American Fidelity Assurance Company
A member of the American Fidelity Group

American Fidelity Assurance Company
Mail to: AWD Benefits Department
P.O. Box 268898 | Oklahoma City, OK 73126-8898
Toll Free Phone # 1-800-437-1011
Local Fax # (405)-523-5762
Toll Free Fax # 1-888-243-3453

Cancer Claim Filing Instructions

Use this form for Cancer benefits, Intensive Care benefits, Dread Disease benefits and Heart Attack/Stroke benefits.

CANCER CLAIM FILING INSTRUCTIONS

If you live in the states of GA, OK, SC, or TX please refer to the Special Instructions below for additional steps needed in filing your claim. Also, regardless of your state of residence, if your policy is one of our C3, C4, C5, or C489 cancer policies (please see bottom left corner of policy), please refer to the Special Instructions below for additional steps needed in filing your claim.

1) Complete the **STATEMENT OF INSURED** found on page 3 of this form.
2) Attach **ITEMIZED BILLS** from each of your providers, with a complete breakdown of charges for each date of service.
3) Have your physician complete the **ATTENDING PHYSICIAN'S STATEMENT** found on page 4 of this form.
4) If your claim is for a cancer diagnosis, we must have a copy of the **PATHOLOGY REPORT** from the **FIRST PROCEDURE** in which cancer was diagnosed before any benefits can be provided. Your oncologist or your primary treating physician should be able to furnish you with a copy of this report.

SPECIAL INSTRUCTIONS

1) If your cancer policy is one of our C3, C4, C5, or C489 policies, you must also attach the corresponding Explanations of Benefits (EOB) from your primary medical coverage that corresponds to each itemized bill requested above.
2) If you live in the states of GA, OK, SC, or TX, and your cancer policy is one of our C3, C4, C5, C6, C7, C8, C9, or C489 policies, you must also attach the corresponding Explanations of Benefits (EOB) from your primary medical coverage that corresponds to each itemized bill requested above.
3) If you live in the states of GA, OK, SC, or TX, and you are filing for ICU benefits on any of our cancer policies, you must also attach the corresponding Explanations of Benefits (EOB) from your primary medical coverage that corresponds to each itemized hospital bill requested above.

Incomplete claims may delay processing. Please call us at 1-800-437-1011 if you are unsure which type of policy you have with our company or what documents you should submit with your claim. We will be happy to assist you.

FRAUD WARNING

Warning: Any person who knowingly and with intent to injure, defraud, or deceive an insurer files a statement of claim containing any false, incomplete, or misleading information may be guilty of insurance fraud and subject to criminal and civil penalties.

Alaska - 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.
AR, DC, LA, MD, NJ, NM, RI, TX, and WV - 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.
AZ and CA - For your protection, state 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.
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.
DE, ID, IN, and OK - WARNING: 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.
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.
ME, TN and VA - 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.
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.
Minnesota - A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.
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.
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.
Oregon - Any person who knowingly and with intent to defraud or solicit another to defraud an insurer: (1) by submitting an application, or (2) by filing a claim containing a false statement as to any material fact, may be violating state law.
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.

SIGNATURE OF THE INSURED

Signature of the Insured	Printed Name of the Insured	Date

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2000 N. Classen Boulevard Oklahoma City, Oklahoma 73106

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION PROTECTED FEDERAL LAW (HIPAA)

I hereby authorize the entities specified below to disclose any information about my health or the health of my minor dependents that are included under the coverage, including my or my dependents' entire medical record, except psychotherapy notes, to individuals representing American Fidelity Assurance Company (AFAC) who are involved in determining whether I am eligible for benefits under my insurance coverage. Those so authorized are: a) licensed physicians or medical practitioners; b) hospitals, clinics or medically-related facilities; c) health plans; d) Veteran's Administration; e) past or present employers; f) consumer reporting agencies; g) insurance companies; h) the Medical Information Bureau (MIB); and i) Department of Motor Vehicles.

NOTICE: Information authorized for release may include information on communicable or venereal diseases such as hepatitis, syphilis, gonorrhea, HIV/AIDS (Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome) or other conditions for which you may have been treated.

I understand that I may refuse to sign this authorization; however, if I do not sign the authorization, my failure to sign the authorization may result in a denial or a delay of benefits. I understand that I may revoke this authorization at any time by writing to AWD Benefits Department, American Fidelity Assurance Company, PO Box 268898, 2000 N. Classen Boulevard, Oklahoma City, Oklahoma 73126, or by calling, toll-free, 1-800-437-1011. I understand that my right to revoke this authorization is limited to the extent that: AFAC has taken action in reliance on the authorization; or, the law provides AFAC with the right to contest my insurance coverage or a claim under my insurance coverage.

I understand that if protected health information is disclosed, the information may be redisclosed only in accordance with any other state or federal regulations.

For health insurance coverage this authorization will expire twenty-four months from the date it is signed or upon termination of my insurance policy, whichever occurs first. For insurance coverage other than health insurance, this authorization will expire twenty-four months from the date it is signed or upon expiration of my claim for benefits, whichever occurs first. For Arizona residents, release of HIV/AIDS-related information can only be disclosed for a period not to exceed 180 days from the date shown below

A copy of this authorization will be as valid as the original. I am aware that I, or my personal representative, am entitled to and will receive a copy of this authorization.

AFA Account#	Printed Name	Date of Birth
Signature (Patient) or Personal Representative (if applicable)	Date	
Relationship of Personal Representative to Representative to Patient	*If authorization is supplied by a personal representative, a description of the authority to act on behalf of the Insured must be included.*	

Please retain a copy for your personal records, or you may request a copy from our Company.

REQUEST FOR INDIVIDUAL CANCER, INTENSIVE CARE OR DREAD DISEASE BENEFITS

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See page 1 for fraud statements & filing instructions.

STATEMENT OF INSURED

A. ABOUT YOU

Insured's Last Name	First Name	Middle Initial	Date of Birth	Account Number

Address (City, State, Zip) — Insured's Social Security Number

Employer - Name — Home Telephone #

B. ABOUT THE PATIENT

Patient's Name	Patient's Date of Birth	Patient's Social Security Number

Relationship To Insured ☐ Self ☐ Husband ☐ Wife ☐ Son ☐ Daughter ☐ Other _____ (Specify Relationship)

For dependent child between 21-25 years of age

School — Hours Enrolled

If a full-time student, please enclose a copy of the transcripts.

C. ABOUT CLAIM

Is this claim for ☐ Cancer Benefits ☐ Intensive Care Benefits ☐ Dread Disease Benefits ☐ Heart Attack/Stroke Benefits

Illness Condition

Has this condition caused previous trouble? — If so, when?

Date first treated

Have you been confined to a hospital? ☐ Yes ☐ No — If "yes," when From To

D. DIRECT DEPOSIT AUTHORIZATION

Please complete if you desire benefits deposited directly into your bank account.

I authorize AFAC to initiate credit entries to my account at the depository named below. This authorization is to remain in force and effect until AFAC receives written notification from me of its termination in such time and in such manner as to afford AFAC and the Depository opportunity to act on it. **This authorization applies to benefits payable under all insurance policies held with AFAC.**

Signature _____

NOTE: You must attach a voided check to begin direct deposit.

If your claim is for a cancer diagnosis, we must have a copy of the PATHOLOGY REPORT from the FIRST PROCEDURE in which cancer was diagnosed before any benefits can be provided. Your oncologist or your primary treating physician should be able to furnish you with a copy of this report.

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ATTENDING PHYSICIAN'S STATEMENT

1. Patient's Name _____ Age _____ Date of Birth _____

   Social Security Number _____

2. Diagnosis _____ (ICDA Code) _____

3. When did symptoms first appear? _____ Date _____

4. When did patient first consult you for this condition? _____ Date _____

5. Has patient ever had same or similar condition? ☐ Yes ☐ No (If "Yes," state when and describe)

   _____

6. Was patient referred to you by another physician? ☐ Yes ☐ No (If "Yes," list name and address of referring physician)

   Name _____ Address _____

7. If patient hospitalized, give name and address of hospital _____

   Admit Date _____ Discharge Date _____

   Date _____ Signed _____
   Degree

   _____
   (Street Address) (City or Town) (State) (Zip Code)

   Tax ID Number _____

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