalf of a deceased, please check here ☐**
4. **If you are the Authorized Representative, please sign below and indicate your relationship to the claimant/patient/deceased. In addition, include a copy of the legal document(s) authorizing you to act on their behalf.**
5. **Fax this form to 1-877-844-0201 or return the form to Aflac New York, Attn: Claims Department, Worldwide Headquarters, 1932 Wynnton Road, Columbus, GA 31999-7255 as soon as possible to expedite the review of your claim.**

Policyholder Name:	**Policy Number(s):**	**Date of Birth:**
Policyholder Address:		
Claimant/Patient Name (if different from named policyholder listed above):		**Date of Birth:**

Name and Address of health care provider(s), company, or individual authorized to release the requested information:

This authorization shall be valid for a period of two years from the sign date unless a lesser time frame is indicated. Alternate Expiration Date:

Purpose of Disclosure: Evaluate claims for benefits during the time this authorization is valid.

I, or my authorized representative, request that information regarding my past, present, or future physical or mental health condition (excluding psychotherapy notes), employment, other insurance coverage, or any other nonmedical facts be released to **American Family Life Assurance Company of New York (Aflac New York)** or any person or entity acting on its part. This could include, but is not limited to, 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.

I understand that:

1. Protected health information may include information and records protected under Federal and State Law such as: alcohol, drug abuse, mental health, AIDS or HIV testing or treatment.
2. My treatment, payment or eligibility for benefits may not be conditioned on signing this authorization.
3. I understand that I may revoke this authorization at any time by writing to **Aflac New York, Attn: Claims Department, Worldwide Headquarters, 1932 Wynnton Road, Columbus, GA 31999-7255**, except to the extent that:
   a. Aflac New York has taken action in reliance to this authorization, or
   b. Other law provides Aflac New York with the right to contest a claim under the policy or the policy itself.
4. If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.

It is recommended I retain a copy of this signed form for my records, understanding that a copy is as valid as the original.

Signature of claimant/patient, guardian or authorized representative **Date**

Printed name of claimant/patient, guardian or authorized representative **Relationship**