

HOSPITAL INDEMNITY CLAIM FORM

Thank you for trusting Aflac with your Hospital Indemnity needs.

If you are interested in filing your claim online or uploading documentation on an existing claim, register using aflac.com/smartclaim.

To prevent delays, please provide documentation from your healthcare provider to support this claim. If you have additional bills or medical documentation that relates to this diagnosis other than the documentation defined, please submit them for review of additional benefits.

- Service related items can be obtained directly from the patient's healthcare provider(s) by requesting a UB04 hospital bill or HCFA 1500 non-hospital bill.
- Failure to complete all sections may result in a delay in processing this claim.
- Disclaimer: Some of the services listed may not be covered by your policy.

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 Describe how the injury occurred: Was this disability caused by an incident that occurred while performing the duties of the patient's employment? No Yes 																														
• V	 Was this a motor vehicle accident in which the patient was the driver? ☐ No ☐ Yes (If yes, please submit a copy of the Police Report.) 																													
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 First date of treatment for this condition:/																														
	 Was the patient treated by any other physicians for this sickness or a related condition? ☐ No ☐ Yes 																													
· V	If yes, physician's name(s):																													
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	ou have additional bills or medical documentation that relates to this diagnosis other than the documentation ined, please submit them for review of additional benefits.						
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*Dat	e of Birth (mm/dd/yy)						
Pa	tient Information:						
	t Name *First Name *Date of Birth (mm/dd/yy)						
Pre	gnancy claims:						
•	Date of delivery:/ Vaginal Cesarean						
•	If not delivered, expected delivery date:/						
•	Please advise of any complications:						
For	all claims, please complete all remaining sections.						
•	Please provide the name, address and phone number of the patient's primary treating physician.						
	Name: Phone Number:						
	Address:						
•	Was the patient confined to the hospital as a result of this condition? \square No \square Yes (If yes, please submit the itemized hospital bill, UB04, or HCFA 1500)						
	Hospital Name:						
	City:State:						
•	Was the patient confined to the intensive care unit as a result of this condition? \square No \square Yes (If yes, please submit the itemized bill, UB04, or HCFA 1500.)						
•	Was the patient confined to a rehabilitation unit as a result of this condition? \square No \square Yes (If yes, please submit the itemized bill, UB04, or HCFA 1500.)						
•	Was patient treated in an emergency room as a result of this condition? \square No \square Yes (If yes, please submit the emergency room report, UB04, or HCFA 1500.)						
	Hospital name: Date of treatment: /						
•	Was the patient transported by an ambulance as a result of this condition? \square No \square Yes (If yes, please submit the ambulance bill)						
•	Was surgery performed as a result of this condition? \square No \square Yes (If yes, please submit a copy of the operative report, UB04, or HCFA 1500.)						
•	Were medical imaging services (i.e. CT Scan, MRI, EEG, etc.) provided as a result of this condition? \square No \square Yes (If yes, please submit a copy of the exam report and/or billing, UB04, or HCFA 1500.)						
app	y person who knowingly and with intent to defraud any insurance company or other person files an olication for insurance or statement of claim containing any materially false information or conceals for purpose of misleading, information concerning any fact material thereto commits a fraudulent urance act, which is a crime, and subjects such person to criminal and civil penalties.						
POI	ICYHOLDER/PATIENT SIGNATURE FAMILY RELATIONSHIP. IF NOT POLICYHOLDER DATE						

American Family Life Assurance Company of Columbus (Aflac)
ATTN: Claims Department • 1932 Wynnton Road • Columbus, GA 31999
For information or to check claim status, visit aflac.com or call 1-800-99-AFLAC (1-800-992-3522)
Claims may be faxed to 1-877-44-AFLAC (1-877-442-3522)