

REQUEST FOR ACCIDENT  
ONLY POLICY BENEFITS



ATTN: AFES BENEFITS DEPT.  
P.O. Box 25160  
Oklahoma City, Oklahoma 73125  
1-800-662-1113 Local 523-5025  
Fax No: 1-800-818-3453  
www.afadvantage.com

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 may be guilty of insurance fraud and subject to criminal and civil penalties.

CLAIM FILING INSTRUCTIONS

CLAIM PROCESSING:

FOR MEDICAL EXPENSE BENEFITS:

1. Complete all questions on the front of this form.
2. Include a copy of the itemized bill.

FOR DISABILITY BENEFITS

1. Complete the Statement of Insured section on the front and back of this form, answering all questions in full.
2. Have your Employer complete the Statement of Employer section on the back of this form, answering all questions in full.
3. Have your physician complete the Attending Physician's Statement on the back of this form.
4. Fax or mail the completed claim form.

STATEMENT OF INSURED

A. ABOUT YOU	INSURED'S LAST NAME	First Name	Initial	Date of Birth	ACCOUNT NUMBER
	Address (City, State, Zip)				Insured's Social Security Number
	Employer - Name				Home Telephone #
B. ABOUT THE PATIENT	PATIENT INFORMATION (CHECK ONE) For whom do you make this request? <input type="checkbox"/> Self <input type="checkbox"/> Wife <input type="checkbox"/> Husband <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Other _____ <small>identify</small>	Patient's Name	Patient's Birth Date	Patient's Social Security No.	
		If Claim is for a Dependent Child Under 21, is Such Child Living in Your Household? <input type="checkbox"/> Yes <input type="checkbox"/> No		If Dependent Child is between age 21 and 25 years old is (s)he a full-time student? <input type="checkbox"/> Yes <input type="checkbox"/> No	
C. ABOUT THE ACCIDENT	Did the accident result from employment? _____ Yes _____ No				
	If yes, are you filing or will you be filing for Workers' Compensation? _____ Yes _____ No				
	How, when, and where did the accident occur? _____ _____ _____				
	Were you transported to an emergency center or hospital by ambulance? _____ Yes _____ No				
	Were you hospital confined due to this accident? _____ Yes _____ No				
	If yes, give admit and discharge dates, and name and address of hospital. admitted ___/___/___ discharged ___/___/___				
	Are you making a claim under your Disability benefit? _____ Yes _____ No <b>IF YES, COMPLETE THE BACK OF THIS FORM.</b>				
E. ABOUT THE INFORMATION RELEASE	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. 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 telephone at 1 (800) 662-1113. 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 (but not psychotherapy notes) 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. Print Patient's Name: _____ Signature: _____ Date: _____ 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.				

# ONLY COMPLETE FOR DISABILITY BENEFITS

## INSURED STATEMENT

1. Last date worked: \_\_\_\_\_  
2. Dates you were totally disabled: From \_\_\_\_\_ Thru \_\_\_\_\_  
3. On what date did you return to work? Part time \_\_\_\_\_ Full Time \_\_\_\_\_  
4. If you have not yet returned to work, when do you anticipate returning to work? \_\_\_\_\_

## ATTENDING PHYSICIAN'S STATEMENT

1. Diagnosis and concurrent condition (If diagnosis code other than ICDA\* used, give name) ICDA Code \_\_\_\_\_
2. Is condition due to injury arising out of patient's employment? \_\_\_\_ Yes \_\_\_\_ No
- |   |  |
|---|--|
| 3. Date of services since disability commenced, not previously reported:<br>_____<br>_____<br>_____   | 4. If patient hospitalized, give name and address of hospital and dates:<br>Name of hospital: _____<br>Address of hospital: _____<br>Admitted ____/____/____ Discharged ____/____/____ |
| 5. Date accident happened: _____  | 6. Date patient first consulted you for this condition: _____  |
| 7. Has patient ever had same or similar condition?<br>____ Yes ____ No If yes, when and describe.     | 8. Is patient still under your care for this condition?<br>____ Yes ____ No  |
| 9. Patient was continuously and totally disabled?<br>(unable to work)<br><br>From _____ Through _____ | 10. Patient was partially disabled?<br><br>From _____ Through _____  |
| 11. If still disabled, date patient should be able to return to work.                                 | 12. Was there a referring physician? ____ Yes ____ No<br>If so, what is his name and address?  |

Date \_\_\_\_\_ Physician's Name (Print) \_\_\_\_\_ Signature \_\_\_\_\_ Degree \_\_\_\_\_ Fax \_\_\_\_\_ Telephone \_\_\_\_\_

Street \_\_\_\_\_ City and State \_\_\_\_\_ Zip Code \_\_\_\_\_ Tax Identification # \_\_\_\_\_

## STATEMENT OF EMPLOYER

Company Name	Phone No.
Name of Employee	What percentage of the employees premium is paid by the employer? ____%
Employee's Title <input type="checkbox"/> Weekly Salary <input type="checkbox"/> Monthly Salary <input type="checkbox"/> Annual Salary (if commissioned)	Are the employee paid premiums for this policy withheld before or after taxes? Before <input type="checkbox"/> After <input type="checkbox"/>
Is this loss a result of employment? ____ Yes ____ No	Has the employee made claim for or is he entitled to Workers' Compensation? ____ Yes ____ No
Date employee last worked ____/____/____	Date returned to work ____/____/____
Give final date of paid sick leave to which employee is entitled ____/____/____	
At the time of this disability was the employee <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> On Leave <input type="checkbox"/> Retired <input type="checkbox"/> No Longer Employed (Check One)? Is employee eligible for any other paid compensation? ____ Yes ____ No If yes, explain what type of benefit this is: Monthly Benefit _____ Period eligible _____	
(Signature of Employer Representative)	(Date Signed)

**American Fidelity Assurance Company**  
 A member of the American Fidelity Group  
 Local Phone # 523-5025  
 Toll Free # 1-800-662-1113  
 Fax # 1-800-818-3453  
 afadvantage.com

**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 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.**

**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 \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Account No. \_\_\_\_\_  
 (Please Print (Last) (First) (M.I.) (Mo) (Day) (YR) 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. 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 (but not psychotherapy notes) 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)

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**American Fidelity Assurance Company**

A member of the American Fidelity Group

www.afadventure.com

Local Phone # (405) 523-5025

Toll Free # (800) 662-1113

Fax Toll Free # (800) 818-3453

**INDIVIDUAL CANCER DIAGNOSTIC BENEFITS STATEMENT  
RETURN THIS BENEFIT FORM AND ATTACHMENTS TO:**

**AMERICAN FIDELITY ASSURANCE COMPANY**

**American Fidelity Educational Services**

**ATTN: BENEFITS DEPARTMENT**

**P.O. BOX 25160**

**OKLAHOMA CITY, OK 73125**

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**INSTRUCTION TO INSURED**

1. Complete STATEMENT OF INSURED
2. Please attach **bill, receipt, or evidence of the test**

**STATEMENT OF INSURED**

1. FULL NAME \_\_\_\_\_ Account No. \_\_\_\_\_  
(Please Print) (Last) (First) (M.I.)

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Sec. # \_\_\_\_-\_\_\_\_-\_\_\_\_  
(MO) (Day) (YR)

2. Address \_\_\_\_\_  
(Street) (City) (State) (Zip Code)

3. If claim is for dependent, give name of dependent \_\_\_\_\_ Relationship \_\_\_\_\_  
Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_  
(Mo) (Day) (YR)

**DIAGNOSTIC TESTING BENEFIT**

- Covered diagnostic test and benefit amounts vary by series of the plan.
- Please read your policy for the covered diagnostic tests and the exact amount of your benefit.

**MAIL TO:**

**American Fidelity Assurance Company  
American Fidelity Educational Services  
Attn: Benefits Dept - Cancer Claim  
P.O. Box 25160  
Oklahoma City, OK 73125-0160**

# Group Disability Claim Filing Instructions

**(Not for use when filing for Physician's Expense Benefits)**

1. Complete Employee's Disability Benefits Application in full.
2. Have the treating physician complete the Attending Physicians Statement and return to you.
3. Have your Employer complete the Employer's Report of Claim.
4. Submit the completed:
  - A. Employee's Disability Benefits Application
  - B. Employers Report of Claim
  - C. Attending Physician's Statement

To the address below or submit via our toll-free fax @ 1-800-818-3453

**All portions of this form package must be completed to avoid undue delay in processing claimant's request for benefits. If you have any questions regarding completion of this form please call:**

Toll Free Phone # 1-800-662-1113  
Local Phone # 405-523-5025



**A member of the American Fidelity Group®**

Educational Services Division  
Benefits Department  
P.O. Box 25160  
Oklahoma City, Oklahoma 73125-0160  
[www.afadvantage.com](http://www.afadvantage.com)

**EMPLOYER'S REPORT OF CLAIM**

<b>E M P L O Y E R '' R E P O R T</b>	Name of Employer: _____		Phone No.: ( ) ( ) ( )
	Mailing Address: (include street, city, state and zip code) _____		Fax No.: ( ) ( ) ( )
	Name of Employee: _____		Social Security Number: - - -
	Address: (include street, city, state and zip code) _____		Phone No.: ( ) ( ) ( )
	Date of Hire: _____	Effective date of employee's coverage: _____	Occupation: (please attach job description)
	Status of employment at time of disability: <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Leave of Absence <input type="checkbox"/> Terminated <input type="checkbox"/> Retired		
Number of hours worked per week at time of disability: _____		Inhouse days: _____	
Number of contract days: _____ for _____ school year.		First Day _____ Last Day _____	
Has employee's status of employment changed? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, current status and date of status-change? _____			
<b>P R E M I U M S</b>	Does employee participate in Social Security? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, hired after 4/1/86? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	Please furnish the percentage of the employee's AFA disability premium you pay: _____%		
	Are the AFA disability premiums withheld before or after taxes? <input type="checkbox"/> Before <input type="checkbox"/> After		
<b>S A L A R Y</b>	<b>SALARY AT TIME OF DISABILITY</b>		
	Monthly: \$ _____	Effective Date: _____	<input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/> 12 Month Work Schedule
	Annual: \$ _____ (for educators)	Effective Date: _____	<input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/> 12 Month Work Schedule
<b>D I S A B I L I T Y</b>	Date employee last worked: _____		
	Has employee returned to work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	If Yes, date returned to work: Full Time: _____ Part Time: _____		
<b>O T H E R I N C O M E</b>	Did Employee's disability result from employment? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	If yes, name, address and phone number of Worker's Compensation carrier: _____		
	Has employee made a claim for or entitled to Worker's Compensation? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	If yes, weekly rate of compensation: \$ _____		
	Provide: The final date the employee is entitled to fully paid sick leave _____		
	The first date the employee is entitled to differential/sabbatical pay, if any _____		
	The last date the employee is entitled to differential/sabbatical pay _____		
The daily rate of differential/sabbatical pay \$ _____			
Name, address and phone number of any other disability carrier: (include street, city, state and zip code) _____			
Is employee eligible for disability retirement benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No			

**Remember - To attach a copy of the applicable school calendar for any contracted employee. FAILURE TO DO SO COULD RESULT IN DELAYED BENEFITS**

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: \_\_\_\_\_

Title: \_\_\_\_\_ Date: \_\_\_\_\_



A member of the American Fidelity Group

www.afadvantage.com
American Fidelity Assurance Company
Mail to: AFES Benefits Department
P.O. Box 25160
Oklahoma City, OK 73125-0160
Local Phone # (405) 523-5025
Toll Free Phone # 1-800-662-1113
Toll Free Fax # 1-800-818-3453

EMPLOYEE'S DISABILITY BENEFITS APPLICATION

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 may be guilty of insurance fraud and subject to criminal and civil penalties.

Form with multiple sections for personal information, medical history, and authorization. Includes fields for name, address, birth date, occupation, and medical treatment details. Contains a large authorization section at the bottom regarding protected health information.



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**American Fidelity Assurance Company**  
**Mail to:** AFES Benefits Department  
 P.O. Box 25160  
 Oklahoma City, OK 73125-0160  
**Local Phone #** (405) 523-5025  
**Toll Free Phone #** 1-800-662-1113  
**Toll Free Fax #** 1-800-818-3453

**ATTENDING PHYSICIAN'S STATEMENT**

Name of Patient:	Date of Birth:	Account Number:
D I A G N O S I S	Diagnosis: (including complications) <span style="float:right">ICDA Code:</span>	
	Is disability due to injury or sickness arising out of or in the course of patient's employment? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Is disability the result of pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, type of delivery: _____ Date pregnancy was diagnosed? ___/___/___ Date of delivery:(if delivered) ___/___/___ Expected date of delivery? ___/___/___	
H I S T O R Y	When did symptoms first appeared or accident happen? _____ Date patient first consulted you for this condition? ___/___/___ _____/___/___	
	Has the patient ever had the same or similar condition? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, indicate when and describe:	
	Was the patient referred to you? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, full name and address of referring physician:	
T R E A T M E N T	Frequency of treatment: <input type="checkbox"/> Monthly <input type="checkbox"/> Weekly <input type="checkbox"/> Other If not under your regular care and attendance please explain. Date of next appointment : ___/___/___	
	Nature of treatment being rendered (including surgery and any medications being prescribed)	
	List all dates of treatment or medical attention since the disability began:	
	Is patient still under your care for this condition? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, please provide the name of the current treating physician:	
	Has the patient been confined to a hospital? <input type="checkbox"/> Yes <input type="checkbox"/> No Admitted: ___/___/___ Discharged: ___/___/___ If yes, give admit and discharge dates along with name and address of hospital Admitted: ___/___/___ Discharged: ___/___/___	
	Name: _____ Address: _____	
P R O G N O S I S	Dates of total disability: (unable to work) From: _____ Through: _____ Disabled from: Patients Job <input type="checkbox"/> Yes <input type="checkbox"/> No Any other work <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Dates of partial disability? From: _____ Through: _____	
	If the patient is currently disabled, what is the anticipated length of disability? <input type="checkbox"/> 1-2 Months <input type="checkbox"/> 2-3 Months <input type="checkbox"/> 3-6 Months <input type="checkbox"/> 6-12 Months <input type="checkbox"/> More than 12 Months <input type="checkbox"/> Permanent	
	When, in your opinion will the patient recover sufficiently to return to work?	
	Do you believe the patient is competent to endorse checks and direct the use of the proceeds thereof? <input type="checkbox"/> Yes <input type="checkbox"/> No	
I M P A I R M E N T S	Functional Limitations that render your patient totally disabled:	
	Current Treatment Plan:  Attention Physician: This form documents your verification that the above named individual is totally disabled from either their or any other occupation. Your signature generates disbursement of disability benefits. You will be asked periodically for updates related to this individual's disability status and treatment plan.	
Attending Physician's Name: (print)		Degree:
Street Address:		Telephone #: ( ) - ( ) - City: State: Zip Code:
Signature:		Federal Tax ID #: Date:

**STATEMENT OF CLAIMANT**  
**For Physician Expense For Injury or Sickness Only**  
**(Do NOT use this form when filing for disability)**

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ AFA Account # \_\_\_\_\_  
 (Policyholder)

Residence Address \_\_\_\_\_ Social Security No. \_\_\_\_\_  
 (Street) (Town) (State) (Zip)

Mailing Address \_\_\_\_\_  
 (Street) (Town) (State) (Zip)

I am employed at \_\_\_\_\_  
 (Employer) (Address) (City) (State) (Zip)

Telephone No. Home \_\_\_\_\_ Work \_\_\_\_\_ Occupation \_\_\_\_\_

1. Date accident or illness began	_____
2. Nature of illness or accident	_____
3. Was accident or illness work related?	Yes <input type="checkbox"/> No <input type="checkbox"/>
4. If accident, where and how did it happen? (Explain fully)	_____ _____ _____

4. Dates of all Treatment What date(s) were you unable to work a full day?	Office _____ Hospital _____ Admit. Date: _____ Discharge Date: _____
---	--

5. Was school in session on the day of medical treatment?	Yes <input type="checkbox"/> No <input type="checkbox"/> If no Explain (semester break, holiday, week-end, etc.):
A. If yes, were you totally disabled and unable to work one full day on the date of medical treatment?	Yes <input type="checkbox"/> No <input type="checkbox"/> Date unable to work _____
B. If no, would you have been totally disabled and unable to work one full day on the date of medical attention had school been in session?	Yes <input type="checkbox"/> No <input type="checkbox"/>

**PLEASE ATTACH DIAGNOSIS AND ITEMIZED CHARGES FROM THE DOCTOR**

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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").

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Print Patient's Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*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.