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

WELLNESS AND HEALTH SCREENING CLAIM FORM

Failure to complete all sections may result in delayed processing of this claim.
Review your policy for specific benefits covered under your plan.

AUTHORIZATION

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 have checked the answers given by myself and they are correct. I AUTHORIZE any physician, medical practitioner, hospital, clinic other medical or medically related facility, insurance company, consumer report agency, or employer having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment and any non-medical information for me, to give to Continental American Insurance Company or its legal representative, any and all such information. This information is to include, but is not limited to information pertaining to diagnosis, care or treatment for psychiatric disorder, drug or alcohol abuse, treatment or prescriptions, testing and/or treatment of HIV (AIDS virus) and/or other sexually transmitted diseases, including case history and medical antecedents. I UNDERSTAND the information obtained by use of the Authorization will be used by Continental American Insurance Company to determine eligibility for benefits under an existing certificate. Any information obtained will not be released by Continental America Insurance Company to any person or organization EXCEPT to re-insuring companies, or other person or organization performing business or legal services in connection with any claim, or as may otherwise lawfully required or as I may further authorize. I KNOW that I may request to receive a copy of this Authorization. I AGREE that this authorization shall be valid for the duration of my claim.

Policyholder's Signature:_____ **Date:**_____ **Claimant's Signature:**_____ **Date:**_____

POLICYHOLDER/PATIENT INFORMATION

EMPLOYER'S NAME			POLICYHOLDER'S EMAIL ADDRESS		
UNIVERSITY OF CALIFORNIA GROUP #25796					
POLICYHOLDER'S NAME	POLICY NO.	SSN/ EMPLOYEE ID		DATE OF BIRTH	GENDER
POLICYHOLDER'S ADDRESS ☐ **CHECK BOX IF THIS IS A PERMANENT ADDRESS CHANGE**	CITY	STATE	ZIP CODE	POLICYHOLDER'S PHONE NUMBER	
PATIENT'S NAME	RELATIONSHIP TO THE POLICYHOLDER	PATIENT'S DATE OF BIRTH		PATIENT'S 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).

HEALTH SCREENING INFORMATION

DATE HEALTH SCREENING TEST WAS PERFORMED:

WHICH HEALTH SCREENING TEST DID YOU HAVE PERFORMED:

TESTS COVERED UNDER CRITICAL ILLNESS PLAN ONLY

- ☐ Biometric Testing
- ☐ Blood Test for Triglycerides
- ☐ Bone Marrow Testing
- ☐ Breast Ultrasound
- ☐ CA 125 (Blood Test for Ovarian Cancer)
- ☐ Chest X-ray
- ☐ Stress Test (Bicycle or Treadmill)
- ☐ Thermography
- ☐ DNA Stool Analysis
- ☐ CA 15-3 (Blood Test for Breast Cancer)
- ☐ CEA (Blood Test for Colon Cancer)
- ☐ Fasting Blood Glucose Test
- ☐ Flexible Sigmoidoscopy
- ☐ Colonoscopy
- ☐ Hemocult Stool Analysis
- ☐ Mammography
- ☐ Cervical Cancer Screening
- ☐ PSA (Blood Test for Prostate Cancer)
- ☐ Serum Cholesterol Test (HDL and LDL)
- ☐ Serum Protein Electrophoresis (Myeloma)
- ☐ Spiral CT Screening for Lung Cancer

TESTS COVERED UNDER HOSPITAL INDEMNITY PLAN ONLY

- ☐ Mammography

PHYSICIAN INFORMATION

NAME		TELEPHONE NUMBER	
ADDRESS	CITY	STATE	ZIP CODE

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

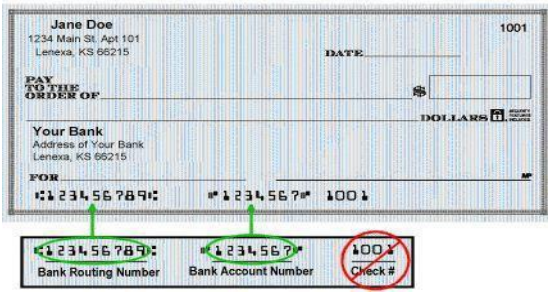
Authorization Agreement for Direct Deposit

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: