Group Disability Claim Filing Instructions

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, Oklahoma 73126-8898
Toll Free Phone # 1-800-437-1011
Toll Free Fax # 1-888-243-3453
www.afadvantage.com

(Not for use when filing for Physician's Expense Benefits)

Disability Claim form is to be completed after you become disabled.

1. Complete Employee's Disability Benefits Application in full.
2. Have the treating physician complete the Attending Physician's Statement and return to you.
3. Have your Employer complete the Employer's Report of Claim.
4. Submit the completed:
   A. Employee's Disability Benefits Application **B.** Employer's Report of Claim **C.** Attending Physician's Statement
   to the address above or submit via our toll-free fax @ 1-888-243-3453
5. Please tell us how you would like to receive benefits payments, if payment is approved.

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 our Toll Free Number: 1-800-437-1011.

PAYMENT INFORMATION:

Please select one payment option below by checking the appropriate box.

❑ **Direct Deposit** - If you have a checking account this is the most efficient way to receive your benefit payments.

❑ **Debit Card** - A Debit Card account will be applied for through First Fidelity Bank of Oklahoma City, OK.

❑ **Check** - Check written by American Fidelity Assurance and forwarded to your mailing address of Record.

Note: A signature and additional information is required when choosing Direct Deposit or Debit Card option. Be sure to complete the appropriate section below.

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.

DEBIT CARD PAYMENT AUTHORIZATION

AUTHORIZATION AGREEMENT FOR DEBIT CARD ACCOUNT: I hereby request and authorize American Fidelity Assurance Company to submit my application for a Debit Card Account with First Fidelity Bank N.A. of Oklahoma City, Oklahoma under my name. Upon approval and opening of this requested account. I understand the account will be used for deposits of my benefit payments from American Fidelity Assurance Company. I further understand that charges will be applied to my account balance from the use of this card; some of those charges include the following.

- ATM Withdrawal (Domestic) = 5 free per month, $3.00 per withdrawal thereafter
- ATM Withdrawal (International) = $3.00 per withdrawal
- Balance Inquiry = $1.00 per inquiry
- No charge for IVR phone or website inquiry
- POS (Point-of Sale) Denial Fee = $1.00 per denial
- Paper Statement = $1.00 per month
- No Charge for Internet Statements
- Inactive Account Fee = $5.00 after 90 days of account inactivity
- Card Replacement = $10.00
- Pin replacement = $5.00
- Expedited Card Delivery = $25.00
- Check Issuance Fee (to close account) = $10.00
- Negative Balance Fee = $15.00

Direct Deposit -or- Debit Card Authorized Signature:

PRINT NAME: _____ DATE: _____

SIGNED: _____

IMPORTANT: Funds from direct deposits and Debit Card Deposits will **NOT** become available to use any earlier than 3-4 business days following the date the benefits are approved and the credit entry is initiated to your Debit Card Account. If you have already completed a Direct Deposit or Debit Card Authorization Agreement and your card is still active, do not complete another. If you are not sure if you debit card is still active please contact First Fidelity Bank N.A. at 1(800)299-7047.

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.*

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EMPLOYER'S REPORT OF CLAIM

EMPLOYMENT

Name of Employer: | Phone No.: ( )

Mailing Address: (include street, city, state and zip code) | Fax No.: ( )

Name of Employee: | Social Security Number: - -

Address: (include street, city, state and zip code) | Phone No.: ( )

Date of Hire: | Effective date of employee's coverage: | Occupation: (please attach job description)

Status of employment at time of disability: ❑ Full-Time ❑ Part-Time ❑ Leave of Absence ❑ Terminated ❑ Retired

Number of hours worked per week at time of disability:_____

Has employee's status of employment changed? ❑ Yes ❑ No If yes, current status and date of status-change? _____

PREMIUMS

Does employee participate in Social Security? ❒ Yes ❒ No If no, hired after 4/1/86? ❒ Yes ❒ No

What percentage of the disability premiums do you pay (employer)? _____%

Are the AFA disability premiums withheld before or after taxes?

SALARY

SALARY AT TIME OF DISABILITY

Hourly: $_____ Monthly: _____

W-2, for previous calendar year $_____ Year-to-date, current calendar year $_____

DISABILITY

Date employee last worked:_____

Has employee returned to work? ❒ Yes ❒ No

If Yes, date returned to work:

Full Time: _____ Part Time: _____

Have AFA Disability premiums been withheld through the last date worked? ❑ Yes ❑ No

If not, what is the last date disability premiums were deducted? _____

OTHER INCOME

Did Employee's disability result from employment? ❑ Yes ❑ No

If yes, name, address and phone number of Worker's Compensation carrier: _____

Has employee made a claim for or is entitled to Worker's Compensation? ❑ Yes ❑ No

Is the employee receiving or eligible to receive any of the following?

	Yes	No	Amount	Wk	Mo	Company Name and Phone Number	Dates Benefits Begin	Dates Benefits End
Other Group Disability	❑	❑	$	❑	❑			
Salary continuation	❑	❑	$	❑	❑			
Sick Leave	❑	❑	$	❑	❑			
PTO/PPT	❑	❑	$	❑	❑			
Other (Bonus, etc)	❑	❑	$	❑	❑			
Retirement/Pension	❑	❑	$	❑	❑			

I hereby certify that the above named employee is a member of our Group Disability Program. The Information stated above is correct to the best of my knowledge and belief.

Authorized signature of employer firm or authorized official: _____

Title: _____ Date: _____

E-mail Address:_____ Extension: _____

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EMPLOYEE'S DISABILITY BENEFITS APPLICATION

See front page for fraud warnings.

Full Name: (last, first, middle initial) | Maiden Name: | Account Number:

Residence: (street, city, state and zip code) | Social Security Number: - -

Mailing Address: (P.O. Box or street, city and zip code) | Date of Birth: / /

Telephone Number: (including area code) ( ) | ❒ Single ❒ Married ❒ Widowed ❒ Divorced

Occupation: | Has your employment terminated? | If so, date:

Names & birth dates of spouse & dependents:

Name _____/____/____ Birth date | Name _____/____/____ Birth date

Name _____/____/____ Birth date | Name _____/____/____ Birth date

1. Date accident or illness began:

2. If accident, explain where and how it happened?

3. Have you ever had the same or similar condition in the past? ❒ Yes ❒ No If so, when? _____

If yes, names and address of treating physicians and/or hospitals:

4. Nature of illness or injury:

5. Dates of medical treatment:

Date of next doctor's appointment:

6. If hospitalized give full name(s) and addresses of hospitals: (attach additional list if necessary) Admit Date: _____/_____/_____ Discharge Date: _____/_____/_____

7. Full names and addresses of all treating physicians: (attach additional list if necessary)

8. Is your disability related to your employment/occupation? ❒ Yes ❒ No
If yes, have you or do you intend to file for Worker's Compensation? ❒ Yes ❒ No

9. On what date did you last work?_____ Dates of total disability: From _____ Thru _____
On what date did you return to work? _____ Part Time _____/_____/_____ Full Time _____/_____/_____
If not returned to work, when do you anticipate returning to work?_____

10. If your request for benefits is approved, do you want us to withhold Federal Taxes from each benefit check? ❒ Yes ❒ No

If yes, amount: $ _____ (indicate amount per month $87.00 minimum)

11. Identify other income sources and amount of income for which you are receiving or may be entitled to receive during this disability

Your Social Security: (disability or retirement)	❒ Yes	❒ No	$_____Mo.	V.A. Benefits:	❒ Yes	❒ No	$_____Mo.
Dependent Social Security:	❒ Yes	❒ No	$_____Mo.	Worker's Compensation:	❒ Yes	❒ No	$_____Mo.
Sick Leave or Wage Continuation:	❒ Yes	❒ No	$_____Mo.	Other Disability Coverage:	❒ Yes	❒ No	$_____Mo
Retirement: (normal early or disability)	❒ Yes	❒ No	$_____Mo.	(identify)_____			
State Disability Income	❒ Yes	❒ No	$_____Mo.	**Include a copy of your award or denial letter for any source in which one has been received.**			
Unemployment	❒ Yes	❒ No	$_____Mo				

Signature: _____ **Date:** _____
I certify this information is true and correct.

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize the entities specified below to disclose any information about my entire medical record, benefits payable, or benefit eligibility for this disability 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.

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. 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.

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, PO 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.

_____ Signature (Patient) or Personal Representative (if applicable)

_____ Printed Name (Patient)

_____ Relationship of Personal Representative to Patient

_____ Date

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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ATTENDING PHYSICIAN'S STATEMENT

See front page for fraud warnings.

Name of Patient: | Date of Birth: | Social Security Number: | Account Number:

DIAGNOSIS

Diagnosis: (including complications) ICDA Code:

Is disability due to injury or sickness arising out of or in the course of patient's employment? ❑ Yes ❑ No

Is disability the result of pregnancy? ❑ Yes ❑ No If yes, type of delivery: _____

Date pregnancy was diagnosed? ____/____/____ Date of delivery:(if delivered) ____/____/____ Expected date of delivery? ____/____/____

HISTORY

When did symptoms first appear or accident happen? Date patient first consulted you for this condition?

_____/_____/_____ _____/_____/_____

Has the patient ever had the same or similar condition? ❑ Yes ❑ No If yes, indicate when and describe:

Was the patient referred to you? ❑ Yes ❑ No If yes, full name and address of referring physician:

TREATMENT

Frequency of treatment: ❑ Monthly ❑ Weekly ❑ Other

Date of next appointment : _____/_____/_____

Nature of treatment being rendered (including surgery and any medications being prescribed)

List all dates of treatment or medical attention since the disability began:

Is patient still under your regular care for this condition? ❑ Yes ❑ No If no, please explain and provide name of the current treating physician:

Has the patient been confined to a hospital? ❑ Yes ❑ No Admitted: _____/_____/_____ Discharged: _____/_____/_____

If yes, give admit and discharge dates along with name and address of hospital. Admitted: _____/_____/_____ Discharged: _____/_____/_____

Name:_____ Address: _____

PROGNOSIS

Dates of total disability: (unable to work) From: _____ Through: _____

Disabled from: Patient's Job ❑ Yes ❑ No Any other work ❑ Yes ❑ No

Dates of partial disability? From: _____ Through: _____

If the patient is currently disabled, what is the anticipated length of disability?

❑ 1-2 Months ❑ 2-3 Months ❑ 3-6 Months

❑ 6-12 Months ❑ More than 12 Months ❑ Permanent

When, in your opinion, will the patient recover sufficiently to return to work?

IMPAIRMENTS

Functional Limitations that render your patient totally disabled:

Current Treatment Plan:

Attending Physician's Name: (print) | Specialty: | Telephone #: ( ) - | Fax #: ( ) -

Street Address: | City: | State: | Zip Code:

Signature: | Federal Tax ID #: | Date:

Email address: