



ACCIDENTAL INJURY CLAIM FORM

Thank you for trusting Aflac with your Accidental Injury 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

Accidental Injury Checklist

- Date of the injury: ____/____/____
- Describe how the injury occurred: _____
- Was this injury caused by an incident that occurred while performing the duties of his/her 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.)
- Was death a result of this injury? No Yes (If yes, please submit the certified death certificate and the Life-Beneficiary's Statement.)
- Was the patient confined to the hospital as a result of this injury? No Yes (If yes, please submit the UB04 (Universal Billing 2004), itemized hospital bill, or HCFA 1500.)
- Hospital Name: _____
- City _____ State _____

