CONTINENTAL AMERICAN INSURANCE COMPANY
Post Office Box 84075 * Columbus, GA. 31993
Phone (800)-433-3036 * Fax (866-849-2970)

ACCIDENT CLAIM FORM

Failure to complete all sections may result in a delay in processing this claim.
To prevent delays, please provide documentation from your healthcare provider to support this claim.
Please review your policy for specific benefits covered under your plan.

✓ **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.**

AUTHORIZATION

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 made to the foregoing questions are both complete and true to the best of my knowledge and belief. I have read the fraud notice included in this form.

Policyholder's Signature: _____ Date: _____

Patient's Signature: _____ Date: _____

PART A POLICYHOLDER/PATIENT'S INFORMATION

1	EMPLOYER'S NAME			POLICYHOLDER'S EMAIL ADDRESS	
2	POLICYHOLDER'S NAME	POLICY NO.	SOCIAL SECURITY NO.	DATE OF BIRTH	GENDER
3	POLICYHOLDER'S ADDRESS	STREET	CITY	STATE	ZIP CODE
	☐ CHECK BOX IF THIS IS A PERMANENT ADDRESS CHANGE.				
4	PATIENT'S NAME (PERSON WHO IS SICK OR INJURED)	DATE OF BIRTH	GENDER	POLICYHOLDER'S TELEPHONE NO. (INCLUDE AREA CODE)	
5	RELATIONSHIP TO POLICYHOLDER				

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).

- Date of the Injury: _____
- Describe how the injury occurred: _____
  _____
- Location of the injury? ☐ On the job ☐ Off the job
  - Has a Worker's Compensation claim been filed? ☐ No ☐ Yes
    - If yes, status of the claim: ☐ Approved ☐ Pending ☐ Denied
- Was the patient injured in a motor vehicle accident? ☐ No ☐ Yes (If yes, please submit the Police Report)

ACCIDENT CLAIM FORM

- Was death a result of this injury? ☐ No ☐ Yes (If yes, please submit the certified death certificate and the Life-Beneficiary's Statement.)

- Was the patient confined to the hospital as a result of this injury? ☐ No ☐ Yes (If yes, please submit the itemized hospital bill, UB04, or HCFA 1500)
  Admission date: _____ Discharge Date: _____

  Hospital name: _____

  City: _____ State: _____

- Was the patient transported by an ambulance as a result of this injury? ☐ No ☐ Yes (If yes, please submit the ambulance bill)

- If any of the following were the result of your injury, please provide medical records or physician's office notes:
  - Coma
  - Paralysis
  - Degree of Burn
  - Injury to the Eye
  - Laceration (including length and method of repair)
  - Dislocation (X-ray reports or major diagnostic exam reports are needed)
  - Concussion (Major diagnostic exam reports are needed)
  - Fractures (X-ray reports or major diagnostic exam reports are needed)

- Was an aid in locomotion (mobility) prescribed as a result of this injury? (i.e. Crutches, Wheelchairs, Leg Braces, Walking Boots, Back Braces, Walkers, Cervical Collars) ☐ No ☐ Yes (If yes, please submit documentation from the prescribing provider.)

- Your policy covers the following surgeries:*
  - Open Reduction, Internal Fixation (Fractures or Dislocations)
  - Ruptured Disc Repair
  - Knee Cartilage Repair
  - Tendon or Ligament Repair
  - Open Abdominal/Thoracic Surgery
  - Eye Surgery
  - Were any of these surgical procedures performed as a result of this injury? ☐ No ☐ Yes (If yes, please submit a copy of the operative report.)

- Was a major diagnostic exam (i.e. CT Scan, MRI, MRA, EEG) performed as a result of this condition?
  ☐ No ☐ Yes (If yes, please submit a copy of the exam report or billing.)

- Provide all dates of treatment related to injury on the lines below (please submit supporting medical documentation for each visit indicated below):*
  - Initial date of treatment: _____
  - Follow ups: _____
  - Physical Therapy: _____

**See policy for time limit provisions.*

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 benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

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.

OHIO: 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 is guilty of insurance fraud.

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.

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.

PENNSYLVANIA: 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 extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

TENNESSEE: 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.

TEXAS: 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.

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.

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.

RHODE ISLAND and WEST VIRGINIA: 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.

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.

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CONTINENTAL AMERICAN INSURANCE COMPANY
Post Office Box 84075 * Columbus, GA. 31993
Phone (800) 433-3036 * Fax (866) 849-2970

AUTHORIZATION TO OBTAIN INFORMATION

MAIL TO: Continental American Insurance Company
P.O. Box 84075
Columbus, Georgia 31993

CALL: 1.800.433.3036 (toll-free)
CLAIM FAX: 1.866.849.2970

Primary Certificateholder's Name:	**SSN**(optional):	**Date of Birth:**
Certificate Number(s):		
Address:		
Name of Individual Subject to Disclosure (If not the primary Certificateholder):		**Date of Birth:**
Relationship to Primary Certificateholder: ☐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 Health Information:
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 may request 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 redisclosed 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 Signed

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

Electronic Funds Transaction Authorization

Send to: **Continental American Insurance Company**
Post Office Box 84075
Columbus, Georgia 31993

Phone: (800) 433-3036 Fax (866) 849-2970
Email: groupclaimfiling@aflac.com

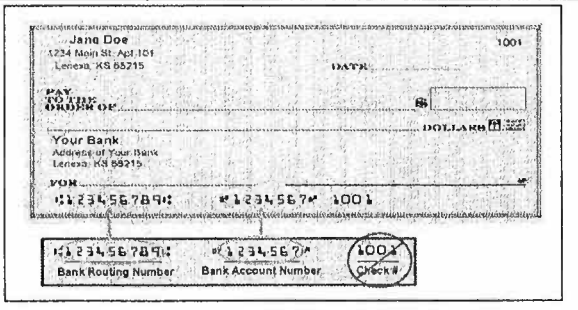
I would like to:

☐ Start ☐ Stop ☐ Change direct deposit of my claim payment(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:

Authorization Agreement for Direct Deposit

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's Name (*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)*

Policy/Certificate Holder Signature ***(Required)***
Note: Forms received without signature will not be processed. _____

Date Signed: _____