Post Office Box 84075 * Columbus, GA. 31993
Phone (800) 433-3036 * Fax (866) 849-2970
groupclaimfiling@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			
POLICYHOLDER'S FIRST NAME	POLICYHOLDER'S LAST 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 FIRST NAME	PATIENT'S LAST 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 ACCIDENT PLAN ONLY	**TESTS COVERED UNDER HOSPITAL INDEMNITY ONLY**	**TESTS COVERED UNDER CRITICAL ILLNESS PLAN ONLY**
☐ Annual Physical Exam	☐ Annual Physical Exam	☐ Breast Ultrasound
☐ Eye Examination	☐ HSN Strains (Herpes Simplex Virus)	☐ Chest Xray
☐ Immunization	☐ Immunization	☐ Colonoscopy
☐ Vision Screening	☐ Non-diagnostic Vascular Screening Urinalysis	☐ Hemocult Stool Analysis
		☐ Skin Cancer Screening
		☐ Stress Test (Bicycle or Treadmill)
		☐ Thermography

TESTS COVERED UNDER ALL PLANS

☐ Biometric Testing	☐ CA 15-3 (Blood Test for Breast Cancer)	☐ Mammography
☐ Blood Screening	☐ CEA (Blood Test for Colon Cancer)	☐ PAP Smear
☐ Blood Test for Triglycerides	☐ Fasting Blood Glucose Test	☐ PSA (Blood Test for Prostate Cancer)
☐ Bone Marrow Testing	☐ Flexible Sigmoidoscopy	☐ Serum Cholesterol Test (HDL and LDL)
☐ CA 125 (Blood Test for Ovarian Cancer)	☐ HIV (Human Immunodeficiency)	☐ Serum Protein Electrophoresis (Myeloma)
	☐ HPV (Human Paillomavirus)	☐ Ultrasound

PHYSICIAN INFORMATION

NAME		TELEPHONE NUMBER	
ADDRESS	CITY	STATE	ZIP CODE

HIPAA-AUTHORIZATION TO OBTAIN INFORMATION

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

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

Primary Certificate Holder First Name:	**Primary Certificate Holder Last Name:**		
Certificate Number(s):	**SSN** (optional):		**Date of Birth:**
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 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 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 Trans action Authorization

Mail To: Continental American Insurance Company
PO Box 84075, Columbus, GA 31993
Phone: 800.433.3036 Fax: 866.849.2970
Email: groupclaimfiling@aflac.com

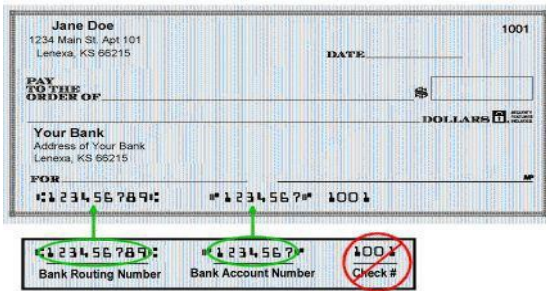
Important: <u>Do not</u> complete this form if your policy number has both letters and numbers (e.g. 0Y123B45). Policies containing both letters and numbers are administered by Aflac and not Aflac Group (CAIC). Direct deposit registration for Aflac is located at https://phs.aflac.com/aflac.phs.app/account/login. Aflac Group (CAIC) cannot process direct deposit requests for Aflac.

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:

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 First Name (*Print*):	Policy/Certificate Holder's Last 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)*

Note: Forms received without signature will <u>not</u> be processed. Electronic signatures not accepted.

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