

# ACCIDENTAL INJURY CLAIM FORM

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

- Complete Policyholder/Patient Information and sign your claim form.
- Have the treating physician complete Section B: Physician's Statement and sign the claim form or
- If hospitalized and/or confined to an intensive care unit/step-down unit, please send a copy of your hospital bill showing charges and the number of days you were confined. These items can be obtained directly from your healthcare provider(s) by requesting a UB04 (hospital bill) or HCFA1500 (non-hospital bill).
- If you are filing for disability, please complete the Initial Disability Claim Form (S00224) as well. **Forms are available on our web site at [aflac.com](http://aflac.com).**
- All bills should include the diagnosis, services rendered, and actual charges for the service.

**Policyholder Information**  
(Please print.)

Policy Number

First Name Initial Last Name

Mailing Address

City State ZIP

Check box if this is a new permanent address:

**Patient Information**  
(Please print.)

Social Security Number

Phone Number

First Name Initial Last Name

Relationship:

Primary Policyholder  Spouse Sex:  Male  Female Patient Birth Date: \_\_\_\_\_

Dependent Child  Check here if dependant child is a full-time student (if over the age 19, please provide school name and contact information).

**Please answer the following questions. The claim cannot be processed until all necessary information is provided:**

Date of accident: \_\_\_\_\_ Describe how the accident happened: \_\_\_\_\_

Location of the accident?  On the job  Off the job  Other (please describe): \_\_\_\_\_

Was the patient the driver in a motor vehicle accident?  Yes (Attach the police report)  No

If the patient sought treatment ( 50 /  100) or more miles from his/her residence and required lodging for patient's relative while the patient was confined in hospital then submit the hotel receipt(s). Please check your policy to verify the mileage your policy covers.

**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.**

CLAIMANT SIGNATURE

FAMILY RELATIONSHIP, IF NOT POLICYHOLDER

DATE

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](http://aflac.com)  
Toll-free fax number 1-877-44-AFLAC (1-877-442-3522)