



# PHYSICIAN'S VISIT BENEFIT CLAIM FORM

If you are interested in filing your claim online, register using [aflac.com/smartclaim](http://aflac.com/smartclaim).

- > Benefits of filing your claim online include faster claim processing time and receiving claim communications by email.

Your policy pays a Physician's Visit Benefit for services rendered under the supervision of a physician, after the effective date of your policy. Please refer to your policy to verify your eligibility for this benefit.

- Failure to complete all sections may result in a delay in processing this claim.
- Submit only one treatment date per claim form.
- Do not attach receipts, statements or other claim documentation to this form.
- Please sign, date and mail/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.

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

Date of Physician's Visit:  M M D D Y Y Y Y  
 \*Please submit only one date per form.

Physician's Phone Number:  -  -

Physician's Name

Physician's Street Address

Physician's City  State:  Zip:

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

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