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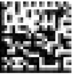

Worksite Group Benefits Department | P.O. Box 25160 | Oklahoma City, Oklahoma 73125-0160
American Fidelity Assurance Company | 1-800-662-1113 | Fax: 1-800-818-3453 | **americanfidelity.com**

Hospital Indemnity Claim Filing Instructions

Faster, Easier Online Claim Filing

Through your online or mobile account, you can file your claim, check claim status, sign up for notifications, update personal information, enroll in direct deposit, view your detailed policy, and much more!

Two Easy Ways to Register

Online at **americanfidelity.com**

Download AFmobile® from the **Apple App Store** or **Google Play**

SB-32082-0219

Stop here! Paper claim filing is not the fastest option. Receive your money faster when you file online or through AFmobile.

Claim Filing Instructions for Mail or Fax:

Please complete this packet in full to avoid delays in your claim processing.

For the fastest claim turnaround time, **please complete and submit separate claim forms for each diagnosis.**
For example, if you are filing for knee pain and pregnancy, please submit a separate form for each diagnosis.

1. Complete the Statement of Insured.
2. Complete the Authorization to Disclose Protected Health Information.
3. For **hospital confinement** or **imaging** and **advanced studies claims**, please attach itemized bills.
4. For **critical illness** or **accident claims**, please attach copies of the medical records or office notes for treatment.
5. Mail or fax the completed forms to American Fidelity at the address or fax number listed above.

To receive updates on the on the status of your claims, log in or register for an account at **americanfidelity.com** and select your communication preferences.

Your Money Direct, Your Money Faster. Enroll in Direct Deposit.

To set up direct deposit with American Fidelity, provide all required information below with your submitted claim. You may also enroll in direct deposit through your online account.

I authorize American Fidelity Assurance Company (AFA) to initiate credit entries to my account as indicated. I also authorize AFA to debit my account for any deposits made in error. This authorization remains effective and in full force until AFA receives written notification from me of its termination in such time and in such manner as to afford AFA and the Depository a reasonable opportunity to act on it. Please notify AFA immediately if your depository information has changed. This authorization applies to benefits payable under all benefit plans with AFA.

Signature: ______________________________

You must provide the following information:

Routing Number: ______________________________

Account Number: ______________________________

Routing Number Account Number

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STATEMENT OF INSURED *To be completed by Employee*

Name: (last, first, middle initial)	Date of Birth: / /
Social Security Number: / /	Account Number:
Mailing Address: (P.O. Box or street, city and zip code)	
Telephone Number (including area code):	Email Address:
Employer Name:	
For whom do you make this request (check one): ❒ Self ❒ Spouse ❒ Child ❒ Other	
Patient Name: (last, first, middle initial)	
Patient Date of Birth: / /	Patient Social Security Number: / /

PLEASE NOTE: Your specific policy may not include all of the following benefits. Please refer to your policy documents for available coverage details.

SECTION 1 – HOSPITAL CONFINEMENT BENEFITS

If hospital confined, please provide dates: Hospital(s):	Admitted: / /	Discharged: / /
Hospital(s):	Admitted: / /	Discharged: / /
Claim is due to: ❒ Illness ❒ Accident ❒ Pregnancy		
If illness, date of onset: / / Describe injury or illness in detail:	If pregnancy, date first diagnosed: / /	

Please submit a copy of the **itemized hospital bill** with a complete breakdown of charges for each confinement.

SECTION 2 – ACCIDENT BENEFITS

When did the accident occur? / /	Date of the Initial Treatment: / /
Describe how the injury occurred:	

Please submit a copy of the **medical records** or **office notes** for each date of treatment related to your accident.

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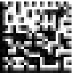

SECTION 3 – CRITICAL ILLNESS BENEFITS

Please attach copies of all **office notes** or **medical records** from the date you were first treated for symptoms associated with the condition up to the present.

STATEMENT OF ATTENDING PHYSICIAN

To be completed by Physician. Please complete the appropriate section for each condition that the patient has been diagnosed.

CANCER

Does the patient have cancer? ❒ Yes ❒ No	Type of cancer: Date cancer diagnosed: / /
Stage of cancer:	Is this an In Situ Cancer? ❒ Yes ❒ No

END STAGE RENAL FAILURE

Does the patient have End Stage Renal Failure presenting as chronic, irreversible failure to function of both kidneys? ❒ Yes ❒ No	Does the patient's kidney failure necessitate regular peritoneal or hemodialysis (at least weekly) or kidney transplantation? ❒ Yes ❒ No
Date of recommendation for patient to begin renal dialysis or kidney transplant: / /	
What is the cause for patient's End Stage Renal Disease:	
Date patient was first treated with signs or symptoms of this condition: / /	

HEART ATTACK (MYOCARDIAL INFARCTION)

Are new and serial electrocardiographic (EKG) findings consistent with Myocardial Infarction? ❒ Yes ❒ No **If yes, attach a copy of the EKG.**	
Were cardiac enzymes elevated above generally accepted laboratory levels of normal for creatine physphokinase (CPK)? ❒ Yes ❒ No	Did diagnostic studies confirm a Myocardial Infarction and the occlusion of one or more coronary arteries? ❒ Yes ❒ No
Date the patient was diagnosed with Myocardial Infarction: / /	

MAJOR ORGAN FAILURE

Has the patient been placed on the UNOS (United Network for Organ Sharing) list, requiring transplantation of any of the following: ❒ heart ❒ liver ❒ lung ❒ entire pancreas	
Date the patient was placed on UNOS list: / /	
What condition caused the need for transplant?	Date patient first treated for signs or symptoms of this condition: / /

PERMANENT DAMAGE DUE TO A STROKE

Did the patient have a stroke? ❒ Yes ❒ No
For how many days did the patient's stroke produce persisting neurological deficits?
Date stroke occurred based on documented neurological deficits and neuroimaging or other neurodiagnostic study: / /

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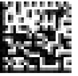

STATEMENT OF ATTENDING PHYSICIAN Continued

PERMANENT PARALYSIS DUE TO A COVERED ACCIDENT

Has the patient experienced permanent paralysis due to injuries to the spinal cord resulting in paraplegia or quadriplegia persisting for a period of 90 consecutive days or more? ❒ Yes ❒ No
Is paralysis expected to be permanent in nature? ❒ Yes ❒ No
Date patient first diagnosed with permanent paralysis: / /
What event resulted in paralysis:
Date patient first treated for signs or symptoms of this condition: / /

PHYSICIAN INFORMATION

Attending Physician's Name & Title: (print)	Specialty:
Phone:	Fax:
Mailing Address: (P.O. Box or Street, City, State and Zip Code)	
Form completed by (name and title):	Signature:
Date: / /	

SECTION 4 – IMAGING & ADVANCED STUDIES

Please submit a copy of your **bill** or **test results**.

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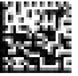

AUTHORIZATION TO DISCLOSE INFORMATION INCLUDING PROTECTED HEALTH INFORMATION

The purpose of this form is to allow American Fidelity Assurance Company (AF), or business partners acting on behalf of AF in the administration of AF products and services to obtain data including but not limited to employment information, financial information, and protected health information about me, from any party holding that information. Once obtained, AF may use this data to review or process benefits, confirm policy information, or otherwise review or process information related to my Customer relationship with them.

I hereby authorize the entities specified below to disclose any information about me or my dependents' health or financial situation 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 AF 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 or their business associates; 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, k) banks or financial institutions and l) Workers' Compensation Carrier. AF will only disclose any data collected pursuant to this authorization as necessary for our legitimate business purposes, and only to the extent allowed by law.

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.

I understand that AF may not condition payment of claims, enrollment, or eligibility for benefits on whether I sign this authorization. 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 an inability to pay benefits under my policy if my failure to sign results in AF not having enough information to process my benefits. I understand that I may revoke this authorization at any time by writing to American Fidelity Assurance Company, 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: AF has taken action in reliance on the authorization; or, the law provides AF 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.

In addition to the types of information described above, I also authorize American Fidelity to access any other type

of information deemed necessary to investigate my claim. This information includes but is not limited to financial information, information submitted or related to insurance claim(s) or insurance coverage(s) and employment records. Any party holding this information is hereby authorized to release it to American Fidelity.

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.

AF Account# ____________ Printed Name of Patient ____________ Patient's Date of Birth ____________

Signature (Patient) or Personal Representative (if applicable) ____________ Date Signed ____________

Relationship of Personal Representative to Patient (if applicable) ____________

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