



CANCER ANNUAL CARE BENEFIT CLAIM FORM

Please read all instructions.

Failure to follow these instructions could delay the processing of your claim.

Your Aflac New York Cancer policy pays one Cancer Annual Care Benefit per year, up to five years following the anniversary of the diagnosis of internal Cancer for any Covered Person surviving Cancer.

- Do not include receipts, statements or other claim documentation with this form.
- Do not write on form except as instructed.
- Please sign, date and mail or fax the completed form to the Aflac New York address/fax number shown below.
- Please use black or blue ink only and print legibly when completing this form in its entirety.
- Failure to complete all sections may result in a delay in processing this claim.

Please keep a copy of this completed form for your records. Please print a separate form for each additional family member or call 1-800-366-3436 to request additional forms. Claims for all other benefits covered under this policy must be filed separately using the claim forms available at aflac.com or by calling 1-800-366-3436.

CANCER ANNUAL CARE BENEFIT CLAIM FORM

Policy Number:

All Fields are required.

Policyholder Information:

Last Name Suffix First Name MI

Date of Birth (mm/dd/yy) / / Telephone Number where we can reach you - -

Home Address

City State Zip Code

Check box if this is permanent address change.

Patient Information:

Last Name First Name Date of Birth (mm/dd/yy) / /

Sex: Male Female

Relationship: Primary Policyholder Spouse Dependent Child

Physician Information:

Physician's Name

Physician's Street Address

Physician's City State: Zip:

Tax ID Number:

Physician's Phone Number: - -

I verify the above mentioned patient is currently under my care as of the date I have signed this form.

Date: / /

Physician Signature

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.

The Provider listed above is authorized to validate the information I have provided.

POLICYHOLDER/PATIENT SIGNATURE

FAMILY RELATIONSHIP, IF NOT POLICYHOLDER

DATE

NY-CW91264CAC NY

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American Family Life Assurance Company of New York
ATTN: Claims Department • 1932 Wynnton Road • Columbus, GA 31999-7255
For information or to check claim status, visit aflac.com or call 1-800-366-3436
Claims may be faxed to 1-877-844-0201