HOSPITAL INDEMNITY CLAIM FORM INSTRUCTIONS

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

Supporting Documentation Needed

- ✓ Itemized bill if there was a hospital stay (UB04 from the hospital or medical facility)
- ✓ Chart Note to include admission and discharge paperwork if there was a hospital stay
- ✓ Itemized bill from physician's office (HCFA 1500 from treating physician's office)
- ✓ Surgical Report if surgery took place
- ✓ Follow Up Visit-receipts for follow up visits or physical therapy with dates and charges if applicable
- ✓ Xray/Diagnostic Tests-receipts with dates and charges if applicable
- ✓ Accident Report-if applicable (ex: police report)
- ✓ 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

HOSPITAL INDEMNITY CLAIM FORM

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

Benefits are payable to you unless we receive written authorization from your provider to assign benefits to them or from you to pay your benefits elsewhere. This is called an assignment. If you wish to assign your benefits, please send a signed written request.

POLICYHOLDER/CLAIMANT INFORMATION			
Employer's Name: **UNIVERSITY OF CALIFORNIA GROUP #25796**			
Policyholder's Name:	Policy Certificate No.:	Social Security No.	Gender:
Policyholder's Address: (Full Street Address in addition to city, state, zip) **Check If This Is A Permanent Address Change** ☐			
Policyholder's E-Mail:	Telephone Number:		
Patient's name:	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).			

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:**

PATIENT'S SIGNATURE: **DATE:**

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PLEASE SIGN AND RETURN ATTACHED HIPAA FORM WITH COMPLETED CLAIM FORM.
IF FILING A CLAIM WITHIN THE FIRST POLICY YEAR FOR BENEFITS, MEDICAL RECORDS MAY BE REQUESTED.

IS MEDICAL 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:

LOCATION OF THE INJURY:	WAS THE PATIENT INJURED IN A MOTOR VEHICLE ACCIDENT?
☐ ON THE JOB ☐ OFF THE JOB	☐ YES ☐ NO (IF YES, PLEASE SUBMIT THE POLICE REPORT)

IS TREATMENT DUE TO A SICKNESS? ☐ YES ☐ NO

IF YES, PLEASE COMPLETE THE FOLLOWING QUESTIONS RELATED TO THE SICKNESS:

1. WHAT IS YOUR SICKNESS DIAGNOSIS:
2. SYMPTOMS FIRST OCCURRED ON WHAT DATE:
3. FIRST DATE OF TREATMENT FOR THIS CONDITION:
4. IF DIAGNOSED WITH CANCER, ON WHAT DATE WAS THE INITIAL DIAGNOSIS?
   (PLEASE SUBMIT PATHOLOGY REPORT WITH YOUR CLAIM SUBMISSION IF DIAGNOSED WITH CANCER)
5. WAS THE PATIENT TREATED BY ANY OTHER PHYSICIANS FOR THIS SICKNESS OR A RELATED CONDITION?
   ☐ YES ☐ NO
6. IF YES, PLEASE PROVIDE THE PHYSICIAN'S NAME(S), ADDRESS(ES) AND PHONE NUMBER(S) BELOW.

TREATMENT DATE	PHYSICIAN NAME	ADDRESS	CITY,STATE,ZIP	PHONE NUMBER

PREGNANCY CLAIMS

DATE OF DELIVERY:	☐ VAGINAL ☐ CESAREAN	IF NOT DELIVERED, EXPECTED DELIVERY DATE:

WHAT WAS THE DATE OF YOUR LAST MENSTRUAL PERIOD?

LIST ANY COMPLICATIONS DUE TO YOUR PREGNANCY:

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COMPLETE THE REMAINING SECTIONS FOR ALL CLAIMS:	
NAME, ADDRESS AND PHONE NUMBER OF THE PATIENT'S PRIMARY TREATING PHYSICIAN.	
WAS THE PATIENT CONFINED TO THE HOSPITAL AS A RESULT OF THIS CONDITION? ☐ NO ☐ YES IF CONFINED, SUBMIT COPY OF PATIENT'S ADMISSION AND DISCHARGE PAPERS OR A COPY OF A UB-04 BILLING INVOICE FROM THE HOSPITAL.	
HOSPITAL (FACILLITY) NAME, ADDRESS AND PHONE NUMBER	
ADMISSION DATE:	DISCHARGE DATE:

WAS THE PATIENT CONFINED TO THE INTENSIVE CARE UNIT AS A RESULT OF THIS CONDITION? ☐ NO ☐YES (IF YES, SUBMIT COPY OF A UB-04 BILLING INVOICE FROM THE HOSPITAL FACILITY TO IDENTIFY THE DAYS SPENT IN THE INTENSIVE CARE UNIT).
WAS THE PATIENT CONFINED TO A REHABILITATION UNIT AS A RESULT OF THIS CONDITION? ☐ NO ☐ YES (IF YES, SUBMIT COPY OF PATIENT'S ADMISSION AND DISCHARGE PAPERS OR A COPY OF A UB-04 BILLING INVOICE FROM THE HOSPITAL).
WAS THE PATIENT TREATED IN AN EMERGENCY ROOM AS A RESULT OF THIS CONDITION? ☐ NO ☐ YES (IF YES, SUBMIT EMERGENCY ROOM ADMISSION AND DISCHARGE PAPERS)
WAS SURGERY PERFORMED AS A RESULT OF THE MEDICAL CONDITION? ☐ NO ☐ YES (IF YES, SUBMIT A COPY OF THE OPERATIVE REPORT.)

**FOR OUTPATIENT PRESCRIPTION DRUG BENEFITS, please submit pharmacy receipts showing the name of the prescription, the physician name prescribing it and the date prescribed.

AUTHORIZATION TO OBTAIN INFORMATION

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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			

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***

Electronic Funds Transaction Authorization

Send to: **ContinentalAmericanInsurance Company** Post Office Box 84080
Columbus, GA 31993-4080

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

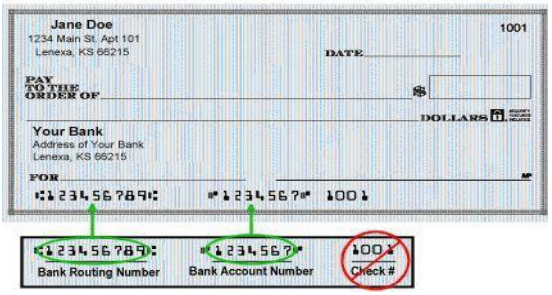
Authorization Agreement for Direct Deposit

I would like to: ☐ Start ☐ Stop ☐ Change direct deposit of my claimpayment(s).

Account Type:

☐ Checking ☐ Savings

****** Please provide a blank voided check or direct deposit form from your financial institution. Incomplete or inaccurate information will not be processed.**



9-Digit Routing Number:		Account Number:
Name of Financial Institution:		
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 #:

****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)*

Note: Forms received without signature will not be processed. Electronic signatures not accepted.

Policy/Certificate Holder Signature *(Required)*: Date Signed:

FRAUD WARNING NOTICES

For use with Claim Forms

PLEASE READ THE FRAUD WARNING NOTICE FOR YOUR STATE

ALASKA: A person who knowingly and with intent to injury, defraud or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.	**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.
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.	**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.
ARKANSAS: 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.	**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.
CALIFORNIA: For your protection California law requires the following to appear on this form: Any person who knowingly presents a 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.	**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.
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 insuranceand 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.	**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.
DELAWARE: 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.	**MINNESOTA:** A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilt of a crime.
DISTRICT OF COLUMBIA: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.	**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.
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.	**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 instate prison.
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 is guilty of a felony.	**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 deceptive 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 crime andmay be subject to fines and confinement in prison.
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.	