ACCIDENT WELLNESS BENEFIT CLAIM FORM

Some of the tests listed may not be covered under the Wellness Benefit of your policy. Please check your policy for a list of covered wellness procedures or call 1-800-99-AFLAC (1-800-992-3522) for a Wellness Form specifically tailored for your policy.

Please use black or blue ink only and print legibly when completing this form in its entirely. Keep a copy of the supporting documentation and this completed form for your records. Sign, date, and mail the completed form to the Aflac address shown below.

[redacted]

Policyholder **First** Name: | Middle Initial: | Policyholder **Last** Name:

Policyholder **Birth** Date: M M D D Y Y Y Y | ZIP of mailing address:

[redacted]

First Name: | Middle Initial: | Last Name: | Policy Number

Relationship: ☐ Primary Policyholder ☐ Spouse ☐ Dependent Child

Sex: ☐ Male ☐ Female

Patient Birth Date: M M D D Y Y Y Y

[redacted]

Treatment Date: M M D D Y Y Y Y

Treatment date must be provided.

- ☐ Annual physical
- ☐ Ultrasound
- ☐ PSA (blood test for prostate cancer)
- ☐ Pap smear
- ☐ Blood screening
- ☐ Immunizations
- ☐ Eye exam
- ☐ Mammogram
- ☐ Dental exam
- ☐ Flexible sigmoidoscopy

Pap Smear Date: M M D D Y Y Y Y

Mammogram Date: M M D D Y Y Y Y

[redacted]

Phone Number: - -

Name:

Street Address:

City: | State: | ZIP:

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.

I certify that the information provided is true and correct:

POLICYHOLDER SIGNATURE _____ **DATE** _____

American Family Life Assurance Company of Columbus (Aflac)
Attn: Claims Department • 1932 Wynnton Road • Columbus, GA 31999-7251
1-800-99-AFLAC (1-800-992-3522) • aflac.com • 1-800-SI-AFLAC (1-800-742-3522) en español

Z06197AD

Cancer Screening Wellness Benefit Claim Form

Some of the tests listed may not be covered under the Wellness Benefit of your policy. Please check your policy for a list of covered wellness procedures or call 1-800-99-AFLAC (1-800-992-3522) for a Wellness Form specifically tailored for your policy.

Policyholder First Name:

Policy Number

Policyholder Last Name:

Policyholder Birth Date: M M D D Y Y Y Y

ZIP of mailing address:

Patient First Name:

Middle Initial:

Patient Last Name:

Relationship to Policyholder:

☐ Primary Policyholder ☐ Spouse ☐ Dependent Child

Patient Sex: ☐ Male ☐ Female

Patient Birth Date: M M D D Y Y Y Y

Wellness Exam Treatment Date: M M D D Y Y Y Y

- ☐ Colonoscopy
- ☐ Virtual colonoscopy
- ☐ Flexible sigmoidoscopy
- ☐ Pap smear - ThinPrep
- ☐ Pap smear
- ☐ Breast MRI
- ☐ Testicular Ultrasound
- ☐ Hemocult stool specimen
- ☐ CEA (blood test for colon cancer)
- ☐ CA 125 (blood test for ovarian cancer)
- ☐ Mammogram
- ☐ Chest X-Ray
- ☐ CA153
- ☐ Thermography
- ☐ PSA (blood test for prostate cancer)
- ☐ Breast ultrasound/Breast sonogram
- ☐ Biopsy

Pap Smear Date: M M D D Y Y Y Y

Mammogram Date: M M D D Y Y Y Y

Provide actual cost for Mammogram: .

Doctor or Medical Facility Name and Address.

Must be completed in its entirety.

Phone Number: - -

Name

Street Address:

City

State:

ZIP:

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I certify that the information provided is true and correct:

Policyholder Signature **Printed Name** **Date**

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Worldwide Headquarters • 1932 Wynnton Road • Columbus, GA 31999-7251
1-800-99-AFLAC (1-800-992-3522) • aflac.com • 1-800-SI-AFLAC (1-800-742-3522) en español