CONTINUING DISABILITY 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)**:**

☐ 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 ( )
MAILING ADDRESS ☐ CHECK BOX IF THIS IS A NEW PERMANENT ADDRESS		
CITY	STATE	ZIP
PLACE OF EMPLOYMENT:		PHONE NUMBER ( )
MAILING ADDRESS		
CITY	STATE	ZIP

PATIENT'S INFORMATION	
LAST FIRST INITIAL	
SOCIAL SECURITY NUMBER (optional)	BIRTHDATE
☐ MALE ☐ FEMALE ☐ SINGLE ☐ MARRIED ☐ OTHER	RELATIONSHIP: ☐ SELF ☐ SPOUSE ☐ DEPENDENT -- 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 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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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

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