American Fidelity Assurance Company

American Fidelity Assurance Company | Mail to: AWD Benefits Department
P.O. Box 268898 | Oklahoma City, Oklahoma | 73126-8898
Toll Free Phone # 1-800-437-1011
Toll Free Fax # 1-888-243-3453
www.americanfidelity.com

# Group Disability Claim Filing Instructions

Account Number

## DISABILITY CLAIM FORM

To be completed ***AFTER*** you become disabled. (Not for use when filing for Physician's Expense Benefits)

(Please Print)

**1**

**Save Time and Paper – File Your Claim Online!**
Before you get started, don't forget to have your employer and attending physician complete the Employer's Report of Claim and Attending Physician's Statement. These forms can be found in this packet or when filing this claim online.

**How to File Online:**
1. Login to your secured Online Service Center (OSC) account at www.americanfidelity.com/MyAccount.
2. On the homepage, click "File A Claim" to get started.
3. Follow the step-by-step instructions to complete your online claim filing process.
4. Conveniently upload your completed Attending Physician's Statement and Employer's Report of Claim during your claim filing process.

Check the status of your claim by selecting the "My Claims" tab at the top of the screen!

**To file your claim by fax or by mail, follow the steps below:**

1. Complete Employee's Disability Benefits Application in full.
2. Have the treating physician complete the Attending Physician's Statement.
3. Have your employer complete the Employer's Report of Claim form.
4. Submit the completed forms to the address above or submit via our toll-free fax @ 888-243-3453:
   a. Employee's Disability Benefits Application
   b. Employer's Report of Claim
   c. Attending Physician's Statement
   d. Payment Information Form
5. Please provide the names of all persons authorized to discuss the claim on your behalf.

_____ _____

_____ _____

_____ _____

Signature **I authorize AFAC to discuss the details of my claim with the parties named above** Date

**All portions of this form package must be completed to avoid delay in processing claimant's request for benefits. If you have any questions regarding completion of this form please call our toll free number: 1-800-437-1011.**

**2**

**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. **California** - for your protection, California law requires the following to appear on this form. Any person who knowingly presents 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. **AR, DC, LA, MD, NJ, NM, 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. **DE, ID, IN, MN, OH, 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. **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. **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. **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. **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 guilty of insurance fraud. **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. **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. **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. **Hawaii** - for your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

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# Group Disability Claim Payment Options

Account Number

## PAYMENT INFORMATION

Please select one payment option below by checking the appropriate box.

3 ☐ **DIRECT DEPOSIT** - A checking account is the most efficient way to receive your benefit payments.

***Note: A signature and additional information is required when choosing direct deposit option. Be sure to complete the appropriate section below.***

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:** _____ **Date:** _____

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

VOIDED CHECK

4 ☐ **DEBIT CARD** - A debit Card account will be applied for through First Fidelity Bank of Oklahoma City, OK.

**AUTHORIZATION AGREEMENT FOR DEBIT CARD ACCOUNT:** I hereby request and authorize American Fidelity Assurance Company to submit my application for a Debit Card Account with First Fidelity Bank N.A. of Oklahoma City, Oklahoma under my name. Upon approval and opening of this requested account I understand the account will be used for deposits of my benefit payments from American Fidelity Assurance Company. I further understand that charges will be applied to my account balance from the use of this card; some of those charges include the following.

- ATM Withdrawal (Domestic) = 5 free per month, $3.00 per withdrawal thereafter
- ATM Withdrawal (International) = $3.00 per withdrawal
- Balance Inquiry = $1.00 per inquiry
- No charge for IVR phone or website inquiry
- POS (Point-of Sale) Denial Fee = $1.00 per denial
- Paper Statement = $1.00 per month
- No Charge for Internet Statements
- Inactive Account Fee = $5.00 after 90 days of account inactivity
- Card Replacement = $10.00
- Pin replacement = $5.00
- Expedited Card Delivery = $25.00
- Check Issuance Fee (to close account) = $10.00
- Negative Balance Fee = $15.00

### Debit Card Authorized Signature:

**Print Name:** _____ **Date:** _____

**Signed:** _____

**IMPORTANT:** Funds from direct deposits and debit card deposits will **NOT** become available to use any earlier than 3-4 business days following the date the benefits are approved and the credit entry is initiated to your debit card account. If you have already completed a Direct Deposit or Debit Card Authorization Agreement and your card is still active, do not complete another. If you are not sure if your debit card is still active please contact First Fidelity Bank N.A. at **1(800)299-7047**.

5 ☐ **CHECK** - Check written by American Fidelity Assurance and forwarded to your mailing address of Records.

**Signature:** _____ **Date:** _____

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# Employee's Disability Benefits Application

## EMPLOYEE INFORMATION

To be completed by Employee. See front page for fraud warnings.

(Please Print)

**6**

| | |
|---|---|
| Full Name: (last, first, middle initial) | Account Number: |
| Residence: (street, city, state and zip code) | |
| Mailing Address: (P.O. Box or street, city and zip code) | Date of Birth: / / |
| Telephone Number: (including area code) | Social Security Number: / / |

Names and birth dates of spouse or dependents:

| | | | |
|---|---|---|---|
| Name | Birth Date / / | Name | Birth Date / / |
| Name | Birth Date / / | Name | Birth Date / / |

## DISABILITY INFORMATION

**7**

1. Is the disability due to: ❒ illness OR ❒ accident Date of onset / / If accident, provide cause/details:

2. Have you ever had the same or similar condition in the past? ❒ Yes ❒ No If so, when? / /

3. Full names, addresses, and phone numbers of all treating physicians along with dates of medical treatment: (attach additional list if necessary):

4. Is your disability related to your employment/occupation? ❒ Yes ❒ No
   If yes, have you or do you intend to file for Worker's Compensation? ❒ Yes ❒ No

5. On what date did you return to work? / / If not returned to work, when do you anticipate returning to work? / /

6. If your request for benefits is approved, do you want us to withhold Federal Taxes from each benefit check? ❒ Yes ❒ No
   If yes, amount: $ (indicate amount per month $88.00 minimum)

7. Identify other income sources and amount of income for which you are receiving or may be entitled to receive during this disability. Please check yes or no for each of the following:

| | Yes | No | Amount/Month | | Yes | No | Amount/Month |
|---|---|---|---|---|---|---|---|
| Your Social Security: (disability or retirement) | ❒ | ❒ | $ | V.A. Benefits: | ❒ | ❒ | $ |
| Dependent Social Security: | ❒ | ❒ | $ | Worker's Compensation: | ❒ | ❒ | $ |
| Retirement: (normal early or disability) | ❒ | ❒ | $ | Other Disability Coverage: (identify) | ❒ | ❒ | $ |
| State Disability Income | ❒ | ❒ | $ | Union: | ❒ | ❒ | $ |
| Unemployment | ❒ | ❒ | $ | **Include a copy of your award or denial letter for any source in which one has been received.** | | | |

I certify this information is true and correct.

**Signature:** **Date:** / /

**8**

### AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize the entities specified below to disclose any information about my entire medical record, benefits payable, or benefit eligibility for this disability and history of treatment for physical and/or emotional illness to include psychological testing, 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) pharmacies; g) insurance companies; h) the Social Security Administration; i) retirement systems; j) Department of Motor Vehicles; and k) Workers' Compensation Carrier.

**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. This authorization excludes disclosure of the result of a test for HIV if you have tested HIV positive but have not developed symptoms of the disease AIDS. Such test results shall not be discovered or published. Nothing in this caveat will prohibit this authorization from including the fact that you have AIDS.

**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, PO Box 268898, Oklahoma City, OK 73126-8898 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. A copy of this authorization will be as valid as the original.

I understand that if protected health information is disclosed to a person or organization that is not required to comply with federal privacy regulations, the information may be redisclosed and no longer protected by the federal privacy regulations.

Unless otherwise required by law, this authorization will expire upon completion of the investigation of the claim for which this authorization was signed or upon termination of the insurance policy, whichever occurs first. In no event shall this authorization be valid for more than twenty-four months.

Signature (Patient) or Personal Representative (if applicable) Date / /

Printed Name Relationship of Personal 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.

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# Attending Physician's Statement

## DISABILITY CLAIM FORM

To be completed by Physician. (Please Print)

**9** Name of Patient: | Date of Birth: / / | Social Security Number: / / | Account Number:

## DIAGNOSIS

**10** Disabling Diagnoses: | ICD Code:

Is disability the result of pregnancy? ❑ Yes ❑ No If yes, type of delivery:
Date pregnancy was diagnosed: / / Date of delivery (if delivered): / / Expected date of delivery: / /

## HISTORY

**11** When did symptoms first appear or accident happen? / / Date patient first consulted you for this condition? / /

Has the patient ever had the same or similar condition? ❑ Yes ❑ No If yes, indicate when and describe:

Was the patient referred to you? ❑ Yes ❑ No If yes, provide full name, address, and phone number of referring physician:

Is the disability work related? ❑ Yes ❑ No

## TREATMENT

**12** Frequency of treatment: ❑ Monthly ❑ Weekly ❑ Other, describe | Date of next appointment : / /

Please describe treatment:

List all dates of treatment or medical attention since the disability began:

Is patient still under your regular care for this condition? ❑ Yes ❑ No

If no, please explain and provide name and phone number of the current treating physician:

Has the patient been confined to a hospital? ❑ Yes ❑ No If yes, give admit and discharge dates along with name and address of hospital.

Admitted: / / Discharged: / / | Admitted: / / Discharged: / /

Name: | Address:

## PROGNOSIS

**13** Date total disability began: / / What is the expected return to work date? / /

If the patient is currently disabled, what is the anticipated length of disability?

❑ 1-2 Months ❑ 2-3 Months ❑ 3-6 Months
❑ 6-12 Months ❑ More than 12 Months ❑ Permanent

Is the patient released to return to work with restrictions? ❑ Yes ❑ No If yes, From: / / Through: / /

Please list return to work restrictions: _____

_____

## IMPAIRMENTS

**14** What are the disabling impairments that prevents the patient from working?

❑ Class 1 - No limitation of functional capacity, capable of heavy work. No Restrictions *(0-10%)
❑ Class 2 - Medium manual activity *(15-30%)
❑ Class 3 - Slight limitation of functional capacity; capable of light work activity *(35-55%)
❑ Class 4 - Moderate limitation of functional capacity; capable of clerical/administrative sedentary activity. *(60-70%)
❑ Class 5 - Severe limitation of functional capacity: Incapable of minimum sedentary activity *(75-100%)

Please list functional limitations/restrictions that render your patient temporarily totally disabled:

## PHYSICIAN INFORMATION

**15** Attending Physician's Name & Title: (print) | Specialty: | Telephone #: ( ) | Fax #: ( )

P.O. Box or Street Address: | City: | State: | Zip Code:

Signature: | Date: / /

**If you require completion of your own authorization for the release of medical records please submit the form along with the physician statement.**

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# Employer's Report of Claim

## EMPLOYMENT

To be completed by the employer after the employee's last date of work. (Please Print)

**16**

Name of Employer:

Mailing Address: (P.O. Box or Street, City, State and Zip Code)

Name of Employee: Social Security Number: / /

Date of Hire: / / Occupation (please attach job description):

Status of employment at time of disability: ❑ Full-Time ❑ Part-Time ❑ Leave of Absence ❑ Terminated ❑ Retired

Number of hours worked per week at time of disability: Date of Status Change: / /

## DISABILITY

**17**

Date employee last worked: / /

Has employee returned to work? ❒ Yes ❒ No If yes, date returned to work: / / Full Time ❒ Part Time ❒

## PREMIUMS

**18**

Does the employee have FICA taxes withheld from their paycheck? ❒ Yes ❒ No If no, hired after 4/1/86? ❒ Yes ❒ No

Does employer pay a portion of the disability premium? ❒ Yes ❒ No If yes, what percent? %

Are disability premiums deducted from employee's pay on a pre-tax (section 125) basis? ❒ Yes ❒ No

Have AFA Disability premiums been withheld through the last date worked? ❑ Yes ❑ No

If not, what is the last date disability premiums were deducted? / /

## SALARY AT TIME OF DISABILITY

**19**

Hourly: $ Monthly: $

Gross salary for previous calendar year: $ Year-to-date, gross salary: $

Commissions/Bonus? ❒ Yes ❒ No If yes, how often?

Is overtime required? ❒ Yes ❒ No If yes, how often?

## OTHER INCOME

**20**

Did Employee's disability result from employment? ❑ Yes ❑ No

Has employee made a claim for Workers' Compensation? ❑ Yes ❑ No

If yes provide the name, address, and phone number of Workers' Compensation carrier:

Is employee entitled for Workers' Compensation for this disability? ❑ Yes ❑ No

Is the employee receiving or eligible to receive any of the following?

| | Yes | No | Amount | Wk | Mo | Company Name and Phone Number | Begin | End |
|---|---|---|---|---|---|---|---|---|
| Other Group Disability | ❑ | ❑ | $ | ❑ | ❑ | | | |
| Salary Continuation | ❑ | ❑ | $ | ❑ | ❑ | | | |
| Sick Leave | ❑ | ❑ | $ | ❑ | ❑ | | | |
| PTO/PPT | ❑ | ❑ | $ | ❑ | ❑ | | | |
| Other (Bonus, etc) | ❑ | ❑ | $ | ❑ | ❑ | | | |
| Retirement/Pension | ❑ | ❑ | $ | ❑ | ❑ | | | |
| Union Benefits | ❑ | ❑ | $ | ❑ | ❑ | | | |
| State Disability | ❑ | ❑ | $ | ❑ | ❑ | | | |

I hereby certify that the above named employee is a member of our Group Disability Program. The information stated above is correct to the best of my knowledge and belief.

**Authorized signature of employer firm or authorized official**: _____

Printed Name: _____ **Date:** / /

Email Address: _____ Phone: (____)_____

Fax: (____)_____ How do you prefer to be contacted? ❑ Email ❑ Phone ❑ Fax



**Benefits may be delayed if the claim form is not fully completed.**