



# PHYSICIAN'S VISIT BENEFIT CLAIM FORM

If you are interested in filing your claim online, register using [aflac.com/smartclaim](http://aflac.com/smartclaim).

- Benefits of filing your claim online include faster claim processing time and receiving claim communications by email.

Your policy pays a Physician's Visit Benefit for services rendered under the supervision of a physician, after the effective date of your policy. Please refer to your policy to verify your eligibility for this benefit.

- Failure to complete all sections may result in a delay in processing this claim.
- Submit only one treatment date per claim form.
- Do not attach receipts, statements or other claim documentation to this form.
- Please sign, date and mail/fax the completed form to the Aflac address/fax number shown below.
- Please use black or blue ink only and print legibly when completing this form in its entirety.

Policy Number:

**All Fields are required.**

### Policyholder Information:

Last Name  Suffix  First Name  MI

Date of Birth (mm/dd/yy)  /  /  Telephone Number where we can reach you  -  -

Home Address

City  State  Zip Code

Check box if this is permanent address change.

### Patient Information:

Last Name  First Name  Date of Birth (mm/dd/yy)  /  /

Sex:  Male  Female

Relationship:  Primary Policyholder  Spouse  Dependent Child

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Date of Physician's Visit:

\*Please submit only one date per form.

Physician's Phone Number:  -  -

Physician's Name

Physician's Street Address

Physician's City  State:  Zip:

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

The Provider listed above is authorized to validate the information I have provided.

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POLICYHOLDER/PATIENT SIGNATURE  
CWHCIWEB CO

\_\_\_\_\_  
FAMILY RELATIONSHIP, IF NOT POLICYHOLDER  
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\_\_\_\_\_  
DATE

02/14