Long Term Care / Home Health Care Claim

For Claims Customer Service: ☎ **Phone:** (800) 433-3036
For Claims Submission: 🖷 **Fax:** (866) 849-2970 ✉ **Email:** groupclaimfiling@aflac.com
Mail: Attn: Life Claims PO Box 84075, Columbus, GA 31993

Instructions: In order to provide prompt service to your request for Long Term Care, Home Health Care, and/or Adult Care Benefits, complete form as follows:

- ***Section A – Statement of the Insured*** in its entirety
- Sign and Date the ***Disclosure Authorization***
- ***Attending Physician's Statement*** to be completed by your physician

Section A – Statement of the Insured

Certificate #: _____ Group #: _____

Name: _____ DOB: ____/____/____ SSN: _____

Address: _____
Street City State Zip Code

Phone #_____ ☐ Home ☐ Cell ☐ Work E-Mail Address: _____

What activities of Daily Living are you currently unable to perform without assistance? (*Please check all that apply*)

☐ Bathing ☐ Continence ☐ Dressing ☐ Walking ☐ Eating ☐ Transferring

If any checked above, please explain: _____

If patient / insured is incompetent, please provide name, address, and ***notarized*** papers for Guardian, Conservator, Power of Attorney, or Trustee who is responsible for financial affairs.

Name: _____

Address: _____

Qualified Care Provider Name: Dates:
Facility Address: City: State: Zip:
Phone: Fax
Cause:

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

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Section B – Attending Physician's Statement *(To be completed by the Attending Physician)*

Your prompt completion of all items on this form will help us help your patient

Name of Patient: _____ Age: _____

Date of illness (1st Symptom): ____/____/____ Date 1st consulted you for this condition: ____/____/____

If patient has had same or similar illness or injury, list dates & diagnosis: _____

Name & Address of Referring Physician or Other Sources (Public Health Agency):

_____
Name Street City State Zip Code

Has patient any chronic or constitutional disease, physical defect, or deformity? ☐ Yes ☐ No

If yes, describe:_____ _____

Patient's Diagnosis & ICD-Code: _____

The patient needs assistance with the following (please check all that apply):

☐ Bathing ☐ Continence ☐ Dressing ☐ Walking ☐ Eating ☐ Transferring

Cognitive Impairment: ❑ Yes ❑ No

Does patient suffer from any mental, psychoneurotic or personality disorder without demonstrable organic disease? ☐ Yes ☐ No

If yes, describe:_____

Physician Who Is Certifying Care: _____
Name Address Date of Service

Doctors Consulted Other Than Certifying Physician, For Present Condition:

_____
Name Address Phone Dates

Qualified Care Provider Name:

Type of Service Receiving				
Receiving This Service?	**Type of Agency/ Facility**	**Name & Address of Agency / Facility**	**Phone #**	**License #**
❑ Yes	Home/Health Care			
❑ Yes	Adult Care Center			
❑ Yes	Nursing Care Facility			
❑ Yes	Assisted Living			

Signature_____ Date ____/____/____

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State Required Fraud Warnings

Fraud Statement for Alaska and New Hampshire Residents: A person who knowingly and with intent to injure, defraud or deceive an insurance company, files a claim containing false, incomplete or misleading information may be prosecuted under state law.

Fraud Statement for AZ Residents: 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.

Fraud Statement for CA Residents: For your protection, California law requires the following to appear: 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.

Fraud Statement for CO Residents: 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.

Fraud Statement for FL Residents: 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.

Fraud Statement for Kansas, and Oregon Residents: Any person who knowingly, and with the intent to injure, defraud, or deceive an insurance company, files a statement of claim containing any false, incomplete, or misleading information may be guilty of insurance fraud, which may be a crime.

Fraud Statement for KY Residents: A 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.

Fraud Statement for Arkansas, Louisiana, New Mexico, Texas, and West Virginia Residents: 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.

Fraud Statement for Maryland Residents: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or 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.

Fraud Statement for MN Residents: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

FRAUD STATEMENT FOR PENNSYLVANIA RESIDENTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES ANY 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.

Fraud Statement for 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 Statement for Ohio Residents: 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.

FRAUD STATEMENT FOR DISTRICT OF COLUMBIA, MAINE, TENNESSEE, VIRGINIA AND WASHINGTON RESIDENTS: 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.

Fraud Warning for Delaware, Idaho, Indiana, and Oklahoma, As Well as for the Residents of All States Not Specifically Listed WARNING: Any person who knowingly, and with the intent to injure, defraud, or deceive an insurance company, files a statement of claim containing any false, incomplete, or misleading information may be guilty of insurance fraud, which is a felony.

HIPAA-AUTHORIZATION TO OBTAIN INFORMATION

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

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

Primary Certificate Holder Name:	**SSN**(optional):	**Date of Birth:**	
Certificate Number(s):			
Address:	**City:**	**State:**	**Zip:**
Name of Individual Subject to Disclosure (If not the primary Certificate Holder):		**Date of Birth:**	
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******