Hospital 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
- ☐ First consult date of injury or illness
- ☐ For injury: Description and location
- ☐ For illness: Date symptoms first occurred
- ☐ For pregnancy: Date and type of delivery
- ☐ Types of services received and details of charges
- ☐ Invoices for ambulance and transportation
- ☐ Ask your physician to provide a completed HCFA 1500 or ask the hospital to provide a completed UB04

For further details, download your state-approved claim form here.

File your claim faster through the Aflac SmartClaim® Process:

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 to do so.)
2. Click Start a SmartClaim or File a Claim on the MyAflac mobile app to begin.
   Aflac 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, to qualify for One Day Pay℠ processing.*
   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: Log in to 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, your check will be mailed to you.

Aflac®

This checklist is intended to assist policyholders when filing claims and does not constitute a guarantee of claims payments. *One Day Pay℠ 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. Coverage is underwritten by American Family Life Assurance Company of Columbus. In New York, coverage is underwritten by American Family Life Assurance Company of New York.

HOSPITAL INDEMNITY CLAIM FORM

Thank you for trusting Aflac with your Hospital Indemnity 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

Hospital Indemnity Checklist

***If filing for a claim within the first two years of the policy, medical records may be requested for evidence of insurability.**

Is treatment due to an injury? ☐ No ☐ Yes ***If yes, please complete the following questions related to the injury:***

- Date of the injury: _____/_____/_____
- Describe how the injury occurred: _____
- Was this disability caused by an incident that occurred while performing the duties of the patient's employment? ☐ No ☐ Yes
- 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.)

Is treatment due to a sickness? ☐ No ☐ Yes ***If yes, please complete the following questions related to the sickness:***

- Symptoms first occurred on: _____/_____/_____
- First date of treatment for this condition: _____/_____/_____
- If diagnosed with cancer, date of initial diagnosis: _____/_____/_____
- Was the patient treated by any other physicians for this sickness or a related condition? ☐ No ☐ Yes
  - If yes, physician's name(s): _____
  - Phone Number(s): _____
  - Address: _____

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)

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)

Pregnancy claims:

- Date of delivery: ____/_____/_____ ☐ Vaginal ☐ Cesarean
- If not delivered, expected delivery date: _____/_____/_____
- Please advise of any complications: _____

For all claims, please complete all remaining sections.

- Please provide the name, address and phone number of the patient's primary treating physician.
  Name: _____ Phone Number: _____
  Address: _____
- Was the patient confined to the hospital as a result of this condition? ☐ No ☐ Yes (If yes, please submit the itemized hospital bill, UB04, or HCFA 1500)
  Hospital Name: _____
  City: _____ State: _____
- Was the patient confined to the intensive care unit as a result of this condition? ☐ No ☐ Yes (If yes, please submit the itemized bill, UB04, or HCFA 1500.)
- Was the patient confined to a rehabilitation unit as a result of this condition? ☐ No ☐ Yes (If yes, please submit the itemized bill, UB04, or HCFA 1500.)
- Was patient treated in an emergency room as a result of this condition? ☐ No ☐ Yes (If yes, please submit the emergency room report, UB04, or HCFA 1500.)
  Hospital name: _____ Date of treatment: _____/_____/_____
- Was the patient transported by an ambulance as a result of this condition? ☐ No ☐ Yes (If yes, please submit the ambulance bill)
- Was surgery performed as a result of this condition? ☐ No ☐ Yes (If yes, please submit a copy of the operative report, UB04, or HCFA 1500.)
- Were medical imaging services (i.e. CT Scan, MRI, EEG, etc.) provided as a result of this condition? ☐ No ☐ Yes (If yes, please submit a copy of the exam report and/or billing, UB04, or HCFA 1500.)

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)