AMERICAN FIDELITY
a different opinion

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.

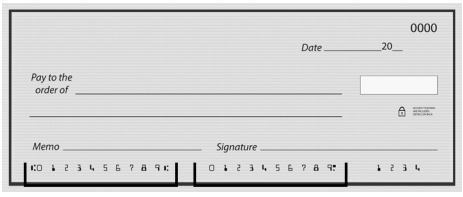
I authorize American Fidelity Assurance Company to initiate credit entries to my account as indicated. I also authorize American Fidelity to debit my account for any deposits made in error. This authorization remains effective and in full force until American Fidelity receives written notification from 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

AMERICAN FIDELITY
a different opinion

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

Statement of the Insured To be filled out by employee.

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)	Email:
Work Schedule:	

Leave Reason:

☐ Medical Leave ☐ Family Leave ☐ Safe Leave

Family Leave - Bonding with a child or caring for a family member with a serious health condition.

Medical Leave - Caring for your own serious health condition, including the insured's own medical treatment or injury due to domestic violence, harassment, sexual assault, or stalking.

Safe Leave - Seeking other help related to domestic violence, harassment, sexual assault, or stalking, including assisting a minor child/dependent related to an experience of domestic violence, harassment, sexual assault, or stalking.

Date(s) of Leave:	Leave Type: ☐ Intermittent ☐ Continuous
Have you returned to work?:	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: _____

AMERICAN FIDELITY
a different opinion

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

Verification Requirements

Medical Leave: Covered Individual'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 Leave: Bonding

One of the following is required:

☐ the child's birth certificate or Consular Report of Birth Abroad

☐ a document issued by a health care provider of the child or pregnant parent

☐ a hospital admission form associated with delivery

☐ another document approved by the Oregon Employment Department for this purpose

Family Leave: Bonding Adoption or Placement

One of the following is required:

☐ a copy of a court order verifying placement

☐ a letter signed by the attorney representing the prospective foster or adoptive parent that confirms the placement

☐ a document from the foster care, adoption agency, or social worker involved in the placement that confirms the placement

☐ a document for the child issued by the United States Citizenship and Immigration Services; or

☐ another document approved by the Oregon Employment Department for this purpose

Verification must show the following:

- the covered individual's first and last name as parent or guardian of the child after birth or placement of the child through foster care or adoption
- the child's first and last name
- the date of the child's birth or placement

Family 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.

Safe Leave: Covered Individual Seeking Help Related to Domestic Violence, Harassment, Sexual Assault or Stalking

One of the following is required:

☐ a copy of a federal agency or state, local, or tribal police report, or a formal complaint to a school's Title IX Coordinator indicating that the covered individual or the covered individual's child was a victim of domestic violence, harassment, sexual assault or stalking

☐ a copy of a protective order or other evidence from a federal, state, local, or tribal court, administrative agency, school's Title IX Coordinator, or attorney that the covered individual or the covered individual's child appeared in or was preparing for a civil, criminal, or administrative trial related to domestic violence, harassment, sexual assault or stalking

☐ documentation from an attorney, law enforcement officer, health care provider, licensed mental health professional or counselor, member of the clergy, or victim services provider that shows the covered individual or the covered individual's child was undergoing treatment or counseling, obtaining services, or relocating as a result of domestic violence, harassment, sexual assault, or stalking

In cases where a covered individual can show good cause for not providing one of the above forms of documentation, the covered individual may provide a written statement attesting that they are taking eligible safe leave. Good cause for not providing documentation is determined at the discretion of the company and includes, but is not limited to, the following:

- difficulty obtaining verification due to a lack of access to services
- or concerns for the safety of the covered individual or the covered individual's child

AMERICAN FIDELITY
a different opinion

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

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 ☐ 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: _____

AMERICAN FIDELITY
a different opinion

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

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 insured. Information requested is related only to the condition for which the insured is taking leave.

Insured's Full Name: (last, first, middle initial)

Patient's Name (if different than insured):

Descriptions of serious health conditions that qualify under the Oregon Paid Family and Medical Leave program are available on page six. Please check the appropriate category or categories for your leave request.

☐ Inpatient Care ☐ Pregnancy and/or prenatal care ☐ Permanent or long-term condition requiring supervision

☐ Absence plus treatment ☐ Chronic condition requiring treatment ☐ Multiple treatment for non-chronic conditions

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) _____

If this is a chronic condition or pregnancy, is the patient presently incapacitated? *(see page six for definition)* ☐ Yes ☐ No

If yes, duration and frequency of incapacity:

Will it be necessary for the patient to take leave only intermittently or to work on a less than full-time 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 insured will use leave intermittently or work a less-than-full-time 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 six for definition)*

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

If no, would the insured'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) _____

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

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.

- **Absence Plus Treatment**
  A period of incapacity of more than three consecutive 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, or
  - Treatment by a health care provider on at least one occasion results in a regimen of continuing care 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 care 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 care regimen does not include taking over-the-counter medications such as aspirin, antihistamines, or salves, bed rest, drinking fluids, exercise, or any other activities that can be initiated without a visit to a health care provider.

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

- **Constant or Continuing Care**
  A Serious Health Condition that requires constant or continuing care, including home care administered by a health care provider.
- **Chronic Conditions Requiring Treatments**
  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 employee 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.

- **Terminal/Possibility of Death Prognosis by Treating Health Care Provider**
  A Serious Health Condition that, in the medical judgment of the treating health care provider, poses an imminent danger of death or is terminal in prognosis with a reasonable possibility of death in the near future.

- **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.

Incapacitated means the inability to work, attend a school or perform other regular daily activities due to the Serious Health Condition, treatment and recovery for the Serious Health Condition.

Treatment or Care Regimen means the patient is under your supervision. We require a general description of the regimen, such as prescription drugs or physical therapy requiring special equipment. If the treatments are provided by another provider of health services, such as a physical therapist, please state the nature of the treatments.

AMERICAN FIDELITY
a different opinion

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

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 twenty-four 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 insured must be included.

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