CANCER WELLNESS BENEFIT CLAIM FORM

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

Treatment Date: M M D D Y Y Y Y

Mammogram Date: M M D D Y Y Y Y

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

☐ Breast MRI	☐ Testicular Ultrasound	☐ CA153
☐ Chest X-ray	☐ Hemocult Stool Specimen	☐ Thermography
☐ Colonoscopy/Virtual Colonoscopy	☐ CEA (blood test for colon cancer)	☐ PSA (blood test for prostate cancer)
☐ Flexible Sigmoidoscopy	☐ CA 125 (blood test for ovarian cancer)	☐ Breast ultrasound/Breast sonogram
☐ Pap Smear/Pap Smear - ThinPrep	☐ Mammogram	☐ Biopsy
☐ HPV Screening	☐ Cervical Cancer Screening	☐ Cancer Prevention Vaccine

Actual Cost of Mammogram | Physician's Phone Number:

Physician's Name

Physician's Street Address

Physician's 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.

The Provider listed above is authorized to validate the information I have provided.

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

American Family Life Assurance Company of Columbus (Aflac)
ATTN: Claims Department • 1932 Wynnton Road • Columbus, GA 31999
For information or to check claim status, visit aflac.com or call 1-800-99-AFLAC (1-800-992-3522)
Claims may be faxed to 1-877-44-AFLAC (1-877-442-3522)