ACCIDENTAL INJURY CLAIM FORM - PHYSICIAN'S STATEMENT

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

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.

Policy Number: _		Policyhol	lder Name:				
Patient Name:			Date of Birth:				
SECTION B: P	HYSICIAN'S ST	ATEMENT Please ansv	ver each qu	uestion COMPLETE	ELY.		
Physician's Name			Phone Number (Fax Number ()		
Mailing Address			City		State	ZIP	
DATES OF DIAGNOSIS DIAGNOSIS SERVICE CODE ICD		DIAGNOSIS DESCRIPTIO	OSIS DESCRIPTION PROCEDURE CODE		PROCEDURE DESCRIPTION		
Date of incident:		Describe where and	how the inc	sident occurred:			
Was the patient re	eferred to you by a	nother physician?	Yes □ No				
Referring physician's address:							
		of this diagnosis? \Box Ye					
		Discharge:/_					
Hospital Name: _							
City:					State:		
PHYSICIAN'S SIGNATURE			DATE		TAX ID NU	TAX ID NUMBER	

American Family Life Assurance Company of Columbus (Aflac)
Attention: Claims Department • Worldwide Headquarters • 1932 Wynnton Road • Columbus, GA 31999
For information or help filing your claim, please call toll-free 1-800-99-AFLAC (1-800-992-3522) or visit our Web site at aflac.com
Toll-free fax number 1-877-44-AFLAC (1-877-442-3522)