American Fidelity Assurance Company
A member of the American Fidelity Group

American Fidelity Assurance Company
Mail to: AWD Benefits Department
P.O. Box 268898
Oklahoma City, OK 73126-8898
Toll Free Phone # 1-800-437-1011
Local Fax # (405)-523-5762
Toll Free Fax # 1-888-243-3453
www.afadvantage.com

Accident Only Claim Filing Instructions

ACCIDENT ONLY CLAIM FILING INSTRUCTIONS:

1. Complete the **STATEMENT OF INSURED** found on page 3 of this form.
2. Attach copies of all **OFFICE NOTES OR MEDICAL RECORDS** for treatment of your accidental injury. Also please provide a **POLICE REPORT** if available.
3. Itemized bills from your providers and Explanation of Benefits (EOB) from your primary insurance carrier often do not provide needed information in order to make a proper benefits determination. We may require corresponding office notes or medical records to review for possible benefits.
4. Discharge papers from the ER or Hospital do not always provide needed information in order to make a proper benefits determination. We may require corresponding ER or hospital records to review for possible benefits.
5. Please have your employer and physician complete page 4 **ONLY IF** you have the Accident Only Disability Rider and are making a claim for Accident Only Disability benefits. If you do not have this disability rider, there is no need to have your physician complete this form.

Warning: Any person who knowingly and with intent to injure, defraud, or deceive an insurer files a statement of claim containing any false, incomplete, or misleading information may be guilty of insurance fraud and subject to criminal and civil penalties.

California - For your protection, California law requires the following to appear on this form. Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

AR, DC, LA, MD, NJ, NM, TX, and WV - ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

DE, ID, IN, MN, OH, and OK - **WARNING:** Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

Colorado - 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.

New Hampshire - Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

Kentucky - Any person who knowingly and with intent to defraud any insurance company or other person files a 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.

Oregon - Any person who knowingly and with intent to defraud or solicit another to defraud an insurer: (1) by submitting an application, or (2) by filing a claim containing a false statement as to any material fact, may be guilty of insurance fraud.

Pennsylvania - 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.

Arizona - For your protection, Arizona law requires the following statement to appear on this form: Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

Florida - Any person who knowingly, and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Hawaii - *For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.*

American Fidelity Assurance Company

A member of the American Fidelity Group®

American Fidelity Assurance Company
Mail to: AWD Benefits Department
P.O. Box 268898
Oklahoma City, OK 73126-8898
Toll Free Phone # 1-800-437-1011
Local Fax # (405)-523-5762
Toll Free Fax # 1-888-243-3453
www.afadvantage.com

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize the entities specified below to disclose any information about me or my dependents' health including my or my dependents' entire medical record and history of treatment for physical and/or emotional illness to include psychological testing, except psychotherapy notes, to individuals representing American Fidelity Assurance Company (AFAC) who are involved in determining whether I am eligible for benefits under my insurance coverage. Those so authorized are: a) licensed physicians or medical practitioners; b) hospitals, clinics or medically-related facilities; c) health plans; d) Veteran's Administration; e) past or present employers; f) pharmacy; g) insurance companies; h) the Social Security Administration; i) retirement systems; j) Department of Motor Vehicles, and k) Workers' Compensation Carrier. Colorado state law prohibits the redisclosure or reuse of information disclosed about a Colorado resident under this authorization.

NOTICE: Information authorized for release may include information on communicable or venereal diseases such as hepatitis, syphilis, gonorrhea, HIV/AIDS (Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome) or other conditions for which you may have been treated. For Maine residents, information authorized for release may include information on communicable or venereal diseases such as hepatitis, syphilis, gonorrhea, AIDS/ARC (Acquired Immune Deficiency Syndrome /AIDS Related Complex) or other conditions for which you may have been treated. This authorization excludes disclosure of the result of a test for HIV if you have tested HIV positive but have not developed symptoms of the disease AIDS. Such test results shall not be discovered or published. Nothing in this caveat will prohibit this authorization from including the fact that you have AIDS. For Vermont residents, this authorization does not require disclosure of prior HIV-related tests. For Wisconsin residents, results of AIDS/HIV test do not need to be reported if they were done at any anonymous counseling and testing site, if the test was not an FDA-licensed blood test, or through the use of a home test kit. For Arizona residents, release of HIV/AIDS-related information can only be disclosed for a period not to exceed 180 days from the date shown below.

I understand that I may refuse to sign this authorization; however, if I do not sign the authorization, my failure to sign the authorization may result in a denial or a delay of benefits. I understand that I may revoke this authorization at any time by writing to AWD Benefits Department, P.O. Box 268898, Oklahoma City, OK 73126-8898 or by calling, toll-free, 1-800-437-1011. I understand that my right to revoke this authorization is limited to the extent that: AFAC has taken action in reliance on the authorization; or, the law provides AFAC with the right to contest my insurance coverage or a claim under my insurance coverage. A copy of this authorization will be as valid as the original.

I understand that if protected health information is disclosed to a person or organization that is not required to comply with federal privacy regulations, the information may be redisclosed and no longer protected by the federal privacy regulations.

For health insurance coverage this authorization will expire twenty-four months from the date it is signed or upon termination of my insurance policy, whichever occurs first. For insurance coverage other than health insurance, this authorization will expire twenty-four months from the date it is signed or upon expiration of my claim for benefits, whichever occurs first.

AFA Account#	Printed Name	Date of Birth
Signature (Patient) or Personal Representative (if applicable)	Date	
Relationship of Personal Representative to Representative to Patient	*If authorization is supplied by a personal representative, a description of the authority to act on behalf of the Insured must be included.*	

Please retain a copy for your personal records, or you may request a copy from our Company.

REQUEST FOR
ACCIDENT ONLY
POLICY BENEFITS

American Fidelity Assurance Company
A member of the American Fidelity Group

American Fidelity Assurance Company
Mail to: AWD Benefits Department
P.O. Box 268898
Oklahoma City, OK 73126-8898
Toll Free Phone # 1-800-437-1011
Local Fax # (405)-523-5762
Toll Free Fax # 1-888-243-3453
www.afadvantage.com

See page 1 for fraud statements and filing instructions. Attach copies of all OFFICE NOTES OR MEDICAL RECORDS for treatment of your accidental injury. Also please provide a POLICE REPORT if available.

STATEMENT OF INSURED

A. ABOUT YOU

INSURED'S LAST NAME	First Name	Middle Initial	Date of Birth	Account Number

Address (City, State, Zip)	Insured's Social Security Number
Employer - Name	**Home Telephone #**

B. ABOUT THE PATIENT

PATIENT INFORMATION (CHECK ONE)

For whom do you make this request?
☐ Self ☐ Son
☐ Wife ☐ Daughter
☐ Husband ☐ Other _____ identify

Patient's Name	Patient's Birth Date	Patient's Social Security Number

If Claim is for a Dependent Child Under 21, is Such Child Living in Your Household? ☐ Yes ☐ No

If Dependent Child is between age 21 and 25 years old is (s)he a full-time student? ☐ Yes ☐ No
If yes, submit transcripts or grade reports.

C. ABOUT THE ACCIDENT

Date of Accident

Type of Injury

Describe how the accident occurred

Were you transported to an emergency center or hospital by ambulance? ☐ Yes ☐ No

Were you hospital confined due to this accident? ☐ Yes ☐ No

If yes, give admit and discharge dates, and name and address of hospital. admitted ____/____/____ discharged ____/____/____

Are you making a claim under your Accident Only Disability benefit? ☐ Yes ☐ No **IF YES, COMPLETE THE BACK OF THIS FORM.**

DIRECT DEPOSIT AUTHORIZATION

Please complete if you desire benefits deposited directly into your bank account.

I authorize American Fidelity Assurance Company to initiate credit entries to my account at the depository named below. This authorization is to remain in force and effect until AFAC receives written notification from me of its termination in such time and in such manner as to afford AFAC and the Depository opportunity to act on it.

This authorization applies to benefits payable under all insurance policies held with AFAC.

Signature _____

NOTE: You must attach a voided check to begin direct deposit.

ONLY COMPLETE FOR ACCIDENT ONLY DISABILITY RIDER BENEFITS

See page 1 for fraud statements and filing instructions. **INSURED STATEMENT**

1. Last date worked _____
2. Dates you were totally disabled From _____ Thru _____
3. On what date did you return to work? Part time _____ Full Time _____
4. If you have not yet returned to work, when do you anticipate returning to work? _____
5. Did the accident result from employment? ☐ Yes ☐ No
6. If yes, are you filling or will you be filling for Workers' Compensation? ☐ Yes ☐ No

STATEMENT OF PHYSICIAN

1. Diagnosis and concurrent condition
   (If diagnosis code other than ICDA used, give name)
   ICDA code _____
2. Is condition due to injury arising out of patient's employment? ☐ Yes ☐ No
3. Date of services since disability commenced, not previously reported
   _____
   _____
   _____
4. If patient hospitalized, give name and address of hospital and dates
   Name of hospital _____
   Address of hospital _____
   Admitted ____/____/____ Discharged ____/____/____
5. Date accident happened
6. Date patient first consulted you for this condition
7. Has patient ever had same or similar condition?
   ☐ Yes ☐ No If yes, when and describe.
8. Is patient still under your care for this condition?
   ☐ Yes ☐ No
9. Patient was continuously and totally disabled? (unable to work)
   From Through
10. Patient was partially disabled?
    From Through
11. If still disabled, date patient should be able to return to work.
12. Was there a referring physician? ☐ Yes ☐ No
    If so, what is his name and address?

Date	Physician's Name (Print)	Signature	Degree	Fax	Telephone

Street	City and State	Zip Code	Tax Identification #

STATEMENT OF EMPLOYER

Company Name — Phone No.

Name of Employee — What percentage of the employees premium is paid by the employer? ____%

Employee's Title

☐ Weekly Salary $_____
☐ Monthly Salary $_____
☐ Annual Salary (if commissioned) $_____

Does the employee participate in Social Security? ☐ Yes ☐ No
If no, hired after 4/1/1986? ☐ Yes ☐ No
Are employee paid premiums for this policy withheld before or after taxes?
Before ☐ After ☐

Is this loss a result of employment? ☐ Yes ☐ No

Has the employee made claim for or is he entitled to Worker's Compensation? ☐ Yes ☐ No

Date employee last worked / / — Date returned to work / /

Give final date of paid sick leave to which employee is entitled / /

At the time of this disability was the employee? ☐ Full Time ☐ Part Time ☐ On Leave ☐ Retired ☐ No Longer Employed (Check One)

Is employee eligible for any other paid compensation? ☐ Yes ☐ No If yes, explain what type of benefit this is: Monthly Benefit _____

Period Eligible _____

(Signature of Employer Representative) (Date Signed)