

ACCIDENT CLAIM FORM

CONTINENTAL AMERICAN INSURANCE COMPANY (AFLAC)

Failure to complete all sections may result in a delay in processing this claim.

To prevent delays, please provide documentation from your healthcare provider to support this claim.

Please review your policy for specific benefits covered under your plan.

Benefits are payable to you unless we receive written authorization from your provider to assign benefits

to them or from you to pay your benefits elsewhere. This is called an assignment. If you wish to assign

your benefits, please send a signed written request.

By providing your e-mail address below, you consent to the use of electronic transactions in connection

with your CAIC policies, contracts, and/or accounts to the extent available and permitted by law.

CLAIM DETAILS

Date of the Injury:

December 28, 2025

Describe how the injury occurred:

The patient slipped on an icy parking lot surface while exiting a vehicle, lost balance, and fell forward, striking the right knee and left wrist on the pavement.

Location of the injury?

[X] Off the job [] On the job

Has a Worker's Compensation claim been filed?

[X] No [] Yes

Was the patient injured in a motor vehicle accident?

[] No [X] Yes

Police Report submitted separately.

PART A - POLICYHOLDER / PATIENT INFORMATION

Employer's Name:

Grace Community Church

Policyholder's Email Address:

manderson@gracecommunity.org

Policyholder's Name:

Michael Anderson

Policy Number:

ACC-559201-AFL

Social Security Number:

XXX-XX-4839

Date of Birth:

March 17, 1983

Gender:

Male

Policyholder's Address:

Street: 1250 Riverside Drive

City: Columbus

State: OH

Zip Code: 43221

[] Check box if this is a permanent address change

Patient's Name (person who is sick or injured):

Daniel Roberts

Patient's Date of Birth:

August 14, 1989

Patient Gender:

Male

Policyholder's Telephone Number (include area code):

(614) 555-2199

Relationship to Policyholder:

Employee

INJURY & MEDICAL INFORMATION

Was death a result of this injury?

[] No [] Yes

Was the patient confined to the hospital as a result of this injury?

[X] No [] Yes

Hospital Name:

Riverside Methodist Hospital

City:

Columbus

State:

OH

Was the patient transported by an ambulance?

[X] No [] Yes

Medical Conditions Resulting from Injury:

[X] Laceration (Left wrist - sutured, 4 cm)

[X] Concussion (Mild - CT Scan performed)

[] Coma

[] Paralysis

[] Degree of Burn

[] Injury to Eye

[] Dislocation

[] Fracture

Was an aid in locomotion prescribed?

[X] Yes [] No

Aid prescribed:

Walking boot for right knee stabilization

Were any covered surgical procedures performed?

[] No [X] Yes

Procedure:

Arthroscopic knee cartilage repair

Was a major diagnostic exam performed?

[X] Yes [] No

Diagnostic Exams:

CT Scan (Head)

MRI (Right Knee)

DATES OF TREATMENT

Initial Date of Treatment:

December 28, 2025

Follow-up Visits:

January 5, 2026

January 19, 2026

Physical Therapy:

January 22, 2026 - February 28, 2026

FRAUD WARNING NOTICES - PAGE 3

ALASKA:

A person who knowingly and with intent to injure, defraud or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

ARIZONA:

Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

ARKANSAS:

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit is guilty of a crime.

CALIFORNIA:

Any person who knowingly presents a false or fraudulent claim is guilty of a crime and may be subject to fines and confinement in state prison.

COLORADO:

It is unlawful to knowingly provide false, incomplete, or misleading facts to an insurance company.

DELAWARE:

Any person who knowingly files a statement of claim containing false information is guilty of a felony.

DISTRICT OF COLUMBIA:

It is a crime to provide false information to an insurer.

FLORIDA:

Any person who knowingly files a fraudulent claim is guilty of a felony of the third degree.

IDAHO:

Any person who knowingly files a false insurance claim is guilty of a felony.

INDIANA:

Any person who knowingly files false insurance information commits a felony.

KENTUCKY:

Any person who knowingly defrauds an insurer commits a fraudulent insurance act.

LOUISIANA:

Any person who knowingly presents a false claim may be fined or imprisoned.

MAINE:

It is a crime to knowingly provide false information to an insurer.

MARYLAND:

Any person who knowingly files a false claim is guilty of a crime.

MINNESOTA:

A person who commits insurance fraud is guilty of a crime.

NEW HAMPSHIRE:

Any person who knowingly files a false claim is subject to prosecution.

NEW JERSEY:

Any person who knowingly files false information is subject to criminal penalties.

FRAUD WARNING NOTICES - PAGE 4 (CONTINUED)

NEW MEXICO:

Any person who knowingly presents a false insurance claim is guilty of a crime.

NEW YORK:

Any person who knowingly files a false insurance claim commits a fraudulent insurance act.

OHIO:

Any person who submits false information to defraud an insurer is guilty of insurance fraud.

OKLAHOMA:

Any person who knowingly files false insurance information is guilty of a felony.

OREGON:

Any person who commits insurance fraud may be guilty of a crime.

PENNSYLVANIA:

Any person who knowingly files a false claim commits a fraudulent insurance act.

PUERTO RICO:

Any person who knowingly presents fraudulent insurance information commits a felony.

TENNESSEE:

It is a crime to knowingly defraud an insurance company.

TEXAS:

Any person who knowingly files a false claim may be fined or imprisoned.

VIRGINIA:

It is a crime to knowingly defraud an insurer.

WASHINGTON:

Providing false insurance information is a crime.

ALL OTHER STATES:

Any person who knowingly defrauds an insurance company commits a criminal offense.

AUTHORIZATION TO OBTAIN INFORMATION - PAGE 5

Primary Certificateholder's Name:

Michael Anderson

SSN (optional):

XXX-XX-4839

Date of Birth:

March 17, 1983

Certificate Numbers:

ACC-559201-AFL

Address:

1250 Riverside Drive, Columbus, OH 43221

Name of Individual Subject to Disclosure:

Daniel Roberts

Relationship to Primary Certificateholder:

- Self
- Spouse
- Domestic Partner
- Child
- Stepchild
- Grandchild

Authorization granted for disclosure of medical records to Continental American Insurance Company (AFLAC) for claim evaluation purposes.

Signature of Individual Subject to Disclosure:

Daniel Roberts

Date Signed:

January 2, 2026

ELECTRONIC FUNDS TRANSACTION AUTHORIZATION - PAGE 6

Request:

Start direct deposit of claim payments

Account Type:

Checking

Savings

9-Digit Routing Number:

071000013

Account Number:

834729155

Name of Financial Institution:

Huntington National Bank

Address:

41 S High Street

City:

Columbus

State:

OH

Zip:

43215

Phone:

(614) 555-8800

Policy/Certificate Holder's Name (Print):

Michael Anderson

Address:

1250 Riverside Drive, Columbus, OH 43221

Phone:

(614) 555-2199

E-mail Address:

manderson@gracecommunity.org

Employer Name or Group #:

Grace Community Church

Certificate #:

ACC-559201-AFL

Policy/Certificate Holder Signature:

Michael Anderson

Date Signed:

January 2, 2026

END OF COMPLETED AFLAC ACCIDENT CLAIM FORM
