Accident Claims Checklist

Have this information handy to identify your policy:

- Policy number
- Policyholder's name and date of birth
- Policyholder's address

Here's a list of common items you will need to file a claim*:

- Patient's name and date of birth
- Patient's relationship to policyholder
- Date and description of injury
- Location of accident
- Copy of police report (motor vehicle accidents)
- For hospital stay: Ask your hospital to provide a completed UB04 document or ask your physician to provide a completed HCFA1500 document
- Include all ambulance, mobility aids, lodging and transportation invoices

Details of all requirements can be found by downloading your state-approved claim form here.

File your claim faster using the MyAflac mobile app:

1. Log in to MyAflac or download the MyAflac mobile app. (If you haven't registered on aflac.com/myaflac you will need your policy number.)
2. Click Start a SmartClaim or File a Claim on the MyAflac mobile app to begin. SmartClaim guides you through every step of the way.
3. Upload required documents by scanning or taking a quick snapshot.
4. Submit your completed claim before 3 p.m. ET, Monday - Friday, and qualify for One Day Pay[SM]. SmartClaims received after 3 p.m. ET will be processed the next business day.*

Other ways to file a claim:

Fax: 1.877.44.AFLAC (1.877.442.3522)
Mail: Aflac, Attention: Claims Department
1932 Wynnton Road, Columbus GA 31999

Helpful tips: Register on aflac.com/myaflac so you can:

View benefit details
Here you'll find a copy of your policy to see what's covered and benefit amounts.

Track your claim
Follow your claim from start to finish and receive alerts if we need additional information through our integrated Claim Status Tracker.

Sign up for direct deposit and receive benefits faster
Be sure to register at least 24 hours before filing a claim. Otherwise, we will mail you a check.

This checklist is intended to assist policyholders when filing claims and does not constitute a guarantee of claims payments or act as an all inclusive list. *One Day Pay[SM] is available for certain individual claims submitted online through the Aflac SmartClaim® process. Claims may be eligible for One Day Pay processing if submitted online through Aflac SmartClaim®, including all required documentation, by 3 p.m. ET. Documentation requirements vary by type of claim; please review requirements for your claim(s) carefully. Aflac SmartClaim® is available for claims on most individual Accident, Cancer, Hospital, Specified Health, and Intensive Care policies. Processing time is based on business days after all required documentation needed to render a decision is received and no further validation and/or research is required. Individual Company Statistic, 2018.
Aflac herein means American Family Assurance Company of Columbus.

ACCIDENTAL INJURY CLAIM FORM

Thank you for trusting Aflac with your Accidental Injury needs.

- **If you are interested in filing your claim online or uploading documentation on an existing claim, register using aflac.com/smartclaim.**

To prevent delays, please provide documentation from your healthcare provider to support this claim. If you have additional bills or medical documentation that relates to this diagnosis other than the documentation defined, please submit them for review of additional benefits.

- **Service related items can be obtained directly from the patient's healthcare provider(s) by requesting a UB04 hospital bill or HCFA 1500 non-hospital bill.**
- **Failure to complete all sections may result in a delay in processing this claim.**
- **Disclaimer: Some of the services listed may not be covered by your policy.**

***Policy Number:**

Policyholder Information: This * denotes a required field.

*Last Name   Suffix   *First Name   MI

*Date of Birth (mm/dd/yy) / /   Telephone Number where we can reach you - -

*Home Address

*City   *State   *Zip Code -

☐ *Check box if this is a permanent address change.*

Patient Information:

*Last Name   *First Name   *Date of Birth (mm/dd/yy) / /

*Sex: ☐ Male ☐ Female

*Relationship: ☐ Primary Policyholder ☐ Spouse ☐ Dependent Child

Accidental Injury Checklist

- Date of the injury: ______/______/______
- Describe how the injury occurred: ______________________
- Was this injury caused by an incident that occurred while performing the duties of his/her employment? ☐ No ☐ Yes
- Was injury a result of participating in an organized sporting activity? ☐ No ☐ Yes
  Type of Event______________ Sporting Organization______________
- Was this a motor vehicle accident in which the patient was the driver? ☐ No ☐ Yes (If yes, please submit a copy of the Police Report.)
- Was death a result of this injury? ☐ No ☐ Yes (If yes, please submit the certified death certificate and the Life-Beneficiary's Statement.)
- Was the patient confined to the hospital as a result of this injury? ☐ No ☐ Yes (If yes, please submit the UB04 (Universal Billing 2004), itemized hospital bill, or HCFA 1500.)
- Hospital Name: ______________________
- City ______________ State ______________

If you have additional bills or medical documentation that relates to this diagnosis other than the documentation defined, please submit them for review of additional benefits.

*Policy Number: | | | | | | | | |

Policyholder Information:

*Last Name | Suffix | *First Name | MI

*Date of Birth (mm/dd/yy) ☐☐/☐☐/☐☐

Patient Information:

*Last Name | *First Name | *Date of Birth (mm/dd/yy) ☐☐/☐☐/☐☐

- Was the patient transported by an ambulance as a result of this injury? ☐ No ☐ Yes (If yes, please submit the ambulance bill.)
- Was an aid in locomotion (mobility) prescribed as a result of this injury? (I.e. crutches, wheelchairs, leg braces, back braces, walkers, cervical collars, etc.) ☐ No ☐ Yes (If yes, please submit documentation from the prescribing provider, UB04 or HCFA 1500.)
- If any of the following were the result of your injury, please provide medical records, physician's office notes, or any bills received for these conditions that describe the diagnosis or type of treatment received:
  - Coma
  - Paralysis
  - Burn
  - Injury to the Eye
  - Laceration
  - Dislocation
  - Concussion (major diagnostic exam reports are acceptable)
  - Fractures (x-ray reports or major diagnostic exam reports are acceptable)
- Was surgery performed as a result of this injury? ☐ No ☐ Yes (If yes, please submit a copy of the operative report or detailed billing from the surgeon's office, such as UB04 or HCFA 1500.)
- Was a major diagnostic exam (i.e. CT Scan, MRI, MRA, EEG) performed as a result of this condition? ☐ No ☐ Yes (If yes, please submit a copy of the exam report, billing information, UB04 or HCFA 1500.)
- Dates of treatment related to injury (please submit supporting medical documentation for each visit indicated below):

Date	Provider Name	Provider Address	Provider Phone Number	Type of Treatment
				☐ Follow up ☐ Therapy *
				☐ Follow up ☐ Therapy *

* Some policies provide benefits for therapy including physical, speech, and occupational therapy. Not all types are available on all policies. Please submit information indicating date of treatment, treatment type, and who provided it to determine benefit.

- Transportation/Lodging Information: Please complete if you are filing a claim for transportation or lodging and please submit the hotel receipts and mileage information. For additional information, please refer to your policy language.

Date	To/From	Round-Trip Mileage

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.

POLICYHOLDER/PATIENT SIGNATURE | **FAMILY RELATIONSHIP, IF NOT POLICYHOLDER** | **DATE**

American Family Life Assurance Company of Columbus (Aflac)
ATTN: Claims Department • 1932 Wynnton Road • Columbus, GA 31999
For information or to check claim status, visit aflac.com or call 1-800-99-AFLAC (1-800-992-3522)
Claims may be faxed to 1-877-44-AFLAC (1-877-442-3522)