



HOSPITAL INDEMNITY CLAIM FORM

Thank you for trusting Aflac New York with your Hospital Indemnity needs.

- If you are interested in filing your claim online or 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 Dependent Child

Hospital Indemnity Checklist

***If filing for a claim within the first two years of the policy, medical records may be requested for evidence of insurability.**

Is treatment 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
- Was this a motor vehicle accident in which the patient was the driver? No Yes (If yes, please submit a copy of the Police Report.)

Is treatment due to a sickness? No Yes *If yes, please complete the following questions related to the sickness:*

- Symptoms first occurred on: _____ / _____ / _____
- First date of treatment for this condition: _____ / _____ / _____
- If diagnosed with cancer, date of initial diagnosis: _____ / _____ / _____
- Was the patient treated by any other physicians for this sickness or a related condition? No Yes
If yes, physician's name(s): _____
Phone Number(s): _____
Address: _____

