Aflac
Underwritten by Trustmark Insurance Company

Initial Waiver of Premium Claim

For Claims Customer Service: **Phone:** (800) 225-3859

For Claims Submission: **Fax:** (508)853-0310 **Email:** groupclaimfiling@aflac.com
Mail: **Attn:** Group Claims PO Box 84075, Columbus, GA 31993

Section A-Insured Information			
Name	DOB	SSN	Policy/Certificate #
Address, City, State, Zip			
Phone	☐ Home ☐ Cell ☐ Work		Email Address
Employer Name & Address, City, State, Zip			
Date Employed	Occupation		
Principle Duties			
Doctors Consulted			
Name	Address	City, State, Zip	
Name	Address	City, State, Zip	
Name	Address	City, State, Zip	
Name of Hospital	Date Admitted	Date Discharged	
Describe nature of illness or injury			
If illness, what date did you first notice the illness?			
If Accident, on what date?	Were you at work? ☐ Yes ☐ No		
How did the accident happen?			
Date and time you stopped working ☐ AM ☐ PM			
Dates you were continuously confined to your home From To			
Date and time you resumed working ☐ AM ☐ PM			
If unable to resume work at present, about what date should you be well enough to resume work?			
Are you making claim with any other company? ☐ Yes ☐ No			
If yes, please provide	Company Name	Amount of Policy	
	Company Name	Amount of Policy	

****** Complete and Sign Disclosure Authorization Portion of Claim Form******

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Mail:	**Attn:** Life Claims	PO Box 60676, Worcester, MA 01606

Section B- Employer Statement	
This statement must be completed by the supervisor or timekeeper of the employer. If the insured is self-employed, the insured will complete the following statement giving all the details.	
Name of Employee	Policy/Certificate #
Occupation of the insured at the time of disability	
Employed how many days per week?	Average monthly earning?
Date and time employee last worked ☐ AM ☐ PM	
Date and time employee returned to work ☐AM ☐ PM	
Occupation of which the insured returned?	
Company Name	
Address, City, State, Zip	
Printed Name	Official Title
Phone #	Fax#
Signature	Date

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Section C- Attending Physician's Statement

(To be completed by the Attending Physician)

Name of Patient		Patient ID #
History	When did symptoms 1st appear or accident happen?	Date patient ceased work because of disability?
	Has patient ever had same or similar condition? ☐ Yes ☐ No	
	If yes, when and describe	
	Is condition due to injury or sickness arising out of patient's employment ☐Yes ☐No ☐ Unknown	
	Name and addresses of other treating physicians	
	Name	Address, City, State, Zip
Diagnosis (Including any complications)	Diagnosis	
	Subjective Symptoms	
	Objective findings (including current Xrasys, EKGs, Lab Data and any clinical findings)	
Dates of treatment	Date of 1st visit	Date of last visit
		Frequency: ☐ Weekly ☐ Monthly ☐ Other
Nature of Treatment (including surgery and medications prescribed, if any)	Treatment	
	Will treatment substantially improve function and employability? ☐Yes ☐ No	
Progress	Has patient ☐Recovered ☐ Improved ☐ Unchanged ☐ Retrogressed	
	Is patient ☐ Ambulatory ☐ House Confined ☐ Bed Confined	
Physical Impairment (Please, check one.)	☐Class 1-No limitation of functional capacity; capable of heavy physical activity. No restrictions (0-10%)	
	☐Class 2-Slight limitation of functional capacity; capable of light manual activity (15-30%)	
	☐Class 3-Moderate limitation of functional capacity; capable of clerical/administrative (sedentary) activity (35-55%)	
	☐Class 4-Marked limitation (60-70%)	
	☐Class 5-Severe limitation of functional capacity	
	Remarks	
Mental /Nervous Impairment (if applicable)	☐Class 1-Patient is able to function under stress and engage in interpersonal relations (no limitations)	
	☐Class 2-Patient is able to function in most stress situations and engage in most interpersonal relations (slight limitations)	
	☐Class 3-Patient is able to engage in only limited stress situations and engage in only limited interpersonal relations (moderate limitations)	
	☐Class 4-Patient is unable to engage in stress situations or engage in interpersonal relations (marked limitations)	
	☐Class 5-Patient has significant loss of psychological, personal and social adjustment (sever limitations)	
	Remarks	
Do you believe the patient is competent to endorse checks and direct the use of the proceeds thereof? ☐ Yes ☐ No		

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Prognosis				
	Patient's Job		**Any Other Work**	
Is the patient now totally disabled?	☐ Yes ☐ No		☐ Yes ☐ No	
Do you expect a fundamental or marked change in the future?	☐ Yes ☐ No		☐ Yes ☐ No	
If yes, when will patient recover sufficiently to perform duties?		☐ 1 Mo ☐ 1-3 Mos ☐ 3-6 Mos ☐ Never		☐ 1 Mo ☐ 1-3 Mos ☐ 3-6 Mos ☐ Never
If no, please explain				
Date released to work				
Rehabilitation				
	Patient's Job		**Any Other Work**	
Is the patient a suitable candidate for trial employment?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
If yes, when could trial employment commence?		☐ Full-Time ☐ Part-Time		☐ Full-Time ☐ Part-Time
If yes, what training will patient require?				
If no, please explain.				
Remarks				
Physician's name (please print)			Specialty	
Phone		Fax		
Address, City, State, Zip				
Signature		Date		

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FRAUD WARNING NOTICES

For use with Claim Forms

PLEASE READ THE FRAUD WARNING NOTICE FOR YOUR STATE

ALASKA: A person who knowingly and with intent to injury, defraud or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.	**IDAHO:** Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.
ARIZONA: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.	**INDIANA:** A person who knowingly and with intent to defraud an insurer files a statement of claim containing Any false, incomplete, or misleading information commits a felony.
ARKANSAS: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.	**KENTUCKY:** Any person who knowingly and with intent to defraud any insurance company or other person files a 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.
CALIFORNIA: For your protection California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.	**LOUISIANA:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
COLORADO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.	**MAINE:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.
	MARYLAND: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
DELAWARE: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.	**MINNESOTA:** A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilt of a crime.
DISTRICT OF COLUMBIA: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.	**NEW HAMPSHIRE:** Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.
FLORIDA: 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.	**NEW JERSEY:** Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

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Initial Waiver of Premium Claim

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FRAUD WARNING NOTICES (CONT.)

For use with Claim Forms

PLEASE READ THE FRAUD WARNING NOTICE FOR YOUR STATE

NEW MEXICO: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.	**TENNESSEE:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.
NEW YORK: 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.	**TEXAS:** Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.
OHIO: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.	**VIRGINIA**: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.
OKLAHOMA: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.	**WASHINGTON:** It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.
OREGON: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.	**RHODE ISLAND and WEST VIRGINIA:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
PENNSYLVANIA: 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 subjects such person to criminal and civil penalties.	**ALL OTHER STATES:** 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 subjects such person to criminal and civil penalties.
PUERTO RICO: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand dollars($5,000) and not more than ten thousand dollars($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances are present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.	

Initial Waiver of Premium Claim

DISCLOSURE AUTHORIZATION

Insured's name (Please print)

I **AUTHORIZE** any doctor, hospital, clinic, other medical facility or provider of health care, insurer or reinsurer, consumer reporting agency, insurance support organization, insurance agent, employer, financial institution, the Social Security Administration, the Internal Revenue Service, the Veterans Administration or any other organization or person having any knowledge of me or my health to give to Aflac Group Insurance and affiliates or its employee and agents, or any other consumer reporting agency any information as to cause, treatment, diagnoses, prognoses, consultations, examinations, tests or prescriptions with respect to my physical or mental condition or information concerning me, my occupation, employment, history, earning or finances or information otherwise needed to determine policy claim benefits due me. this may include, but is not limited to, HIV Infection, any disorder of the immune system including Acquired Immune Deficiency Syndrome (AIDS), driving records, mental illness, or use of alcohol or drugs.

If further **AUTHORIZE** the Social Security Administration to release information or records about me to Aflac Group Insurance or authorized representatives. This information is to be released in order to properly adjudicate my claim or continue my eligibility for benefits. Please release detailed earnings for up to the last ten years and/or summary record of tital earnings and/or information from master benefit records regarding award, denial or continuing benefits.

This authorization may be revoked by me. Any such revocation must be in writing, but be signed and dated by me and must be forwarded directly to the Aflac Group Insurance. I AGREE THE information obtained with this Authorization may be used by Aflac Group Insurance and affiliates to determine policy claim benefits with respect to the Insured. A photocopy of this authorization is as valid as the original and I may request a copy. This authorization will be in force for the term of coverage of the policy up to 12 months from the date shown below. I understand that if I revoke or fail to sign this authorization or alter its content it may affect the handling of my claim including denial of benefits under my policy.

I understand that there is a possibility of re-disclosure of any information disclosed pursuant to this authorization and that information, once disclosed, may no longer be protected by federal rules governing privacy and confidentiality.

I **AUTHORIZE** Aflac Group Insurance and affiliates to report to ICS, any dates of past or present claims filed by me.

Residents of Montana-You are entitled to request a record of any subsequent disclosure of information.

Residents of New Mexico-Revocation of the authorization must be made within 10 days after its receipt by Aflac Group Insurance; this applies only to confidential abuse information.

Residents of Florida-Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim or application containing any false, incomplete or misleading information is guilt of a felony of the third degree.

Residents of New York-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 or each such violation.

Signature Date

Relationship, if other than insured Date of Birth

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Initial Waiver of Premium Claim

Insured Statement of Claim-Communication

CONSENT FOR USE OF ELECTRONIC COMMUNICATIONS (EMAIL, SMS/MMS TEXT MESSAGING)

To ensure the best and fastest communication, we would like to communicate with you using either email or text messaging. Please complete this section if we can communicate with you electronically, concerning your claim, benefits, policy, premium or condition.

May we communicate with your electronically?

☐ No
☐ Yes, by Text Messages-Please provide cell phone#
☐ Yes, by Email. Please provide email address.

If you chose to communicate with us electronically, you should be aware that electronic communication is not secure unless it is encrypted. We strongly encourage you to use encrypted communication when sending sensitive and/or confidential information. By sending sensitive or confidential electronic messages that are not encrypted, you accept the risks of such lack of security and possible lack of confidentiality. If you elect to communicate from your workplace computer, you should also be aware that your employer and its agents have access to electronic communication between you and us.

I understand that by selecting text messaging, regular text messaging rates may apply for any texts I receive from Aflac and I assume responsibility for any costs associated with these text messages. This consent shall remain in effect unless revoked in writing.

To ensure a smooth email experience, please be sure that your computer has the most up to date version of Adobe Reader. You should add our email address to your address book contact list an add us to your email server or spam filter approved listing. If you don't see email from us in your inbox, be sure to check your spam, clutter, junk or fulk email folder. You can choose to stop electronic communication at any time by revoking this authorization. If you no longer wish to communicate via electronic means, we will correspond with your via US mail. If you require copies of any communication sent to you by email/text in paper form, please contact us. There is no cost to you to obtain copies of electronic communication in paper format.

Authorization

I may revoke or update this authorization in writing at any time or by email to **groupclaimfiling@aflac.com.** Aflac Group Insurance may rely on the information I provide for the adjudication of my claim as a result of this authorization until receipt of my revocation notice. This authorization is valid for two (2) years. I may request a copy of this authorization and a copy is as valid as the original.

Policy Owner Signature _____ Date _____

Printed Name _____ Social Security Number _____

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Insured Statement of Claim-Communication *(continued)*

THIRD PARTY COMMUNICATION AUTHORIZATION

Please complete this authorization if you would like us to discuss, to release, or to provide information to a family member, friend, or other third party such as your agent or employer.

My Spouse or Partner (Name)

☐ All information (All policy and claim information)

☐ All information except Medical Information (diagnosis, medical condition, reason for claim, treatment, physicians)

My Family Member (Name and Relationship)

☐ All information (All policy and claim information)

☐ All information except Medical Information (diagnosis, medical condition, reason for claim, treatment, physicians)

☐ Other Third Party **My Agent** ☐ Yes ☐ No **My Employer** ☐ Yes ☐ No

Or Name a Specific Third Party (Name and Relationship)

☐ All information (All policy and claim information)

☐ All information except Medical Information (diagnosis, medical condition, reason for claim, treatment, physicians)

I agree that if I authorize release of all claim information this may include health information which may be related to disorders of the immune system including but not limited to HIV and AIDS, use of alcohol or drugs, mental and physical condition, history, or treatment.

I understand that any information shared may be subject to re-disclosure and might not be protected by certain federal regulations governing the privacy of health information relative to my condition.

Authorization

I may revoke or update this authorization in writing at any time or by email to groupclaimfiling@aflac.com. Aflac Group Insurance may rely on the information I provide for the adjudication of my claim as a result of this authorization until receipt of my revocation notice. This authorization is valid for two (2) years. I may request a copy of this authorization and a copy is as valid as the original.

Policy Owner (Or Policy Owner's Personal Representative's Signature) Date