Post Office Box 84075 * Columbus, GA. 31993
Phone (800) 433-3036 * Fax (866) 849-2970
groupclaimfiling@aflac.com

BENEFICIARY'S STATEMENT

Failure to complete all sections may result in a delay in processing of the claim.

Any person who knowingly and with the intent to defraud any insurance company, files a statement of claim containing any materially false, incomplete or misleading information, is guilty of a crime.

AUTHORIZATION: I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medically related facility, insurance company or consumer reporting agency, or employer having any records or information pertaining to the medical history, mental or physical condition, evaluation diagnosis, treatment, prognosis, specifically to include psychiatric, drug or alcohol abuse treatment concerning the deceased and any other non-medical information concerning the deceased to give to Continental American Insurance Company (Continental American) or its legal representatives, any or all such information. I further acknowledge that the information obtained by use of this Authorization will be used by Continental American to determine my eligibility for benefits. I understand that I may request a copy of this authorization. I further agree that a photocopy of this Authorization shall be as valid as the original and that such Authorization shall be valid for two years from the date shown below.

Dated at _____ this _____ day of _____ in the year _____

Beneficiary's Signature	Beneficiary's Address Street, City, State, Zip	Relationship	Date of Birth	Daytime Phone
	Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.
	Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.
	Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.
	Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.

POLICYHOLDER/PATIENT INFORMATION

EMPLOYER'S NAME		POLICYHOLDER'S ADDRESS		
Click here to enter text.		Click here to enter text.		
POLICYHOLDER'S NAME	POLICY NO.	SOCIAL SECURITY NO.	DATE OF BIRTH	GENDER
Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.
POLICYHOLDER'S ADDRESS CITY STATE ZIP Click here to enter text. ☐CHECK BOX IF THIS IS A PERMANENT ADDRESS CHANGE			POLICYHOLDER'S TELEPHONE NO. Click here to enter text.	
PATIENT'S NAME	RELATIONSHIP TO POLICYHOLDER	PATIENT'S DATE OF BIRTH	PATIENT'S GENDER	
Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.	

DECEDENT'S INFORMATION

Deceased's Name in Full	Date of Birth	Place of Birth
Click here to enter text.	Click here to enter text.	Click here to enter text.
Resident's Address	Social Security Number	Last Occupation
Click here to enter text.	Click here to enter text.	Click here to enter text.

Certificate numbers of this company and amounts under which claim is being filed	Certificate numbers, amounts and company name of other insurance being claimed.
Click here to enter text.	Click here to enter text.

I am hereby returning the certificate(s) ☐Yes ☐No If no, explain reason Click here to enter text.

*By providing your e-mail address above, you consent to the use of electronic transactions in connection with your CAIC policies, contracts, and/or accounts to the extent available and permitted by law (which may include, but not limited to: invoices, claim correspondence, contracts, surveys, and other materials that CAIC is, or may be, legally required to deliver to you)

BENEFICIARY'S STATEMENT

A Beneficiary's Statement must be completed by the person(s) to whom the insurance is payable. In connection with such statement, the follow should be observed.

1. If there is more than one beneficiary, all may join in one statement or a separate form will be furnished for each if desired.
2. If the policy is payable to the estate or to the executors or administrators of the insured, the statement should be completed by the executor or administrator, a certified copy of whose appointment and qualifications must be furnished.
3. If the policy is payable to a minor or a mentally incompetent person, a guardian should complete the statement, a certified copy of whose appointment and qualifications must be provided.
4. If the policy has been assigned, enclose a notarized copy of the assignment.

To prevent delays, please complete the remaining sections and submit the following information:

- A certified copy of the decedent's birth certificate or a notarized letter verifying the decedent's date of birth.
- HIPAA Authorization (attached) - This form should be completed by the deceased's next of kin.
- Certified Death Certificate

Under the following circumstances, please send the additional items listed:

- If a minor is the beneficiary- A copy of the court order or other documents appointing the legal custodian or conservator of such minor child's property and/or estate. *(Please note: Legal custody does not qualify as custodianship or conservatorship over a child's property for these purposes.)*
- If the beneficiary has died prior to the death of insured- A copy of the certified death certificate of the beneficiary.

- Date of death: Click here to enter text.
- Place of death: Click here to enter text.
- Cause of death: Click here to enter text.
- If death was due to an injury, please send a copy of the police report, toxicology/BAC report and/or newspaper articles concerning the circumstances and answer the following questions.
    - Date of the injury: Click here to enter text.
    - Details of the injury: Click here to enter text.

- If death was due to a sickness, please answer the following questions.
    - When did the deceased first experience symptoms? Click here to enter text.
    - When did the deceased first consult a physician for this illness? Click here to enter text.

- Please provide the name and addresses of all physicians who attended deceased within three years prior to death:

Name	Address	Dates of Treatment	Disease or Condition
Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.
Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.
Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.
Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.
Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.

- Was deceased disabled at the time of death? ☐No ☐Yes
-
    - If yes, as of what date did they become disabled? Click here to enter text.

- Has the deceased at any time been confined to a hospital? ☐No ☐ Yes

    - If yes, please provide the hospital name and location along with the dates of confinement and condition treated:

Name	Address	Dates of Treatment	Disease or Condition
Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.
Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.
Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.
Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.
Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.

HIPAA-AUTHORIZATION TO OBTAIN INFORMATION

Send to:
Continental American Insurance Company
Post Office Box 84075
Columbus, GA 31993

Phone: (800) 433-3036
Fax: (866) 849-2970
Email: groupclaimfiling@aflac.com

Primary Certificate Holder Name: Click here to enter text.	**SSN**(optional): Click here to enter text.	**Date of Birth:** Click here to enter text.	
Certificate Number(s): Click here to enter text.			
Address: Click here to enter text.	**City:** Click here to enter text.	**State:** Click here to enter text.	**Zip:** Click here to enter text.
Name of Individual Subject to Disclosure (If not the primary Certificate Holder): Click here to enter text.		**Date of Birth:** Click here to enter text.	
Relationship to Primary Certificate Holder: ☐Self ☐ Spouse ☐ Domestic Partner ☐Child ☐Stepchild ☐Grandchild			

I. Authorization:
For the purpose of evaluating my *eligibility for insurance and for benefits* under an existing certificate, including checking for and resolving any issues that may arise regarding incomplete or incorrect information on my application for coverage and/or claim form, I hereby authorize the disclosure of the following information(defined below) about me and, if applicable, my dependents, from the sources listed below to Continental American Insurance Company (CAIC), or any person or entity acting on its part, to include American Family Life Assurance Company of Columbus and American Family Life Assurance Company of New York (collectively, "Aflac).

II. Disclosure of Health Information:
Health information may be disclosed by any health care provider, health plan (including CAIC or Aflac, with respect to other CAIC or Aflac coverages) or health care clearinghouse that has any records or knowledge about me. Health care provider includes, but is not limited to, any licensed physician, medical or nurse practitioner, nurse, pharmacist, osteopath, psychologist, physical or occupational therapist, chiropractor, dentist, audiologist or speech pathologist, podiatrist, hospital, medical clinic or laboratory, pharmacy, rehabilitation facility, nursing home or extended care facility, prescription drug database or pharmacy benefit manager, or ambulance or other medical transport service. Health information may also be disclosed by any insurance company or the Medical Information Bureau (MIB). Health information includes my entire medical record, but does not include psychotherapy notes. Some information obtained may not be protected by certain federal regulations governing the privacy of health information, but the information is protected by state privacy laws and other applicable laws. CAIC will not disclose the information unless permitted or required by those laws.

III. Rights and Expiration:
I understand that I may revoke this authorization at any time, except to the extent that CAIC or Aflac has taken action in reliance on this authorization. If I revoke this authorization, CAIC may not be able to evaluate my application for coverage and/or claim. To revoke this authorization, I must provide a written and signed revocation to CAIC at the address or fax number above. Unless otherwise revoked, this authorization shall remain in effect for two (2) years from the date signed or upon my death, whichever occurs first. I agree that a copy of this authorization is as valid as the original and that I or an authorized representative may request a copy of this authorization.

IV. Notice:
I understand that CAIC is not conditioning payment, enrollment, or eligibility for benefits on whether I sign this authorization. I understand that if the information disclosed is protected health information relating to a health plan and the person or entity receiving the information is a not a health care provider or health plan covered by federal privacy regulations, the information disclosed may be re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.

- **If records are on an adult dependent, (e.g. spouse, child over 18), the dependent must sign this form**
- **If records are on a minor child the natural parent or legal guardian must sign on their behalf.**

Signature of Individual Subject to Disclosure Date Signed

Legal Representative's Printed Name Legal Representative's Signature Legal Relationship Date

******If signed by a legal representative (e.g. Legal Guardian, Estate Administrator, Power of Attorney***

Electronic Funds Transaction Authorization

Send to: **Continental American Insurance Company**
Post Office Box 84075
Columbus, Georgia 31993

Phone: (800) 433-3036 Fax (866) 849-2970
Email: groupclaimfiling@aflac.com

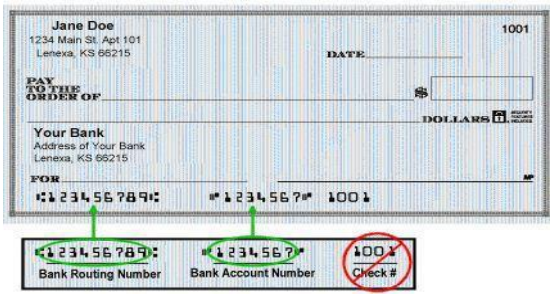
Authorization Agreement for Direct Deposit

I would like to: ☐ Start ☐ Stop ☐ Change direct deposit of my claim payment(s).

Account Type:

☐ Checking ☐ Savings

****** Please provide a blank voided check or direct deposit form from your financial institution. Incomplete or inaccurate information will not be processed.**



9-Digit Routing Number: Click here to enter text.		Account Number: Click here to enter text.
Name of Financial Institution: Click here to enter text.		
Address: Click here to enter text.		City: Click here to enter text.
State: Click here to enter text.	Zip: Click here to enter text.	Phone: Click here to enter text.

I authorize Continental American Insurance Company (CAIC) to initiate credit entries, and, if errors occur, I authorize the correction of entries to my account as indicated. This authorization remains effective and in full force until CAIC receives written notification from me of its termination in such time and in such manner to afford CAIC a reasonable opportunity to act on it. Please notify CAIC immediately if your financial institution information has changed by sending notification to the address indicated above. Should you have any questions, please contact us at 1-800-433-3036.

Policy/Certificate Holder's Name (*Print*): Click here to enter text.	
Address: Click here to enter text.	City/State/Zip: Click here to enter text.
Phone #: Click here to enter text.	E-mail Address: Click here to enter text.
Employer Name or Group #: Click here to enter text.	Certificate #: Click here to enter text.

****By providing your e-mail address above, you consent to the use of electronic transactions in connection with your CAIC policies, contracts, and/or accounts to the extent available and permitted by law (which may include, but not limited to: invoices, claim correspondence, contracts, surveys, and other materials that CAIC is, or may be, legally required to deliver to you)*

Note: Forms received without signature will not be processed. Electronic signatures not accepted.

Policy/Certificate Holder Signature *(Required)* **Date Signed:**

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 toinjure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, ormisleading information is subject to prosecution andpunishment for insurance fraud, as provided in RSA638:20.
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.

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.	