HOSPITAL INDEMNITY PLAN WELLNESS BENEFIT CLAIM FORM

Please read all instructions.
Failure to follow these instructions will delay the processing of your claim.

Do not include receipts, statements or other documentation with this form.

Your Aflac policy provides one Wellness Benefit per policy year. Please note that these benefits are not payable for treatment within the first 12 months of the policy's effective date. To receive your Wellness Benefit, complete the form by following the instructions provided. Please keep a copy of this completed form for your records. Claims for all other benefits covered under your policy must be filed separately using the appropriate claim form.

If your Aflac policy also provides a Mammogram Benefit, please mark the appropriate box and indicate the date the mammogram was performed. Please check your policy for specific benefits covered under your policy.

If your Aflac policy also provides a Pap Smear Benefit, please mark the appropriate box and indicate the date the pap smear was performed. Please check your policy for specific benefits covered under your policy.

- **Do not write on form except as instructed.**
- **Incomplete forms cannot be processed and will be returned.**
- **Please do not fax this completed form to Aflac.**
- **Mark only wellness exam box(es) for test(s) that you had performed.**

American Family Life Assurance Company of Columbus (Aflac)
Attn: Claims Department • 1932 Wynnton Road • Columbus, GA 31999-7251
1-800-99-AFLAC (1-800-992-3522) • aflac.com • 1-800-SI-AFLAC (1-800-742-3522) en espanõl

HOSPITAL INDEMNITY PLAN WELLNESS BENEFIT CLAIM FORM

Some of the tests listed may not be covered under the Wellness Benefit of your policy. Please check your policy for a list of covered wellness procedures or call 1-800-99-AFLAC (1-800-992-3522) for a Wellness Form specifically tailored for your policy.

Please use black or blue ink only and print legibly when completing this form in its entirety. Keep a copy of the supporting documentation and this completed form for your records. Sign, date, and mail the completed form to the Aflac address shown below.

Policyholder Information

Policyholder First Name: | Middle Initial: | Policyholder Last Name:

Policyholder Birth Date: M M D D Y Y Y Y | ZIP of mailing address:

Patient Information

Policy Number

First Name: | Middle Initial: | Last Name:

Relationship: ☐ Primary Policyholder ☐ Spouse ☐ Dependent Child

Sex: ☐ Male ☐ Female

Patient Birth Date: M M D D Y Y Y Y

Wellness Exam

Treatment Date: M M D D Y Y Y Y

Treatment date must be provided.

- ☐ Annual physical
- ☐ Ultrasound
- ☐ PSA (blood test for prostate cancer)
- ☐ Pap smear
- ☐ Blood screening
- ☐ Immunizations
- ☐ Eye exam
- ☐ Dental exam
- ☐ Flexible sigmoidoscopy

Pap Smear Date: M M D D Y Y Y Y

Mammogram Date: M M D D Y Y Y Y

Physician Information

Phone Number: - -

Name:

Street Address:

City: | State: | ZIP:

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

I certify that the information provided is true and correct:

POLICYHOLDER SIGNATURE **DATE**

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