REQUEST FOR HEALTH SCREENING AND CRITICAL ILLNESS POLICY BENEFITS

ATTN: AWD BENEFITS DEPT.
P.O. Box 268898
Oklahoma City, Oklahoma 73126-8898
Toll Free: 1-800-437-1011
Fax: 1-888-243-3453
www.afadvantage.com

INSTRUCTION TO INSURED

1. Complete the **STATEMENT OF INSURED** found on page 3.
2. Complete the **HIPAA AUTHORIZATION** found on page 2.
3. Please have your physician complete the **ATTENDING PHYSICIAN'S STATEMENT** found on pages 3-4 for the Critical Illness for which you are seeking a benefit payment.
4. If claim is for a Cancer Critical Illness, include Pathologist's report.
5. If claim is for Hospital Confinement, include a copy of the bill.
6. If claim is for Occupational HIV or Hepatitis B/C/D, attach a copy of the incident report or notice of exposure.
7. If claim is for Sudden Death Due to Cardiac Arrest, attach a copy of the death certificate.

FOR ALL CLAIMS, PLEASE ATTACH COPIES OF ALL **OFFICE NOTES OR MEDICAL RECORDS** FROM THE DATE YOU WERE FIRST TREATED FOR SYMPTOMS ASSOCIATED WITH THE CONDITION UP TO THE PRESENT.

All portions of this form package must be completed to avoid undue delay in processing claimant's request for benefits. If you have any questions regarding completion of this form please call: Toll Free: 1-800-437-1011.

STATEMENT OF INSURED

1. INSURED FULL NAME_______________ Account No. _______________
(Please Print) (Last) (First) (M.I)

Date of Birth ____/____/____ Insured Social Sec. # ________-______-________ Telephone # _______________
(MO) (Day) (YR)

2. Address ____
(Street) (City) (State) (Zip Code)

3. If claim is for dependent, give name of dependent_______________ Relationship_______________

Date of Birth ____/____/____
(Mo) (Day) (YR)

DIRECT DEPOSIT AUTHORIZATION

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

I authorize AFAC 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.

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

American Fidelity Assurance Company

2000 N. Classen Boulevard Oklahoma City, Oklahoma 73106

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION PROTECTED FEDERAL LAW (HIPAA)

I hereby authorize the entities specified below to disclose any information about my health or the health of my minor dependents that are included under the coverage, including my or my dependents' entire medical record, 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) consumer reporting agencies; g) insurance companies; h) the Medical Information Bureau (MIB); and i) Department of Motor Vehicles.

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.

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, American Fidelity Assurance Company, PO Box 268898, 2000 N. Classen Boulevard, Oklahoma City, Oklahoma 73126, 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.

I understand that if protected health information is disclosed, the information may be redisclosed only in accordance with any other state or federal 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. 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.

A copy of this authorization will be as valid as the original. I am aware that I, or my personal representative, am entitled to and will receive a copy of this authorization.

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.

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A member of the American Fidelity Group®

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See page 1 for fraud statements & filing instructions.

STATEMENT OF INSURED

A. ABOUT YOU

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

Address (City, State, Zip)	Insured's Social Security Number

Employer - Name	Home Telephone #	Email Address

B. ABOUT THE PATIENT

PATIENT INFORMATION (CHECK ONE)
For whom do you make this request?
❑ Self ❑ Wife ❑ Husband
❑ Son ❑ Daughter ❑ Other ______ (Identify)

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

If Claim is for a Dependent Child, is the child under 26 years of age? ❑ Yes ❑ No

C. ABOUT THE CRITICAL ILLNESS

CRITICAL ILLNESS FOR WHICH CLAIM IS BEING MADE (CHECK ALL THAT APPLY)
- ❑ Cancer Critical Illness Benefit Rider (Section 1)
- ❑ Coma Due to a Covered Accident (Section 2)
- ❑ Coronary Angioplasty Recommendation (Section 3)
- ❑ Coronary Bypass Surgery Recommendation (Section 4)
- ❑ End Stage Renal Failure (Section 5)
- ❑ Heart Attack (Myocardial Infarction) (Section 6)
- ❑ Hospital Confinement Benefit Rider (Section 7)
- ❑ Major Burns (Section 8)
- ❑ Major Organ Failure (Section 9)
- ❑ Occupational HIV or Hepatitis B, C, D (Section 10)
- ❑ Stroke, Permanent Damage Due to a (Section 11)
- ❑ Paralysis, Permanent, Due to a Covered Accident (Section 12)
- ❑ Sudden Death Due to Cardiac Arrest Benefit Rider (Section 13)

Date first treated	Have you ever had a similar condition? ❑ Yes ❑ No	If YES, when?

Provide names, addresses and telephone numbers for all attending physicians for the Critical Illness (attach additional sheet of paper, if necessary):

STATEMENT OF THE ATTENDING PHYSICIAN

Please complete the appropriate Section for each Critical Illness with which the patient has been diagnosed.

SECTION 1 CANCER CRITICAL ILLNESS

Does the patient have cancer? ❑ Yes ❑ No Cancer diagnosed: ______
Date the patient was hospitalized: ______ Stage of Cancer: ______ Is this an In Situ Cancer? ❑ Yes ❑ No

SECTION 2 COMA DUE TO A COVERED ACCIDENT

Coma means a continuous profound state of unconsciousness persisting for a minimum of 14 or more consecutive days. A coma must be characterized by severe neurologic dysfunction and unresponsiveness of a prolonged nature. Unresponsiveness means the absence of (1) spontaneous eye movements, (2) response to painful stimuli, and (3) vocalization. The condition must require significant medical intervention, intubation for respiratory assistance, and life support measures. A coma does not include a medically induced coma or a coma resulting from non-accidental causes.

Is the patient in a comatose state? ❑ Yes ❑ No Was the coma medically induced? ❑ Yes ❑ No
Date the coma was diagnosed based on documented neurological dysfunction and prolonged unresponsiveness: ______
What event caused the coma: ______
Did the patient's coma produce severe neurological dysfunction and unresponsiveness persisting for more than 14 days? ❑ Yes ❑ No

SECTION 3 CORONARY ANGIOPLASTY

Does the patient have coronary artery disease? ❑ Yes ❑ No Date Coronary Artery Disease was diagnosed: ______
Date Coronary Angioplasty was recommended: ______ Date Coronary Angioplasty occurred: ______
Coronary Angioplasty procedure performed: ❑ balloon angioplasty ❑ laser angioplasty ❑ stenting

SECTION 4 CORONARY BYPASS SURGERY

Does the patient have coronary artery disease? ❑ Yes ❑ No Date Coronary Artery Disease was diagnosed: ______
Date Coronary Artery Bypass Surgery was recommended: ______ Date surgery occurred: ______
Coronary Artery Bypass Surgery procedure performed: ❑ balloon angioplasty ❑ laser angioplasty ❑ stenting ❑ valve replacement surgery

SECTION 5 END STAGE RENAL FAILURE

Does the patient have End Stage Renal Failure presenting as chronic, irreversible failure to function of both kidneys? ❑ Yes ❑ No
Does the patient's kidney failure necessitate regular peritoneal or hemodialysis (at least weekly) or kidney transplantation? ❑ Yes ❑ No
Date of recommendation for patient to begin renal dialysis or kidney transplant: ______
What is the cause for patient's End Stage Renal Disease: ______
Date patient was first treated for signs or symptoms of this condition: ______

STATEMENT OF THE ATTENDING PHYSICIAN CONTINUED

Patient Name: Date of Birth: Social Security Number:

SECTION 6 **HEART ATTACK (MYOCARDIAL INFARCTION)**

Are new and serial electrocardiographic (EKG) findings consistent with Myocardial Infarction? ❑ Yes ❑ No If YES, attach a copy of the EKG

Were cardiac enzymes elevated above generally accepted laboratory levels of normal for creatine physphokinase (CPK)? ❑ Yes ❑ No

Did diagnostic studies confirm a Myocardial Infarction and the occlusion of one or more coronary arteries? ❑ Yes ❑ No

Did the patient have symptoms consistent with Myocardial Infarction? ❑ Yes ❑ No What symptoms? ___________________________________

Date the patient was diagnosed with a Myocardial Infarction: ____

SECTION 7 **HOSPITAL CONFINEMENT**

Was the patient or is the patient currently hospitalized? ❑ Yes ❑ No Diagnosis: ____

Dates the patient was hospitalized - From: ______________________ To: ______________________

Name and address of the hospital: ____

SECTION 8 **MAJOR BURNS**

Date the burns occurred: ___________________________ Percentage of body surface covered by the burns: ___________________________ %

Degree of the burns: ❑ 1st degree ❑ 2nd degree ❑ 3rd degree ❑ 4th degree

What condition caused the burns: ❑ fire ❑ prolonged exposure to the sun/heat ❑ caustics ❑ electricity ❑ radiation

❑ Other: ____

SECTION 9 **MAJOR ORGAN FAILURE**

Has the patient been placed on the UNOS (United Network for Organ Sharing) list, requiring transplantation of any of the following:

❑ heart ❑ liver ❑ lung ❑ entire pancreas? Date patient was placed on UNOS list: ______________________________

What condition caused the need for transplant: ____

Date patient first treated for signs or symptoms of this condition: ____

SECTION 10 **OCCUPATIONAL HIV or OCCUPATIONAL HEPATITIS B, C, D**

Is the claim for: ❑ Occupational HIV – or – Hepatitis ❑ B ❑ C or ❑ D Date patient positively diagnosed: ______________________________

Date the of accidental exposure to HIV or Hepatitis B/C/D-contaminated body fluids: ____

Did the accidental exposure occur during the normal course of duties of the occupation? ❑ Yes ❑ No

Has the patient previously tested positive for HIV or Hepatitis B/C/D? ❑ Yes ❑ No If YES, give date: __________________

What event caused the HIV or Hepatitis B/C/D: ____

Was a preliminary screening test performed within 14 days of the accidental exposure? ❑ Yes ❑ No Date of the test: ___________________

Was a subsequent screening test performed within 26 weeks of the accidental exposure? ❑ Yes ❑ No Date of the test: ___________________

Were all HIV or Hepatitis B/C/D tests blood tests approved by the FDA? ❑ Yes ❑ No If YES, provide name of test: _____________________

Were all HIV or Hepatitis B/C/D tests performed by a state certified, licensed laboratory? ❑ Yes ❑ No

SECTION 11 **PERMANENT DAMAGE DUE TO A STROKE**

Did the patient have a stroke, meaning an aneurysm rupture, acute cerebral occlusion, or acute cerebral hemorrhage from a cerebral artery, which causes permanent damage to the nervous system which results in a sudden neurological impairment of sensory and/or motor functions persisting for a minimum of 30 consecutive days? (A Stroke does not mean head injury, subdural hematoma, transient ischemic attack, multi-infarct dementia, chronic cerebrovascular insufficiency, or reversible neurological deficits.) ❑ Yes ❑ No

Did the patient's stroke produce neurological deficits persisting for a period of 30 days or greater? ❑ Yes ❑ No

Date stroke occurred based on documented neurological deficits and neuroimaging or other neurodiagnostic study: ___________________________

SECTION 12 **PERMANENT PARALYSIS DUE TO A COVERED ACCIDENT**

Has the patient experienced permanent paralysis due to injuries to the spinal cord resulting in paraplegia or quadriplegia persisting for a period of 90 consecutive days or more? ❑ Yes ❑ No Is paralysis expected to be permanent in nature? ❑ Yes ❑ No

Date patient first diagnosed with paralysis: ______________________ What event resulted in paralysis: ___________________________________

Date patient first treated for signs or symptoms of this condition: ____

SECTION 13 **SUDDEN DEATH DUE TO CARDIAC ARREST**

Date the Cardiac Arrest occurred: _________________________________ Date of the patient's Death: _____________________________________

What condition resulted in the Cardiac Arrest: ____

SIGNATURE OF ATTENDING PHYSICIAN

_______________________________	_______________________	_________________	____________________
Attending Physician's Printed Name	Specialty	Telephone #	Fax #
_______________________________	_______________________	_________________	____________________
Signature of Attending Physician	Date Signed	Email Address	Federal Tax ID #

____

Address