# WAIVER OF PREMIUM CLAIM FORM

**Thank you for trusting Aflac with your Waiver of Premium needs.**

**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 certificate.**
- **To file your claim online, upload documentation on an existing claim, check claim status or get paid fast by signing up for direct deposit, register on Aflac.com or download the MyAflac mobile app.**

## *Certificate Number:

## Certificate Holder Information: This * denotes a required field.

*Last Name | Suffix | *First Name | MI

*Date of Birth (mm/dd/yyyy) | Telephone Number where we can reach you

*Home Address

*City | *State | *Zip Code

☐ *Check box if this is a permanent address change.*

## Patient Information:

*Last Name | *First Name | *Date of Birth (mm/dd/yyyy)

*Sex: ☐ Male ☐ Female

### Waiver of Premium Checklist

- Filing claim for: ☐ Injury ☐ Sickness
- Date of the injury: Location of the injury? ☐ On the job ☐ Off the job
- Details of the injury:
- Symptoms first occurred on: First date of treatment for this condition:
- Please provide the name, address and phone number of the patient's primary treating physician.
  Name: Phone Number:
  Address:
- Was the patient treated by any other physicians for this condition? No Yes
  If yes, physician's name(s):
  Phone Number(s):
  Address:
- Have you applied for Social Security disability? ☐ No ☐ Yes
  - If yes, has your application been approved? ☐ No ☐ Yes (If yes, please attach a copy of the approval.)
- Was the patient confined to the hospital as a result of this condition?* ☐ No ☐ Yes (If yes, please submit the itemized hospital bill, UB04, or HCFA 1500)
  Admission date: Discharge Date:
  Hospital name | City | State

**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.**

**CERTIFICATE HOLDER/PATIENT SIGNATURE** | **FAMILY RELATIONSHIP, IF NOT CERTIFICATE HOLDER** | **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 1-866-849-2970**

# WAIVER OF PREMIUM CLAIM FORM - EMPLOYER'S STATEMENT*

***Certificate Number:**

**Certificate Holder Information:** This * denotes a required field.

*Last Name Suffix *First Name MI

*Date of Birth (mm/dd/yyyy)

*Employee's Name (Last Name, Suffix, First Name, MI)

*Employer's Name/Group # *Employer Phone Number

*Employer's Address

*City *State *Zip Code

- First date of disability:
- Was this disability caused by an incident that occurred while performing the duties of his/her employment? ☐ No ☐ Yes
- Prior to this disability, number of hours worked per week:
- Gross annual income prior to disability: ***Income is subject to verification at time of claim.**
  Self-employed? ☐ No ☐ Yes (If yes, your gross annual income is the average of your net earnings for the past two years. Please submit tax records for the past two years.)
- Has the employee returned to work? ☐ No ☐ Yes
  - If no, expected return to work date: If yes, date returned to work:

**Please complete this section only for Contract 1099/W-2 Employees. (Please contact payroll and/or check the certificate holder's Salary Redirection Agreement/Premium Deduction Authorization card for the answer to these questions.)**

- Certificate holder is: (Check all that apply) Exempt from Social Security ☐ Exempt from Medicare ☐ Subject to RRTA ☐
- Date of hire:
- Is the person still employed? ☐ No ☐ Yes
  If no, last date of employment:
  If yes, is separation due to current disability? ☐ No ☐ Yes
- Job duties employee is unable to perform:

**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.**

**EMPLOYER'S SIGNATURE** **EMPLOYER'S PRINTED NAME** **TITLE** **DIRECT PHONE NUMBER** **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 1-866-849-2970**

# WAIVER OF PREMIUM CLAIM FORM - PHYSICIAN'S STATEMENT*

## *Certificate Number:

## Certificate Holder Information: This * denotes a required field.

*Last Name Suffix *First Name MI

*Date of Birth (mm/dd/yyyy)

## Patient Information:

*Last Name *First Name *Date of Birth (mm/dd/yyyy)

## Physician Information:

*Phone Number *Fax Number

*Physician's Name

*Address

*City State Zip Code

- Primary diagnosis for disability and ICD code: Additional diagnoses:
- If due to an injury, please provide the date and details of the injury:

- Location of the injury? ☐ On the job ☐ Off the job
- Symptoms first occurred on:
  ☐ If diagnosed with cancer, date of initial diagnosis:
- Patient first consulted you for this condition on:
- Date of first visit:
- Has patient ever been treated for this condition or a similar condition? ☐ No ☐ Yes
  - If yes, please describe:

Was the patient treated for the primary diagnosis by another physician? ☐ No ☐ Yes

- If yes, physician's name:
- Treating physician's address: Phone Number:

- First date of disability:
- Date patient was last treated: Frequency of visits: ☐ Weekly ☐ Monthly ☐ Other:
- Is patient permanently disabled? ☐ No ☐ Yes (Medical records will be requested if permanent disability is indicated.)
- Is patient currently receiving hospice care? ☐ No ☐ Yes (If yes, please provide the hospice bill.)
- Is condition terminal? ☐ No ☐ Yes (If yes, please provide the life expectancy: )

**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.**

**PHYSICIAN'S SIGNATURE** **DATE** **TAX ID**

**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 1-866-849-2970**