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Benefits Department | P.O. Box 248929 | Oklahoma City, OK 73124
American Fidelity Assurance Company | 800-662-1113 | Fax: 855-651-1294 | **americanfidelity.com**

Paid Family Medical and Leave Insurance Request Form

Faster, Easier Claim Filing

File your claims through your online or mobile account. You can also check claim statuses, sign up for notifications, enroll in direct deposit, view your policy and more!

Two Ways to Register

1. Online at **americanfidelity.com/register**
2. Download AFmobile® from the **Apple App Store** or **Google Play**

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.

1. Complete the Statement of the Insured section.
2. Submit the documentation indicated under Verification Requirements, based on your type of leave.
3. Have your employer complete the Employer's Report of Claim section and return it to you.
4. Complete the Authorization to Obtain Information including Protected Health Information section.
5. Mail or fax the completed forms to American Fidelity at the address or fax number listed above.

To receive claim status updates, log in to your account at **americanfidelity.com/login** 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.

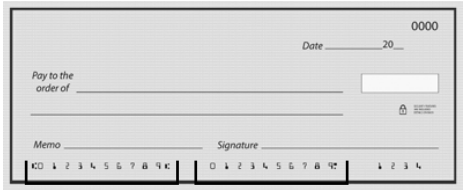
I authorize American Fidelity Assurance Company to initiate credit entries to my account as indicated. I also authorize American Fidelity to debit my account for any deposits made in error. This authorization remains effective and in full force until American Fidelity receives written notification from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

Signature: _____

You must provide the following information:

Routing Number: _____

Account Number: _____



Routing Number Account Number

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Statement of the Insured To be filled out by applicant.

Full Name: (last, first, middle initial)		
Date of Birth: (MM/DD/YYYY)		Social Security Number:
Customer Number:		
Mailing Address: (street, city, state, zip)		
Phone Number: (with area code)	Personal Email:	
Employer / Company Name:	Employer / Company Location: (city, state)	Do you have additional employers? ☐ Yes ☐ No
Are you entitled to any additional compensation or paid leave benefits during leave? If yes, what type? ☐ Workers' Compensation ☐ Short-Term Disability Benefits ☐ Other: _____		
Regular Work Schedule: *If your work schedule varies, check this box:* ☐		Job Title:
Leave Reason: ☐ Medical Leave ☐ Family Caregiving Leave (Relationship: _____) ☐ Parental Leave ☐ Qualifying Exigency Leave **Medical Leave:** Caring for your own serious health condition, including an illness, injury, impairment, or physical or medical condition **Family Caregiving Leave:** Caring for a family member (child, spouse, or parent) with a serious health condition **Parental Leave:** Caring for or bonding with a child (whether from adoption, fostering, or natural birth) in the first year of the child's life **Qualifying Exigency Leave:** Addressing issues associated with a family member's active duty military deployment to a foreign country		
Date(s) of Leave:		Leave Type: ☐ Intermittent or Reduced ☐ Continuous
Have you returned to work? ☐ Yes ☐ No		On what date did you return to work?
If not returned to work, when do you anticipate returning?		

I authorize American Fidelity to use the data in any claim submission for processing leave requests and benefits under other insurance policies or certificates issued by the company.

Signature: _____ Date: _____

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Verification Requirements

Medical Leave: Applicant's Own Serious Health Condition

☐ Have the treating health care provider complete the Health Care Provider Certification form on page 5 of this packet.

Family Caregiving Leave: Family Member with a Serious Health Condition

☐ Have the treating health care provider complete the Health Care Provider Certification form on page 5 of this packet.

Parental Leave: Caring For or Bonding with a New Child

Proof of the birth, upcoming birth, or placement is required, which includes:

☐ A certification of live birth

☐ Court documentation or order

☐ Documentation of placement from a licensed child placement agency or government agency responsible for child placement and documentation of any court appearances, appointments, or travel in anticipation of placement, if applicable

☐ Affidavit of a Kinship Care arrangement

☐ Other reasonable documentation needed to establish proof

Qualifying Exigency Leave: Family Member's Active Duty Military Service

☐ Family member's active duty military orders or other documentation issued by the military, which:

1) indicates that the Family Member is on Active Duty or called to Active Duty and

2) includes the dates of the Family Member's Active Duty service

☐ Reason for Qualifying Exigency leave

☐ Statement detailing whether the leave will be continuous or intermittent/reduced leave
(For intermittent/reduced leave, you must provide expected frequency and duration of the leave)

☐ Other reasonable documentation needed to establish proof

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Employer's Report of Claim To be filled out by the employer.

Name of Employer:	
Phone Number: (with area code)	Fax Number: (with area code)
Mailing Address: (street, city, state, zip)	
Type of Leave Approved:	Dates Approved: ☐ Intermittent or Reduced ☐ Continuous
Approved Leave Period:	Wage Earnings:
Any current breaks from work or anticipated future breaks from work that are unrelated to leave?	

Employer Signature: _____ Date: _____

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Health Care Provider Certification To be filled out by the health care provider.

This form should be completed by the treating health care provider and returned to the applicant. Information requested is related only to the condition for which the applicant is taking leave.

Applicant's Full Name: (last, first, middle initial)	Applicant's Date of Birth: (MM/DD/YYYY)
Patient's Name (if different than applicant):	Patient's Date of Birth: (MM/DD/YYYY)

Descriptions of serious health conditions that qualify under the Delaware Paid Leave program are available on page 6. Please check the appropriate category or categories for this leave request.

- ☐ Inpatient Care
- ☐ Chronic condition
- ☐ Pregnancy and/or prenatal care
  Expected delivery date: _____
- ☐ Multiple treatments for non-chronic conditions
- ☐ Permanent or long-term condition requiring supervision
- ☐ Incapacity plus treatment
- ☐ Donation of a Body Part, Organ, or Tissue

Describe the medical facts that support your certification and explain how they meet the criteria of the selection(s) above:

Approximate date condition began and probable duration: From (MM/DD/YYYY) _____ through (MM/DD/YYYY) _____

Probable duration of patient's present incapacity (if different): From (MM/DD/YYYY) _____ through (MM/DD/YYYY) _____

Is the applicant unable to perform the functions of their position due to their own serious health condition, or (for care of a family member) is the applicant needed to care for a family member who has a serious health condition? ☐ Yes ☐ No

Will it be medically necessary for the patient to take leave only intermittently or to work on a reduced schedule basis because of the condition or treatment? ☐ Yes ☐ No

If yes, duration: Over the next 6 months, episodes of incapacity are estimated to occur _____ times

per (☐ day / ☐ week / ☐ month) and are likely to last approximately _____ per episode.

If other, please explain how the applicant will work an intermittent or reduced schedule. Be specific about the frequency and duration of absences:

If the patient requires a treatment regimen, describe the treatments, estimated number of treatments and intervals between treatments *(see page 6 for definition)*:

Does the patient require assistance with basic medical or personal needs, safety, or transportation? ☐ Yes ☐ No

If no, would the applicant's presence to provide psychological comfort benefit the patient's recovery? ☐ Yes ☐ No

If the patient needs care only intermittently or on a part-time basis, please indicate the probable duration and frequency of this need:

Printed Name of Health Care Provider: _____ Date Signed: _____

Signature of Health Care Provider: _____ Type of Practice/Field of Specialization: _____

Phone Number: (with area code) _____ Fax Number: (with area code) _____

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Definitions

A **Serious Health Condition** is defined as an illness, injury, impairment or a physical/mental condition that involves one of the following:

- **Inpatient Care**
  Inpatient care (i.e., overnight stay) in a medical care facility such as a hospital, hospice, or residential facility. This includes any incapacity or subsequent treatment concerning or consequent to such inpatient care.

- **Incapacity Plus Treatment**
  A period of incapacity of more than three consecutive full calendar days (including any period of incapacity or subsequent treatment relating to the same condition) that also involves:
  - Treatments two or more times by a licensed health care provider, nurse, or physician's assistant under the direct supervision of a health care provider or by a provider of health care services (e.g., physical therapist) under orders of, or on referral by, a health care provider within 30 days of the first day of incapacity unless extenuating cirumstances exist. The first (or only) treatment by a health care provider can be an in-person or telehealth visit and must take place within seven days of the first day of incapacity, or
  - Treatment by a health care provider on at least one occasion (which must be an in-person or telehealth visit within seven days of the first day of incapacity) that results in a regimen of continuing treatment under the health care provider's supervision.
    - Treatment includes examinations to determine if a Serious Health Condition exists and evaluations of the condition. Treatment does not include routine physical, dental, or eye exams.
    - A regimen of continuing treatment includes, for example, a course of prescription medication (e.g., an antibiotic) or therapy requiring special equipment to resolve or alleviate the health condition. A regimen of continuing treatment that includes the taking of over-the-counter medications such as aspirin, antihistamines, or salves; or bed-rest, drinking fluids, exercise, or any similar activities that can be initiated without a visit to a health care provider, is not, by itself, sufficient to constitute a regimen of continuing treatment.

- **Pregnancy**
  Any period of incapacity due to pregnancy, childbirth, miscarriage or stillbirth, pregnancy-related illness, or for prenatal care.

- **Chronic Conditions**
  Any period of incapacity or treatment for such incapacity due to a chronic serious health condition. A chronic Serious Health Condition is one which:
  - Requires periodic visits for treatment by a health care provider, nurse, or physician's assistant under the direct supervision of a health care provider;
  - Continues over an extended period (including recurring episodes of a single underlying condition); and
  - May cause episodic rather than continuing periods of incapacity (e.g., asthma, diabetes, epilepsy, etc.)

- **Permanent/Long-term Conditions Requiring Continuing Care of a Health Care Provider**
  A period of permanent or long-term incapacity due to a condition for which treatment may not be effective. The applicant or family member must be under the continuing care of, but need not be receiving active treatment by, a health care provider. Examples include Alzheimer's, a severe stroke or the terminal states of a disease.

- **Multiple Treatments for Non-Chronic Conditions**
  Any period of absence to receive multiple treatments (including recovery) by a health care provider or by a provider of health care services under orders of, or on referral by, a health care provider, either of restorative surgery after an accident or injury, or for a condition that would likely result in a period of incapacity of more than three consecutive calendar days in the absence of medical intervention or treatment.

Incapacity means the inability to perform at least one essential job function, attend a school, or perform other regular daily activities due to the Serious Health Condition, treatment for or recovery from the Serious Health Condition.

Intermittent Leave means leave taken in separate (non-continuous) periods of time due to a single qualifying reason.

Continuous Leave means leave taken from employment for an uninterrupted, continuous period of time for a single qualifying reason.

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Authorization to Obtain Information Including Protected Health Information

The purpose of this form is to allow American Fidelity Assurance Company, or business partners acting on behalf of American Fidelity in the administration of American Fidelity 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, American Fidelity 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, including psychological testing, except psychotherapy notes, to individuals representing American Fidelity 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. American Fidelity 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 American Fidelity 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 American Fidelity not having enough information to process my benefits. I understand that I may revoke this authorization at any time by writing to American Fidelity, P.O. Box 258897, Oklahoma City, OK 73125-8897 or by calling, toll-free, 1-833-541-0151. I understand that my right to revoke this authorization is limited to the extent that: American Fidelity has taken action in reliance on the authorization; or the law provides American Fidelity 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 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 24 months from the date it is signed or upon the 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.

Customer # | 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 applicant must be included.

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