

ACCIDENTAL INJURY CLAIM FORM

Failure to complete this form in its entirety may result in a delay in processing this claim.

- ☐ Complete Policyholder/Patient Information and sign your claim form.
- ☐ Have the treating physician complete Section B: Physician's Statement and sign the claim form.
- ☐ If hospitalized and/or confined to an intensive care unit/step-down unit, please send a copy of your hospital bill showing charges and the number of days you were confined. These items can be obtained directly from your health care provider(s) by requesting a UB04 (hospital bill) or HCFA1500 (nonhospital bill).
- ☐ If you are filing for disability, please complete the Initial Disability Claim Form (NY-S00224). **Forms are available on our web site at aflacny.com.**
- ☐ All bills should include the diagnosis, services rendered, and actual charges for the service.

Policyholder Information

(Please print.)

Policy Number

First Name

Initial

Last Name

Mailing Address

City

State

ZIP

Check box if this is a
new permanent address: ☐

Social Security Number

Phone Number

Patient Information

(Please print.)

First Name

Initial

Last Name

Relationship:

☐ Primary Policyholder

☐ Spouse

Sex:

☐ Male

☐ Female

Patient Birth Date: _____

☐ Dependent Child

☐ Check here if dependent child is a full-time student (if over the age 19, please provide school name and contact information).

Please answer the following questions. The claim cannot be processed until all necessary information is provided:

Date of accident: _____ Describe how the accident happened: _____

Location of the accident? ☐ On the job ☐ Off the job ☐ Other (please describe): _____

Was the patient the driver in a motor vehicle accident? ☐ Yes (Attach the police report) ☐ No

☐ If the patient sought treatment (☐ 50 / ☐ 100) or more miles from his/her residence and required lodging for patient's relative while the patient was confined in hospital then submit the hotel receipt(s). Please check your policy to verify the mileage your policy covers.

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.

CLAIMANT SIGNATURE

FAMILY RELATIONSHIP, IF NOT POLICYHOLDER

DATE

American Family Life Assurance Company of New York (Aflac New York)
Attention: Claims Department • 1932 Wynnton Road • Columbus, GA 31999-7255
For information or help filing your claim, please call toll-free 1-800-366-3436 or visit our Web site at aflacny.com.
Toll-free fax number: 1-877-844-0201

ACCIDENTAL INJURY CLAIM FORM – PHYSICIAN'S STATEMENT

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Policy Number:

Policyholder Name:

Patient Name: _____ Date of Birth: _____

SECTION B: PHYSICIAN'S STATEMENT Please answer each question COMPLETELY.

Physician's Name	Phone Number ()	Fax Number ()
Mailing Address	City	State ZIP

DATES OF SERVICE	DIAGNOSIS CODE ICD	DIAGNOSIS DESCRIPTION	PROCEDURE CODE	PROCEDURE DESCRIPTION

Date of incident: ____/____/____ Describe where and how the incident occurred: _____

Was the patient referred to you by another physician? ☐ Yes ☐ No

If yes, physician's name: _____

Referring physician's address: _____ Phone number: _____

Was patient hospitalized as a result of this diagnosis? ☐ Yes ☐ No

Admission: ____/____/____ Discharge: ____/____/____

Hospital Name: _____

City: _____ State: _____

PHYSICIAN'S SIGNATURE

DATE

TAX ID NUMBER

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Attention: Claims Department • 1932 Wynnton Road • Columbus, GA 31999-7255
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Claims Authorization to Obtain Information

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Instructions for completing this Health Insurance Portability and Accountability Act of 1996 (HIPAA) compliant form:

1. All areas of this form should be completed.
2. This form must be signed and dated by the claimant/patient below.
3. **IMPORTANT:** If you are filing a claim on behalf of a deceased, please check here
4. If you are the Authorized Representative, please sign below and indicate your relationship to the claimant/patient/deceased. In addition, include a copy of the legal document(s) authorizing you to act on their behalf.
5. Fax this form to 1-877-844-0201 or return the form to Aflac New York, Attn: Claims Department, Worldwide Headquarters, 1932 Wynnton Road, Columbus, GA 31999-7255, as soon as possible in order to expedite claim review.

Policyholder Name:

Policy Number(s):

Date of Birth:

Policyholder Address:

Claimant/Patient Name (if different from named policyholder listed above):

Date of Birth:

This authorization shall be valid for a period of two years from the sign date unless a lesser time frame is indicated. Alternate Expiration Date:

Name and Address of health care provider(s), company, or individual authorized to release the requested information:
(this section will be completed by Aflac New York):

Purpose of Disclosure: Evaluate claims for benefits during the time this authorization is valid.

I, or my authorized representative, request that information regarding my past, present, or future physical or mental health condition (excluding psychotherapy notes), employment, other insurance coverage, or any other nonmedical facts be released to **American Family Life Assurance Company of New York (Aflac New York)** or any person or entity acting on its part. This could include, but is not limited to, any medical professional, medical care institution, insurer (including Aflac New York, with respect to other Aflac New York coverages), reinsurer, government agency (including departments of public safety and motor vehicle departments), consumer reporting agency or employer.

I understand that:

1. Protected health information may include information and records protected under Federal and State Law such as: alcohol, drug abuse, mental health, AIDS or HIV testing or treatment, or the presence of a communicable or noncommunicable disease.
2. My treatment, payment or eligibility for benefits may not be conditioned on signing this authorization.
3. I understand that I may revoke this authorization at any time by writing to **Aflac New York, Claims Department, Worldwide Headquarters, 1932 Wynnton Road, Columbus, GA 31999-7255**, except to the extent that:
 - a. Aflac New York has taken action in reliance to this authorization, or
 - b. Other law provides Aflac New York with the right to contest a claim under the policy or the policy itself.
4. If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. It is recommended I retain a copy of this signed form for my records, understanding that a copy is as valid as the original.

Signature of claimant/patient, guardian or authorized representative

Date

Printed name of claimant/patient, guardian or authorized representative

Relationship