# CONTINUING DISABILITY CLAIM FORM

**Thank you for trusting Aflac New York with your Continuing Disability needs.**

➢ **If you are interested in uploading documentation on an existing claim, register using aflac.com/smartclaim.**

**To prevent delays, please provide documentation from your healthcare provider to support this claim. If you have additional bills or medical documentation that relates to this diagnosis other than the documentation defined, please submit them for review of additional benefits.**

➢ **Service related items can be obtained directly from the patient's healthcare provider(s) by requesting a UB04 hospital bill or HCFA 1500 non-hospital bill.**
➢ **Failure to complete all sections may result in a delay in processing this claim.**
➢ **Disclaimer: Some of the services listed may not be covered by your policy.**

***Policy Number:**

## Policyholder Information: This * denotes a required field.

*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 a permanent address change.*

## Patient Information:

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

*Sex: ☐ Male ☐ Female

*Relationship: ☐ Primary Policyholder ☐ Spouse

### Continuing Disability Checklist

- Is disability due to a sickness? ☐ No ☐ Yes
- Is disability due to an injury? ☐ No ☐ Yes
  - If yes, please complete the following questions related to the injury:
    - Date of the injury: _____/_____/_____
    - Describe how the injury occurred: _____
    - Was this disability caused by an incident that occurred while performing the duties of the patient's employment? ☐ No ☐ Yes

**For all claims, please complete all remaining sections.**

- Was the patient confined to the hospital as a result of this condition? ☐ No ☐ Yes (If yes, please submit the itemized hospital bill, UB04, or HCFA 1500)
- Hospital name: _____
- City: _____ State: _____

**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.**

**POLICYHOLDER/PATIENT SIGNATURE** | **FAMILY RELATIONSHIP, IF NOT POLICYHOLDER** | **DATE**

**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 1-877-44-AFLAC (1-877-442-3522)**

# CONTINUING DISABILITY CLAIM FORM - EMPLOYER'S STATEMENT

***Policy Number:**

**Policyholder Information:** This * denotes a required field.

*Last Name | Suffix | *First Name | MI

*Date of Birth (mm/dd/yy)

*Employee's Name (Last Name, Suffix, First Name, MI)

*Employer's Name/Account # | *Employer Phone Number

*Employer's Address

*City | *State | *Zip Code

- First date of disability: _____/_____/_____
- Has the employee returned to work? ☐ No ☐ Yes

  If no, expected return to work date: _____/_____/_____ If yes, date returned to work: _____/_____/_____
- If the employee has returned to work is he or she working: ☐ Full-Time ☐ Part-Time ☐ Light Duty

  If employee is working part-time or light duty, please provide the number of working hours per week: _____

  If working part-time/light duty, date he or she began part-time/light duty: _____/_____/_____

  If working part-time, date expected to return to work to full time: _____/_____/_____

  If part-time/light duty, is/was the employee earning at least 80% of his/her pre-disability salary? ☐ No ☐ Yes
- Is the person still employed? ☐ No ☐ Yes If no, last date of employment: _____/_____/_____

***Please note:***

The employer is required to report disability benefits paid on pre-tax plans on Form 941 and the employee's Form W-2.

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**EMPLOYER'S SIGNATURE** | **EMPLOYER'S PRINTED NAME** | **TITLE** | **DIRECT PHONE NUMBER** | **DATE**

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# CONTINUING DISABILITY CLAIM FORM - PHYSICIAN'S STATEMENT

***Policy Number:**

**Policyholder Information:** This * denotes a required field.

*Last Name | Suffix | *First Name | MI

*Date of Birth (mm/dd/yy)

## Patient Information:

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

## Physician Information:

*Phone Number | *Fax Number

*Physician's Name

*Address

*City | State | Zip Code

- First date of disability: _____/_____/_____
- Date patient was last treated: _____/_____/_____
- Primary diagnosis for disability and ICD code: _____
- Additional diagnoses: _____
- Pregnancy claims: Date of delivery: _____/_____/_____ ☐ Vaginal ☐ Cesarean
- If not delivered, expected delivery date: _____/_____/_____
- Please advise of any complications: _____
- Have you released the patient to return to work? ☐ No ☐ Yes (Date released: _____/_____/_____)
  - Patient released to work: ☐ Full-Time ☐ Part-Time ☐ Light Duty
  - If part time/light duty, please provide the date the patient is expected to return to full duty: _____/_____/_____
- If patient has not been released, please provide the next appointment date: _____/_____/_____ Please also provide the date of expected release: _____/_____/_____
- If the patient has been released, please provide the date released: _____/_____/_____
- Is patient permanently disabled? ☐ No ☐ Yes (Medical records will be required if permanent disability is indicated; please provide medical records to patient.)

**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.**

**PHYSICIAN SIGNATURE** | **TAX ID NUMBER** | **DATE**

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