Cancer Screening Wellness Benefit Claim Form

Please read all instructions.
Failure to follow these instructions will delay the processing of your claim.

Do not include receipts, statements, or other documentation with this form.

Your Aflac policy provides one Wellness Benefit per covered person, per calendar year, and this form is designed specifically for this benefit. To receive your Wellness Benefit, complete the form by following the instructions provided. Please print a separate form for each additional covered family member or call 1-800-99-AFLAC (1-800-992-3522) to request additional forms. Claims for all other benefits covered under your Cancer policy must be filed separately, using the Cancer Claim Form.

If any of your wellness tests resulted in a diagnosis of cancer, please submit your claim for cancer treatment separately, using the Cancer Claim Form.

If your Aflac policy also provides one Mammogram Benefit per calendar year, please mark the appropriate box and indicate the date the mammogram was performed. Please check your policy for specific benefits covered under your policy.

If your Aflac policy also provides one Pap Smear Benefit per calendar year, please mark the appropriate box and indicate the date the Pap smear was performed. Please check your policy for specific benefits covered under your policy.

- **Do not write on the form except as instructed.**
- **Incomplete forms cannot be processed and will be returned.**
- **Please do not fax this completed form to Aflac.**
- **Mark only wellness exam box(es) for test(s) that you had performed.**

American Family Life Assurance Company of Columbus (Aflac)
Attn: Claims Department • 1932 Wynnton Road • Columbus, GA 31999-7251
1-800-99-AFLAC (1-800-992-3522) • aflac.com • 1-800-SI-AFLAC (1-800-742-3522) en español

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Some of the tests listed may not be covered under the Wellness Benefit of your policy. Please check your policy for a list of covered wellness procedures or call 1-800-99-AFLAC (1-800-992-3522) for a Wellness Form specifically tailored for your policy.

Please use black or blue ink only and print legibly when completing this form in its entirety. Keep a copy of the supporting documentation and this completed form for your records. Sign, date, and mail the completed form to the Aflac address shown below.

Policyholder Information

Policyholder's First Name: | Middle Initial: | Policyholder's Last Name:

Policyholder's Birth Date: M M D D Y Y Y Y | ZIP of mailing address:

Patient Information

Policy Number

First Name: | Middle Initial: | Last Name:

Relationship: ☐ Primary Policyholder ☐ Spouse ☐ Dependent Child

Sex: ☐ Male ☐ Female

Patient's Birth Date: M M D D Y Y Y Y

Wellness Exam

Treatment Date: M M D D Y Y Y Y

- ☐ Colonoscopy
- ☐ Virtual colonoscopy
- ☐ Pap smear - ThinPrep
- ☐ Pap smear
- ☐ Testicular Ultrasound
- ☐ Breast MRI
- ☐ Cancer Prevention Vaccine
- ☐ CA 153
- ☐ CEA (blood test for colon cancer)
- ☐ CA 125 (blood test for ovarian cancer)
- ☐ Mammogram
- ☐ Hemocult stool specimen
- ☐ Flexible sigmoidoscopy
- ☐ Thermography
- ☐ Chest X-ray
- ☐ PSA (blood test for prostate cancer)
- ☐ Breast ultrasound/Breast sonogram
- ☐ Biopsy

Pap Smear Date: M M D D Y Y Y Y

Mammogram Date: M M D D Y Y Y Y

Provide Actual Cost for Mammogram:

Physician Information

Phone Number: - -

Name:

Street Address:

City: | State: | ZIP:

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.

I certify that the information provided is true and correct:

POLICYHOLDER'S SIGNATURE | **DATE**

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Claims Authorization to Obtain Information

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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 1-877-442-3522 or return the form to Aflac, Attn: Claims Department, Worldwide Headquarters, 1932 Wynnton Road, Columbus, GA 31999, as soon as possible in order to expedite claim review.**

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

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:	**Name and Address of health care provider(s), company, or individual authorized to release the requested information:** (this section will be completed by Aflac):
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 Columbus (Aflac)** 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, with respect to other Aflac 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, or the presence of a communicable or noncommunicable disease.
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, Claims Department, Worldwide Headquarters, 1932 Wynnton Road, Columbus, GA 31999**, except to the extent that:
   a. Aflac has taken action in reliance to this authorization, or
   b. Other law provides Aflac 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.
5. 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**