Cancer Claim Filing Instructions

Use this form for Cancer benefits, Intensive Care benefits, Dread Disease benefits and Heart Attack/Stroke benefits.

CANCER CLAIM FILING INSTRUCTIONS

If you live in the states of GA, OK, SC, or TX please refer to the Special Instructions below for additional steps needed in filing your claim. Also, regardless of your state of residence, if your policy is one of our C3, C4, C5, or C11 cancer policies (please see bottom left corner of policy), please refer to the Special Instructions below for additional steps needed in filing your claim.

1) Complete the **STATEMENT OF INSURED** found on page 3 of this form.
2) Attach **ITEMIZED BILLS** from each of your providers, with a complete breakdown of charges for each date of service.
3) Have your physician complete the **ATTENDING PHYSICIAN'S STATEMENT** found on page 3 of this form.
4) If your claim is for a cancer diagnosis, we must have a copy of the **PATHOLOGY REPORT** from the **FIRST PROCEDURE** in which cancer was diagnosed before any benefits can be provided. Your oncologist or your primary treating physician should be able to furnish you with a copy of this report.

SPECIAL INSTRUCTIONS

1) If your cancer policy is one of our C3, C4, or C5 policies, you must also attach the corresponding Explanations of Benefits (EOB) from your primary medical coverage that corresponds to each itemized bill requested above.
2) If you live in the states of GA, OK, SC, or TX, and your cancer policy is one of our C3, C4, C5, C6, C7, C8, or C9 policies, you must also attach the corresponding Explanations of Benefits (EOB) from your primary medical coverage that correspond to each itemized bill requested above.
3) If you live in the states of GA, OK, SC, or TX, and you are filing for ICU benefits on any of our cancer policies, you must also attach the corresponding Explanations of Benefits (EOB) from your primary medical coverage that correspond to each itemized hospital bill requested above.
4) If your cancer policy is one of our C11 policies and you are filing for chemotherapy, immunotherapy, or radiation benefits, you must also attach the corresponding Explanations of Benefits (EOB) from your primary medical coverage that correspond to each itemized bill requested above.

Please call us at 1-800-662-1113 if you are unsure which type of policy you have with our company. We will be happy to assist you.

American Fidelity Assurance Company
A member of the American Fidelity Group

Educational Services Division
Benefits Department
P.O. Box 25160
Oklahoma City, Oklahoma 73125-0160
www.afadvantage.com

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.

American Fidelity Assurance Company
A member of the American Fidelity Group

American Fidelity Assurance Company
EDUCATIONAL SERVICES DIVISION
BENEFITS DEPARTMENT
P.O. Box 25160
Oklahoma City, Oklahoma 73125
1-800-662-1113 (toll free)
1-800-818-3453 (toll free fax)

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize the entities specified below to disclose any information about me or my dependents' health including my or my dependents' entire medical record 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) pharmacy; g) insurance companies; h) the Social Security Administration; i) retirement systems; j) Department of Motor Vehicles, and k) Workers' Compensation Carrier. Colorado state law prohibits the redisclosure or reuse of information disclosed about a Colorado resident under this authorization.

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. For Maine residents, information authorized for release may include information on communicable or venereal diseases such as hepatitis, syphilis, gonorrhea, AIDS/ARC (Acquired Immune Deficiency Syndrome /AIDS Related Complex) 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. For Vermont residents, this authorization does not require disclosure of prior HIV-related tests. For Wisconsin residents, results of AIDS/HIV test do not need to be reported if they were done at any anonymous counseling and testing site, if the test was not an FDA-licensed blood test, or through the use of a home test kit. For Arizona residents, release of HIV/AIDS-related information can only be disclosed for a period not to exceed 180 days from the date shown below.

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 AFES Benefits Department, PO Box 25160, Oklahoma City, OK 73125-0160 or by calling, toll-free, 1-800-662-1113. 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.

For health insurance coverage this authorization will expire twenty-four months from the date it is signed or upon termination of my insurance policy, whichever occurs first. For insurance coverage other than health insurance, this authorization will expire twenty-four months from the date it is signed or upon expiration of my claim for benefits, whichever occurs first.

AFA Account#	Printed Name	Date of Birth
Signature (Patient) or Personal Representative (if applicable)	Date	
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.*	

Please retain a copy for your personal records, or you may request a copy from our Company.

REQUEST FOR INDIVIDUAL CANCER, INTENSIVE CARE OR DREAD DISEASE BENEFITS

American Fidelity Assurance Company
A member of the American Fidelity Group

ATTN: AFES BENEFITS DEPT.
P.O. Box 25160
Oklahoma City, Oklahoma 73125
Toll Free: 1-800-662-1113
Fax: 1-800-818-3453
www.afadvantage.com

See page 1 for fraud statements.

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

If claim is for dependent, give name of dependent	Relationship:	Dependent Date of Birth:
For dependent child between 21-25 years of age: School:		Hours Enrolled

If a full-time student, please enclose a copy of the transcripts.

C. ABOUT CLAIM

Is this claim for ☐ Cancer Benefits ☐ Intensive Care Benefits ☐ Dread Disease Benefits ☐ Heart Attack/Stroke Benefits

Diagnosis/Condition	Date First Treated

D. DIRECT DEPOSIT AUTH.

Please complete if you desire benefits deposited directly into your bank account.

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: _____

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

ATTENDING PHYSICIAN'S STATEMENT

1. Patient's Name_____Age_____ Date of Birth_____
   Social Security Number:_____
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)

Tax ID Number_____