SPECIFIED EVENT CLAIM FORM

Thank you for trusting Aflac with your Specified Event 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.**

***Policy Number:**

Policyholder Information: This * denotes a required field.

*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 a permanent address change.*

Patient Information:

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

*Sex: ☐ Male ☐ Female

*Relationship: ☐ Primary Policyholder ☐ Spouse ☐ Dependent Child

Specified Event Checklist

- Please indicate the condition the patient is filing for below:
  - ☐ **Coma** - Please submit medical documentation from the health care provider indicating the duration of the coma and the ranking on the coma scale.
  - ☐ **Burn** - Please submit medical documentation showing the total percentage of the body with third degree burns.
  - ☐ **Paralysis** - Please submit medical documentation from the health care provider of complete and total loss of use of two or more limbs, including the duration of paralysis.
  - ☐ **Heart attack** - Please submit the electrocardiographic findings or clinical findings together with test results of blood enzymes diagnosing a heart attack.
  - ☐ **Stroke** - Please submit medical documentation of a neurological deficit with complete or partial function loss for more than 24 hours.
  - ☐ **End stage renal failure** - Please submit medical documentation of a diagnosis of permanent and irreversible kidney failure.
  - ☐ **Persistent vegetative state** - Please submit a statement from two physicians indicating cognitive function has been substantially impaired and there is no reasonable expectation that the patient will regain cognitive function.
  - ☐ **Sudden cardiac arrest** - Please submit medical documentation or the discharge summary indicating the diagnosis.
  - ☐ **Coronary artery bypass graft surgery** - Please submit medical documentation from the health care provider indicating open-heart surgery was performed to correct the narrowing or blockage of one or more coronary arteries with bypass grafts.
  - ☐ **Major human organ transplant** - Please submit medical documentation from the health care provider indicating the covered person has received, as a result of surgical transplant, one or more of the following human organs: kidney, liver, heart, lung, or pancreas.
  - ☐ **Heart surgery** - Please submit medical documentation from the health care provider indicating the type of heart surgery performed.
- Symptoms first occurred on: _____/_____/_____ First date of treatment for this condition: _____/_____/_____
- Was death a result of this condition? ☐ No ☐ Yes (If yes, please submit a copy of the death certificate and legal documents verifying the person authorized to handle the affairs of the deceased).

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)

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.

*Policy Number:

Policyholder Information:

*Last Name | Suffix | *First Name | MI

*Date of Birth (mm/dd/yy)

Patient Information:

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

- Was the patient injured in a motor vehicle accident? ☐ No ☐ Yes (If yes, please submit a copy of the Police Report.)
- 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.)

  Hospital name _____

  City _____ State _____
- Was the patient confined to the intensive care unit as a result of this condition? ☐ No ☐ Yes (If yes, please submit the itemized hospital bill, UB04, or HCFA 1500.)
- 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: _____
- Was the patient transported by an ambulance as a result of this condition? ☐ No ☐ Yes (If yes, please submit the ambulance bill.)
- Transportation/Lodging Information: Please complete if you are filing a claim for transportation or lodging and submit the hotel receipts and mileage information. For additional information, please refer to your policy language.

Date	To/From	Round-Trip Mileage

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.

POLICYHOLDER/PATIENT SIGNATURE | **FAMILY RELATIONSHIP, IF NOT POLICYHOLDER** | **DATE**

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