Post
UCTIONS

To avoid delays in processing of your claim form, complete each section attaching documentation below when it applies.

Supporting Documentation Needed

9 Itemized bill if there was a hospital bill from physician's office (HCFA 1500 from treating physician's office)

9 Surgical Report if accident involved surgery

9 Ambulance bill if emergency transport was required

9 Appliance receipt if c C-0.09i8. 0 Tw 0.87 0 Td ( )Tj 0.001 Tc -0.001 Tw 0.22 0

PostOffice Box 84075 *
Columbus, GA31993
Phone (800)433-3036 *
Fax(866) 849-2970
groupclaimfiling@aflac.com

ACCIDENTCLAIMFORM

EMPLOYER'SNAME			POLICYHOLDER'SEMAIL ADDRESS		
POLICYHOLDER'S MAJOR MEDICAL INSURANCE PROVIDER D : K Z D /ID#>					
POLICYHOLDER'SNAME	POLICY NO.	SOCIALSECURITYNO.	DATEOFBIRTH	GENDER	
POLICYHOLDER'SADDRESS STREET		CITY	STATE	ZIPCODE	
CHECKBOXIFTHISISA PERMANENTADDRESSCHANGE					
PATIENT'S NAME(PERSONWHOISSICKORINJURED	DATEOFBIRTH	GENDER	POLICYHOLDER'STELEPHONENO.		
RELATIONSHIPTOPOLICYHOLDER					

PostOffice Box 84075 *
Columbus, GA31993
Phone (800)433-3036 *
Fax(866) 849-2970
groupclaimfiling@aflac.com

- Was the patient transported by an ambulance as a result of this injury? Yes No

  (If yes, please submit the ambulance bill.)
- If any of the following were the result of your injury, please pr 6‰°É™™™™™‘)™™™™™‘$& the

FRAUD WARNING NOTIC

FRAUD WARNING NOTICES (CONT.)
For use with Claim Forms
PLEASE READ THE FRAUD WARNING NOTICE FOR YOUR STATE

NEW MEXICO:

+ , 3 $ $ **AUTHORIZATION TO OBTAIN INFORMATION**

Primary Certificate Holder Name:	**SSN**(optional):	**Date of Birth:**	
Certificate Number(s):			
Address:	**City:**	**State:**	**Zip:**
Name of Individual Subject to Disclosure (If not the primary Certificate Holder):		**Date of Birth:**	

Relationship to Primary Certificate Holder:

☐ Self ☐ Spouse ☐ Domestic Partner ☐ Child ☐

Electronic Funds Transaction Authorization

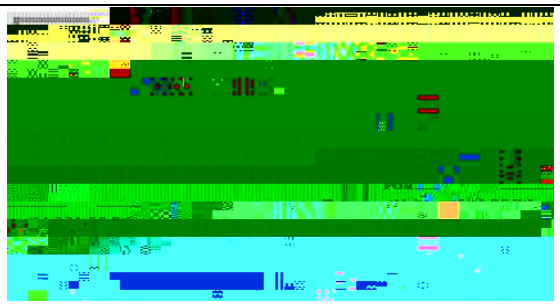
0DLO 7R &RQWLQHQWDO $PHULFDQ ,QVXUDQ
32 %R[&ROXPEXV *$
3KRQH) D[
(PDLO JURXSFODLPILOLQJ#DIODF FRP

I would like to: ☐ Start ☐ Stop ☐ Change direct deposit of my claim payment(s).

Account Type:

☐ Checking ☐ Savings

**** Please provide a blank voided check or direct deposit form from your financial institution. Incomplete or inaccurate information will not be processed.



9-Digit Routing Number:		Account Number:
Name of Financial Institution:		
Address:		City:
State:	Zip:	Phone:

I authorize Continental American Insurance Company (CAIC) to initiate credit entries, and, if errors occur, I authorize the correction of entries to my account as indicated. This authorization remains effective and in full force until CAIC receives written notification from me of its termination in such time and in such manner to afford CAIC a reasonable opportunity to act on it. Please notify CAIC immediately if your financial institution information has changed by sending notification to the address indicated above. Should you have any questions, please contact us at 1-800-433-3036.

Policy/Certificate Holder's Name (Print):	
Address:	City/State/Zip:
Phone #:	E-mail Address:
Employer Name or Group #:	Certificate #:

***By providing your e-mail address above, 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 (which may