



Accident/Hospital Indemnity Wellness Benefit Claim Form

If you are interested in filing your claim online, register using aflac.com/smartclaim.

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

Please read all instructions.

Failure to follow these instructions could delay the processing of your claim.

Your Aflac policy provides a Wellness Benefit. To receive your Wellness Benefit, complete the form by following the instructions provided. Please check your policy for specific details on this benefit.

- Do not include receipts, statements or other claim documentation with this form.
- Do not write on form except as instructed.
- Please sign, date and mail or 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.
- Mark only wellness exam box(es) for test(s) that you had performed.
- Failure to complete all sections may result in a delay in processing this claim.
- Some types of tests and/or treatment listed may not be covered by your policy.

Please keep a copy of this completed form for your records. Please print a separate form for each additional family member or call 1-800-99-AFLAC (1-800-992-3522) to request additional forms. Claims for all other benefits covered under this policy must be filed separately using the claim forms available at aflac.com or by calling 1-800-99-AFLAC (1-800-992-3522).

Accident/Hospital Indemnity Wellness Benefit Claim Form

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

Treatment and Physician Information

Treatment Date: M M D D Y Y Y Y
 Mammogram Date: M M D D Y Y Y Y
 Pap Smear Date: M M D D Y Y Y Y

- | | | |
|---|--|---|
| <input type="checkbox"/> Annual Physical | <input type="checkbox"/> Blood Screening | <input type="checkbox"/> Dental Exam |
| <input type="checkbox"/> Ultrasound | <input type="checkbox"/> Immunizations | <input type="checkbox"/> Flexible Sigmoidoscopy |
| <input type="checkbox"/> PSA (blood test for prostate cancer) | <input type="checkbox"/> Eye Exam | |
| <input type="checkbox"/> Pap Smear | <input type="checkbox"/> Mammogram | |

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.

 POLICYHOLDER/PATIENT SIGNATURE FAMILY RELATIONSHIP, IF NOT POLICYHOLDER DATE