

VISION CLAIM FORM

FILING CLAIM FOR (check all that apply):

Disease/Disorder of the Eye
 Impairment due to Accident
 Hospitalization
 Deceased -- Date Deceased: ____/____/____

Vision Policy Number	Accident Policy Number	Short-Term Disability / Sickness Disability Rider Policy Number	Hospital Indemnity Policy Number	Hospital Intensive Care Policy Number

Failure to complete this form in its entirety may result in a delay in processing this claim.

INSTRUCTIONS:

- Complete **Section A: Policyholder/Patient Information**.
- Be sure to sign your claim form at the bottom of Page 1.
- Have your doctor complete Section B: Physician's Statement.
- If you are filing for the Eye Exam benefit or the Vision Correction benefit please use form S-00222 (Vision NowSM Eye Exam/Vision Correction Materials Claim Form). **Obtain a form by calling 1-800-99-Aflac (1-800-992-3522).**
- If you are filing for disability due to a sickness, please complete the Sickness Claim Form (S-2029) as well. If you are filing for disability due to an accident, please complete the Accident Claim Form (S-00198). **Forms are available on our website at www.aflac.com.**

ADDITIONAL NOTES:

- Submit all bills related to this claim such as hospital, surgery, etc. All bills should be itemized and should include the diagnosis, services rendered and actual charges for the service.
- If hospitalized and/or confined to an intensive care unit, please send a copy of your hospital bill that shows charges and the number of days you were confined. If confined to an intensive care unit, the bill must specify the number of days you spent in the intensive care unit.
- **Be sure to include your policy number(s) on all documents.**

SECTION A: POLICYHOLDER/PATIENT INFORMATION

POLICYHOLDER INFORMATION			
LAST NAME	FIRST NAME	MIDDLE INITIAL	
SOCIAL SECURITY NUMBER (optional)	BIRTH DATE	PHONE NUMBER ()	
ADDRESS			<input type="checkbox"/> CHECK BOX IF THIS IS A NEW PERMANENT ADDRESS
CITY	STATE	ZIP	
PLACE OF EMPLOYMENT		PHONE NUMBER ()	
ADDRESS			
CITY	STATE	ZIP	
PATIENT INFORMATION			
LAST NAME	FIRST NAME	MIDDLE INITIAL	
SOCIAL SECURITY NUMBER (optional)	BIRTH DATE		
<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> OTHER RELATIONSHIP: <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> DEPENDENT - CHECK IF DEPENDENT IS FULL-TIME STUDENT <input type="checkbox"/>			

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.

CLAIMANT SIGNATURE

FAMILY RELATIONSHIP, IF NOT POLICYHOLDER

DATE



Policy #:

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AUTHORIZATION TO OBTAIN INFORMATION

I authorize the following to give information (as defined below) to American Family Life Assurance Company of Columbus (Aflac) or any person or entity acting on its part: any medical professional, medical care institution, insurer (including Aflac, with respect to other Aflac coverages), reinsurer, government agency (including departments of public safety and motor vehicle departments), consumer reporting agency or employer. "Information" means facts or opinions relating to my past, present, or future physical or mental health or condition (excluding psychotherapy notes), employment, other insurance coverage, or any other non-medical facts that Aflac deems appropriate to evaluate claims for benefits during the time this authorization is valid. I understand that any disclosure of information to Aflac for the purpose of evaluating claims for benefits for coverage other than health plan coverage means the information may no longer be protected by federal privacy regulations. I further understand, however, that such information may be re-disclosed only in accordance with other applicable laws or regulations.

I understand that this information will be used by Aflac to evaluate claims for benefits.

I understand that I may revoke this authorization at any time, except to the extent that (1) Aflac has taken action in reliance on this authorization, or (2) other law provides Aflac with the right to contest a claim under the policy or the policy itself. My revocation must be submitted in writing to Aflac, Claims Department, Worldwide Headquarters, 1932 Wynnton Road, Columbus, GA 31999.

Unless otherwise revoked, I agree that this authorization will expire two years from the date indicated below.

I agree that a copy of this authorization is as valid as the original.

Signature

Date

Printed Name

Individual/Guardian/Personal Representative

Printed Name

If this authorization has been signed by a personal representative on behalf of an individual, his/her authority to act on behalf of the individual must be set forth here:

Policy #:

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Printed Name

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RETAIN THIS COPY FOR YOUR RECORDS