A member of the American Fidelity Group

Local Phone # 523-5025
Toll Free # 1-800-662-1113
Fax # 1-800-818-3453
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INDIVIDUAL CANCER , INTENSIVE CARE OR DREAD DISEASE BENEFIT STATEMENT

AMERICAN FIDELITY ASSURANCE COMPANY
ATTN: Benefit Department
P.O. Box 25160
Oklahoma City, OK 73125

Warning: Any person who knowingly and with intent to injure, defraud, or deceive any insurer,makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information may be guilty of insurance fraud.

INSTRUCTIONS TO INSURED

1. Complete STATEMENT OF INSURED.
2. Attach ITEMIZED BILLS.
3. Have physician complete ATTENDING PHYSICIAN'S STATEMENT.
4. If claim is for CANCER BENEFIT, include PATHOLOGIST'S REPORT.

STATEMENT OF INSURED

1. FULL NAME ______ (Please Print (Last) (First) (M.I.) Date of Birth ___/___/___ (Mo) (Day) (YR) Account No. ______
   Social Sec. # ______
2. Address ______ (Street) (City) (State) (Zip Code)
3. Telephone number Work ______ Home ______
4. If claim is for dependent, give name of dependent ______ Relationship ______ Date of Birth: ______ Mo Day Yr

Is this claim for ❑ Cancer Benefits ❑ Intensive Care Benefits ❑ Dread Disease Benefits

5. Illness Condition ______
6. Has this condition caused previous trouble? ______ If so, when? ______
7. Date first treated ______
8. Have you been confined to a hospital? ❑ Yes ❑ No If yes, when From: ______ To: ______
   Name and address of hospital ______
   (Complete if diagnosis was made within the first year of coverage.)
9. Names, addresses and phone numbers of any doctors the patient has consulted in the past five years ______

______

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize any physician, hospital, pharmacy, insurance company, Worker's Compensation carrier, Social Security office, Veterans Administration, retirement system, or other organization to release any information regarding the medical or mental health history, treatment, disability or benefits payable for this disability to the American Fidelity Assurance Company or its representative. A photocopy of this authorization shall be as valid as the original. This authorization shall be considered valid for the duration of the claim, but not to exceed one year from the date signed. I understand that this authorization may be revoked at any time by providing written notice to American Fidelity Assurance Company except to the extent American Fidelity has taken action in reliance of this authorization or to the extent that law allows American Fidelity to contest claims or coverage. Written notice must refer to the authorization by indicating the date it was signed and should be mailed to AFES Benefits Department, P.O. Box 25160, Oklahoma City, OK 73125-0160. By signing below I certify the above information as true and correct to the best of my knowledge.

American Fidelity may use this information to determine what, if any, benefit can be provided for any American Fidelity coverage for which I may be eligible.

By State Law, you must be advised that: THE INFORMATION YOU AUTHORIZE FOR RELEASE MAY INCLUDE INFORMATION WHICH MAY BE CONSIDERED A COMMUNICABLE OR VENEREAL DISEASE WHICH MAY INCLUDE, BUT ARE NOT LIMITED TO DISEASES SUCH AS HEPATITIS, SYPHILIS, GONORRHEA, THE HUMAN IMMUNODEFICIENCY VIRUS ALSO KNOWN AS ACQUIRED IMMUNE DEFICIENCY SYNDROME ("AIDS").

The information you authorize for release may include your history of treatment for physical and/or emotional illness to include psychological testing and treatment records of alcohol and drug abuse.

You do have the right to refuse to sign this authorization; however, failure to sign the authorization may result in a denial of benefits.

American Fidelity Assurance Company and its reinsurers agree to maintain the confidentiality of all the Insured's nonpublic financial or medical information given to us by any authorized entities listed above; *however, federal law (HIPAA) requires you be advised information used or disclosed pursuant to this authorization may be subject to re-disclosure and is no longer protected by HIPAA rules.*

Date: ______ Signature of Patient: ______

Date: ______ Signature of Insured: ______ (Required only if patient is spouse)

If authorization is supplied by a personal representative a description of the authority to act on behalf of the Insured must be included.

RETAIN A COPY FOR YOUR PERSONAL RECORD.

ATTENDING PHYSICIAN'S STATEMENT

1. Patient's Name ______ Age ______ Date of Birth ______
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)

BN-451 (0303)