CANCER WELLNESS BENEFIT CLAIM FORM

If you are interested in filing your claim online, register using aflac.com/smartclaim.

- **Benefits of filing your claim online include faster claim processing time and receiving claim communications by email.**

Please read all instructions.

Failure to follow these instructions could delay the processing of your claim.

Your Aflac policy provides a Wellness Benefit. To receive your Wellness Benefit, complete the form by following the instructions provided. Please check your policy for specific details on this benefit.

- Do not include receipts, statements or other claim documentation with this form.
- Do not write on form except as instructed.
- Please sign, date and mail or fax the completed form to the Aflac address/fax number shown below.
- Please use black or blue ink only and print legibly when completing this form in its entirety.
- Mark only wellness exam box(es) for test(s) that you had performed.
- Failure to complete all sections may result in a delay in processing this claim.
- Some types of tests and/or treatment listed may not be covered by your policy.

Please keep a copy of this completed form for your records. Please print a separate form for each additional family member or call 1-800-99-AFLAC (1-800-992-3522) to request additional forms. Claims for all other benefits covered under this policy must be filed separately using the claim forms available at aflac.com or by calling 1-800-99-AFLAC (1-800-992-3522).

American Family Life Assurance Company of Columbus (Aflac)
ATTN: Claims Department • 1932 Wynnton Road • Columbus, GA 31999
For information or to check claim status, visit aflac.com or call 1-800-99-AFLAC (1-800-992-3522)
Claims may be faxed to 1-877-44-AFLAC (1-877-442-3522)

CANCER WELLNESS BENEFIT CLAIM FORM

Policy Number:

All Fields are required.

Policyholder Information:

Last Name | Suffix | First Name | MI

Date of Birth (mm/dd/yy) | Telephone Number where we can reach you

Home Address

City | State | Zip Code

☐ *Check box if this is permanent address change.*

Patient Information:

Last Name | First Name | Date of Birth (mm/dd/yy)

Sex: ☐ Male ☐ Female

Relationship: ☐ Primary Policyholder ☐ Spouse ☐ Dependent Child

Treatment Date: M M D D Y Y Y Y

Mammogram Date: M M D D Y Y Y Y

Pap Smear Date: M M D D Y Y Y Y

- ☐ Breast MRI
- ☐ Chest X-ray
- ☐ Colonoscopy/Virtual Colonoscopy
- ☐ Flexible Sigmoidoscopy
- ☐ Pap Smear/Pap Smear - ThinPrep
- ☐ HPV Screening
- ☐ Testicular Ultrasound
- ☐ Hemocult Stool Specimen
- ☐ CEA (blood test for colon cancer)
- ☐ CA 125 (blood test for ovarian cancer)
- ☐ Mammogram
- ☐ Cervical Cancer Screening
- ☐ CA153
- ☐ Thermography
- ☐ PSA (blood test for prostate cancer)
- ☐ Breast ultrasound/Breast sonogram
- ☐ Biopsy
- ☐ Cancer Prevention Vaccine

Actual Cost of Mammogram | Physician's Phone Number:

Physician's Name

Physician's Street Address

Physician's City | State: | Zip:

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.

The Provider listed above is authorized to validate the information I have provided.

POLICYHOLDER/PATIENT SIGNATURE | **FAMILY RELATIONSHIP, IF NOT POLICYHOLDER** | **DATE**

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