

CRITICAL ILLNESS CLAIM FORM INSTRUCTIONS

To avoid delays in processing of your claim form, complete each section attaching documentation below when it applies.

Supporting Documentation Needed

- ✓ Chart Note to include admission and discharge paperwork if there was a hospital stay
- ✓ Surgical Report-if surgery took place
- ✓ Pathologist report when diagnosed with a malignant condition
- Benefit Assignment-Benefits are payable to the policy holder unless written authorization is received from you or your healthcare provider to assign benefits to the provider. If you choose to assign benefits, attach a signed and written request.



Send to: Continental American Insurance Company Post Office Box 84080 Columbus, GA 31993-4080 Phone: (800) 433-3036 Fax: (706) 243-7577 Email: aflacgroupclaimsus@aflac.com

CRITICAL ILLNESS CLAIM FORM

- ✓ Please review your policy for specific benefits covered under your plan.
- ✓ To prevent processing delays, complete the claim form in full and return the signed HIPAA.
- ✓ Submit medical documentation from your healthcare provider to support your claim.

POLICYHOLDER/CLAIMANT INFORMATION

Employer's Name: UNIVERSITY OF CALIFORNIA #25796 Policyholder's Name: Policy Certificate No.: Social Security No.: Date of Birth: Gender: Policyholder's Address: (Full Street Address in addition to city, state, zip) Policyholder's E-Mail: Telephone Number: □ Check If This Is A Permanent Address Change Relationship To The Policyholder: Date of Birth: Gender:

*By providing your e-mail address above, you consent to the use of electronic transactions in connection with your CAIC policies, contracts, and/or accounts to the extent available permitted by law (which may include, but not limited to: invoices, claim correspondence, contracts, surveys, and other materials that CAIC is, or May be, legally required to deliver to you).

MAMMOGRAPHY SCREENING:

Check if you are filing for the mammogram screening benefit. Provide the date of service for the mammogram Provide name and address of physician or facility that performed the mammogram.

PLEASE INDICATE THE CONDITION FOR WHICH THE PATIENT IS FILING:

Cancer; Carcinoma in situ; Skin Cancer: Please submit a copy of the pathology report from which the condition was diagnosed.

Heart Attack; Sudden Cardiac Arrest: Please submit a copy of the discharge summary, cardiology consult report, cardiac catheterization report, history & physical, and ER notes.
 Coronary Artery Bypass Surgery: Please submit a copy of the operative report for the procedure.

□ Major Organ Transplant; Bone Marrow Transplant: Please submit a copy of the operative report for the procedure.

Stroke: Please submit a copy of the discharge summary, MRI and/or CT test reports from the initial diagnosis, as well as proof of permanent neurological damage (i.e. follow up CT and/or MRI reports, office notes from neurologist or therapist, etc.)

Renal Failure: Please submit proof of the start date for dialysis or the operative report for transplant. The End Stage Renal Disease Medical Evidence Report is preferred.
 Heart Event: Please submit a copy of the operative report for the procedure.

Loss of Sight, speech, hearing, coma, burns, paralysis: Please submit medical documentation from the health care provider indicating the diagnosis and severity.

Specified Disease-Human Coranvirus: Please submit medical documentation from the health care provider indicating the diagnosis and severity.

CHILDHOOD CONDITIONS RIDER (Include medical documentation which confirms original date of diagnosis)

Autism Spectrum Disorder	□ Cerebral Palsy	Down Syndrome	Pheny lalinine Hy doxy lase Deficiency Disease (PKU)	
Cleft Lip or Palate	🗆 Cy stic Fibrosis	🗆 Spina Bifada	□ Type I Diabetes	
Disclaimer: Some of the conditions and services listed may not be covered by your policy.				

DATE	TO/ FROM	ROUND-TRIP MILEAGE

Several states require that the following statement appear on the claim forms:

Any person, who knowingly and with intent to defraud any insurance company, files a statement of claim containing any materially false, incomplete or misleading information, is guilty of a crime.

I hereby certify that the answers I have provided to the foregoing questions are both complete and true to the best of my knowledge and belief. I have read the fraud notice included with this form.

POLICYHOLDER'S SIGNATURE:

DATE:



Send to: Continental American Insurance Company Post Office Box 84080 Columbus, GA 31993-4080 Phone: (800) 433-3036 Fax: (706) 243-7577 Email: <u>aflacgroupclaimsus@aflac.com</u>

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CRITICAL ILLNESS CLAIM FORM

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WEEKLY) OR WHICH RESULTS IN KIDNEY TRANSPLANTATION?		GE RENAL FAILURE PRESENTING AS CHRONIC, IF	RREVERSIBLE	FAILURE TO FUN	CTION OF BOTH		□NO	
WHAT IS THE CAUSE FOR THE PATIENT'S RENAL DISEASE? DATE THE PATIENT FIRST TREATED FOR SIGNS OR SYMPTOMS OF					□NO			
	WHAT IS THE CAUSE FOR THE PATI	IENT'S RENAL DISEASE?			FIRST TREATED FOR	SIGNS OR	SYMPTOMS OF	



Send to: Continental American Insurance Company Post Office Box 84080 Columbus, GA 31993-4080 Phone: (800) 433-3036 Fax: (706) 243-7577 Email: aflacgroupclaimsus@aflac.com

CRITICAL ILLNESS CLAIM FORM

(Page 3 of 3)

ATTENDING PHYSICIAN'S STATEMENT (continued)					
PATIENT NAME: DATE OF BIRTH:					
5.	IS THE PATIENT UNABLE TO PERFORM JOB DUTIES? INO YES IF YES, PLEASE PROVIDE DATES:				
	WHAT SPECIFIC JOB DUTIES IS PATIEN	IT UNABLE TO PERFORM?			
	RESTRICTIONS AND LIMITATIONS: (PLE	EASE QUANTIFY IN HOURS, W	VEIGHT, ETC.)		
6.	IF RETIRED OR UNEMPLOYED WHICH A	ACTIVITIES OF DAILY LIVING	(ADLS) IS PATIENT UNABL	E TO PERFORM?	
7.	IS THE PATIENT: AMBULATORY BED CONFINED HOUSE CONFINED	WAS THE PATIENT HOSPIT HOSPITAL / ADDRESS:	ALIZED OR CONFINED TO	A SKILLED NURSI	NGFACILITY? IYES INO
	OTHER	DATE ADMITTED:		DATE DISCHA	RGED:
8.	DATE YOU EXPECT PATIENT TO RESU	ME <u>PARTIAL DUTIES</u> ?	DATE YOU EXPECT PAT	IENT TO RESUME	FULL DUTIES?
9.	IF PATIENT IS UNEMPLOYED OR RETIR HIS/HER NORMAL AND NECESSARY AC	,		OF LIKE AGE, GENE	DER AND GOOD HEALTH TO RESUME
10.	WAS THE PATIENT TREATED BY ANY OTHER PHYSICIAN'S FOR THIS CONDITION? YES ON ON PLEASE PROVIDE NAMES AND ADDRESSES OF OTHER TREATING PHYSICIANS:				
	R, IT IS UNLAWFUL TO FILL OUT THIS FOR BE SURE THAT ALL INFORMATION IS COI				
	I HEREBY CERTIFY THAT THE ABOVE DESCRIBED INFORMATION IS BASED UPON REASONABLE MEDICAL PROBABILITY AND IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.				
	ATTENDING PHYSICIAN'S SIGNATURE				
I HEREBY CERTIFY THAT THE ABOVE DESCRIBED INFORMATION IS BASED UPON REASONABLE MEDICAL PROBABILITY, AND IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.					
NAME (ATT	E (ATTENDING PHYSICIAN) PLEASE PRINT: DEGREE: TELEPHONE NUMBER:				TELEPHONE NUMBER:
ADDRESS:		CITY:		STATE:	ZIP CODE:
SIGNATURE	Ē:	DATE:		MEDICAL ID#:	1

AUTHORIZATION TO OBTAIN INFORMATION



Send to:

Continental American Insurance Company Post Office Box 84080 Columbus, GA 31993-4080 Phone: (800) 433-3036 Fax: (706) 243-7577 Email: aflacgroupclaimsus@aflac.com

Primary Certificate Holder Name:	SSN(optional):		Date of Birth:		
Certificate Number(s):	•				
Address:		City:		State:	Zip:
Name of Individual Subject to Disclosure (If not the primary Certificate Holder): Date of Birth:					
Relationship to Primary Certificate Holder: Self Spouse Domestic Partner Child Stepchild Grandchild			hild		

I. Authorization:

For the purpose of evaluating my *eligibility for insurance and for benefits* under an existing certificate, including checking for and resolving any issues that may arise regarding incomplete or incorrect information on my application for coverage and/or claim form, I hereby authorize the disclosure of the following information(defined below) about me and, if applicable, my dependents, from the sources listed below to Continental American Insurance Company (CAIC), or any person or entity acting on its part, to include American Family Life Assurance Company of Columbus and American Family Life Assurance Company of New York (collectively, "Aflac).

II. Disclosure of HealthInformation:

Health information may be disclosed by any health care provider, health plan (including CAIC or Aflac, with respect to other CAIC or Aflac coverages) or health care clearinghouse that has any records or knowledge about me. Health care provider includes, but is not limited to, any licensed physician, medical or nurse practitioner, nurse, pharmacist, osteopath, psychologist, physical or occupational therapist, chiropractor, dentist, audiologist or speech pathologist, podiatrist, hospital, medical clinic or laboratory, pharmacy, rehabilitation facility, nursing home or extended care facility, prescription drug database or pharmacy benefit manager, or ambulance or other medical transport service. Health information may also be disclosed by any insurance company or the Medical Information Bureau (MIB). Health information includes my entire medical record, but does not include psychotherapy notes. Some information obtained may not be protected by certain federal regulations governing the privacy of health information, but the information is protected by state privacy laws and other applicable laws. CAIC will not disclose the information unless permitted or required by those laws.

III. Rights and Expiration:

I understand that I may revoke this authorization at any time, except to the extent that CAIC or Aflac has taken action in reliance on this authorization. If I revoke this authorization, CAIC may not be able to evaluate my application for coverage and/or claim. To revoke this authorization, I must provide a written and signed revocation to CAIC at the address or fax number above. Unless otherwise revoked, this authorization shall remain in effect for two (2) years from the date signed or upon my death, whichever occurs first. I agree that a copy of this authorization is as valid as the original and that I or an authorized representative mayrequest a copy of this authorization.

IV. Notice:

I understand that CAIC is not conditioning payment, enrollment, or eligibility for benefits on whether I sign this authorization. I understand that if the information disclosed is protected health information relating to a health plan and the person or entity receiving the information is a not a health care provider or health plan covered by federal privacy regulations, the information disclosed may be re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.

- If records are on an adult dependent, (e.g. spouse, child over 18), the dependent must sign this form
- If records are on a minor child the natural parent or legal guardian must sign on their behalf.

Signature of Individual Subject to Disclosure	Date Signed		
Legal Representative's Printed Name*	Legal Representative's Signature *	Legal Relationship *	Date

*If signed by a legal representative (e.g. Legal Guardian, Estate Administrator, Power of Attorney

ContinentalAmericanInsurance

Company Post Office Box 84080 Columbus, GA 31993-4080

Send to:



Phone: (800) 433-3036 Fax: (706) 243-7577 Email: aflacgroupclaimsus@aflac.com

	Authorization Agreement for Direct Deposit				
I would like to: Start Stop Change direct deposit of my claimpayment(s).					
Account Type:					
Checking Savings		Jane Doe 1001 1234 Main St. Apt 101 Lenexa, KS 65215 DATE PAY OKDEN OF B DOLLARS 1			
**** Please provide	a blank voided check or	Your Bank Address of Your Bank Lenebas, KS 66215			
direct deposit form	from your financial	FOR			
institution. Incomple	-	*1234567891 *1234567* 1001			
information will not		Bank Routing Number Bank Account Number			
9-Digit Routing Number:		Account Number:			
Name of Financial Institutio	n:				
Address:		City:			
State:	Zip:	Phone:			
I authorize Continental American Insurance Company (CAIC) to initiate credit entries, and, if errors occur, I authorize the correction of entries to my account as indicated. This authorization remains effective and in full force until CAIC receives written notification from me of its termination in such time and in such manner to afford CAIC a reasonable opportunity to act on it. Please notify CAIC immediately if your financial institution information has changed by sending notification to the address indicated above. Should you have any questions, please contact us at 1-800-433-3036.					
Policy/Certificate Holder'sName (Print):					
Address:		City/State/Zip:			
Phone #:		E-mail Address:			
Employer Name or Group #:		Certificate #:			

Important Note: By providing your e-mail address above, you consent to the use of electronic transactions in connection with your CAIC policies, contracts, and/or accounts to the extent available and permitted by law (which may include, but not limited to: invoices, claim correspondence, contracts, surveys, and other materials that CAIC is, or may be, legally required to deliver to you)

Policy/Certificate Holder Signature (*Required*):

Date Signed:

Continental American Insurance Company (CAIC), a proud member of the Aflac family of insurers, is a wholly-owned subsidiary of Aflac Incorporated and underwrites group coverage. Aflac is not licensed to solicit business in New York, Guam, Puerto Rico, or the Virgin Islands. For groups sitused in California, coverage is underwritten by Continental American Life Insurance Company. For groups sitused in New York, coverage is underwritten by Continental American Life Insurance Company. For groups sitused in New York, coverage is underwritten by American Family Life Assurance Company of New York.

Continental American Insurance Company • 1600 Williams St • Columbia, South Carolina 29201 • 1-800-433-3036 toll-free • 1-866-849-2970 fax

FRAUD WARNING NOTICES For use with Claim Forms PLEASE READ THE FRAUD WARNING NOTICE FOR YOUR STATE

IDAHO: Any person who knowingly, and with intent to defraud
or deceive any insurance company, files a statement of claim
containing any false, incomplete, or misleading information is
guilty of a felony.
INDIANA: A person who knowingly and with intent to defraud
an insurer files a statement of claim containing Any false,
incomplete, or misleading information commits a felony.
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.
LOUISIANA: 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.
MAINE: It is a crime to knowingly provide false, incomplete or
misleading information to aninsurance company for the
purpose of defrauding the company. Penalties may include
imprisonment, fines or a denial of insurance benefits.
MARYLAND: Any person who knowingly and willfully presents
a false or fraudulent claim for payment of a loss or benefit or
who knowingly and willfully presents false information in an
application for insurance is guilty of a crime and may be
subject to fines and confinement in prison.
MINNESOTA: A person who files a claim with intent to defraud
or helps commit a fraud against an insurer is guilt of a crime.
NEW HAMPSHIRE: Any person who, with a purpose toinjure,
defraud, or deceive any insurance company, files a statement
of claim containing any false, incomplete, ormisleading
information is subject to prosecution andpunishment for
insurance fraud, as provided in RSA638:20.
NEW JERSEY: Any person who knowingly files astatement of
claim containing any false or misleading information is subject
to criminal and civil penalties.

FRAUD WARNING NOTICES (CONT.)				
For use with Claim Forms PLEASE READ THE FRAUD WARNING NOTICE FOR YOUR STATE				
NEW MEXICO: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefitor knowingly presents false information in an application for insurance is guilty of a crime and may be subject tocivil fines and criminal penalties.	TENNESSEE: It is a crime to knowingly provide false, incomplete or misleading information to aninsurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.			
NEW YORK: 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.	TEXAS: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of acrime and may be subject to fines and confinement in <u>state prison.</u>			
OHIO: Any person who, with intent to defraud orknowing that he is facilitating a fraud against an insurer, submitsan application or files a claim containing a false or deceptive statement is guilty of insurance fraud.	VIRGINIA : It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.			
OKLAHOMA: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information <u>is guilty of a felony.</u>	WASHINGTON: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.			
OREGON: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or <u>deceptive</u> statement may be guilty of insurance fraud.	RHODE ISLAND and WEST VIRGINIA: Any personwho 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 <u>crime andmay be</u> <u>subject to fines and confinement in prison</u> .			
PENNSYLVANIA : Any person who knowingly and withintent 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.	ALL OTHER STATES: 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.			
PUERTO RICO: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand dollars(\$5,000) and not more than ten thousand dollars(\$10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances are present, the penalty thus established may be increased to a maximum of five (5) years, if extenuatingcircumstances are present, it may be reduced to a minimum of two (2) years.				