American Fidelity Assurance Company
A member of the American Fidelity Group

ASSOCIATION and WORKSITE DIVISION
BENEFITS DEPARTMENT
P.O. Box 268898
Oklahoma City, OK 73126-8898

Routine Pregnancy Claim Filing Instructions

Do not use this form for any benefit other than routine child birth.

1. Complete Employee's Disability Benefits Application in full, sign and date the authorization.
2. Have your Employer complete the Employer's Report of Claim.
3. Have the treating physician complete the Attending Physician's Statement and return to you.
4. Submit the completed:
   - **A.** Employee's Disability Benefits Application
   - **B.** Employer's Report of Claim
   - **C.** Attending Physican's Statement to the address below or submit via our toll-free fax at 1-888-243-3453

If you have any questions when completing this form, please call: Toll Free Number – (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.

CHECKING DIRECT DEPOSIT AUTHORIZATION

IMPORTANT: Funds from direct 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 account. If you have already filed a Direct Deposit Authorization Agreement, do not complete another, unless your Bank or Credit Union account information has changed.

PLEASE SIGN BELOW IF YOU DESIRE BENEFITS DEPOSITED DIRECTLY INTO YOUR BANK ACCOUNT AND ATTACH VOIDED/CANCELLED CHECK

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.

DEBIT CARD PAYMENT AUTHORIZATION

IMPORTANT: Funds from 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 Debit Card Authorization Agreement and your card is still active, do not complete another. If you are not sure if you card is still active please contact First Fidelity Bank N.A. at 1(800)299-7047.

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: _____

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Mail to: AWD Benefits Department
P.O. Box 268898 | Oklahoma City, OK 73126-8898
Toll Free Phone # 1-800-437-1011
Toll Free Fax # 1-888-243-3453

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

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.

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.

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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Routine Pregnancy

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See page 1 for fraud statements.

SECTION 1: EMPLOYEE'S DISABILITY BENEFITS APPLICATION

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

Social Security Number: - - | Date of Birth: / / | Telephone Number: (including area code) ( )

Mailing Address: (P.O. Box or street, city and zip code) | Occupation:

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

_____

_____

_____

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

3. On what date did you last work?_____

On what date did you return to work?_____

If not returned to work, when do you anticipate returning to work?_____

Dates of total disability:
From _____ Thru _____

5. 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)

6. Please identify other income sources and amount of income which you are receiving or may be entitled to receive during this disability:

Other Group Insurance ☐ Yes ☐ No $_____ Workers Comp ☐ Yes ☐ No $ _____

Sick Leave or Wage Continuation ☐ Yes ☐ No $_____

Include a copy of **your award or denial letter** from any source that you have received.

SECTION 2: EMPLOYER'S REPORT OF CLAIM

Name of Employer: | Phone No.: ( ) | Fax No.: ( )

Mailing Address: (include street, city, state and zip code)

Name of Employee: | Social Security Number: | Occupation: | Date of Hire:

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

Please furnish the percentage of the employee's AFA disability premium you pay: _____%

Are the AFA disability premiums withheld before or after taxes? ☐ Before ☐ After

Have you withheld the employee's disability premium for the current month?
☐ Yes ☐ No

If not, what is the last month you deducted disability premiums? _____

SALARY AT THE TIME OF DISABILITY:

Hourly: $_____ Monthly: $_____ W-2, for previous Calendar Year: $_____ Year-to-date, Current Calendar Year: $_____

Number of hours scheduled weekly: _____

OTHER SOURCES OF INCOME:

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	☐	☐	$	☐	☐			

Form completed by: (please print)	Title:	Phone Number & Extension:
Employer Name:	Office Phone Number:	Fax Number:
Street Address:	City:	State: Zip Code:
Signature:		Date:

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SECTION 3: ATTENDING PHYSICIAN'S STATEMENT

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

DIAGNOSIS

Diagnosis: | ICDA Code:

Type of delivery: _____

Date pregnancy was diagnosed? ____/____/____

Date of delivery: (if delivered) ___/____/_____

HISTORY

When did symptoms first appear? ____/____/____

Date patient first consulted you for this condition? ____/____/____

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

_____

_____

TREATMENT

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.

Name: _____

Address: _____

PROGNOSIS

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

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

Street Address:	City:	State:	Zip Code:

Signature:	Federal Tax ID #:	Date: