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a different opinion

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

Critical Illness Rider 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.

1. **Complete the Statement of Insured.**
2. **Complete the Authorization to Disclose Protected Health Information.**
3. **Have your treating physician complete the Attending Physician Statement.**
   If claim is for cancer, include Pathologist's report.
   If claim is for Hospital Confinement, include a copy of the itemized hospital bill.
   If claim is for Occupational HIV or Hepatitis B/C/D, attach a copy of the incident report or notice of exposure.
   If claim is for Sudden Death Due to Cardiac Arrest, attach a copy of the death certificate.
4. **Mail or fax the completed forms to American Fidelity at the address or fax number listed above.**

To receive updates 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.

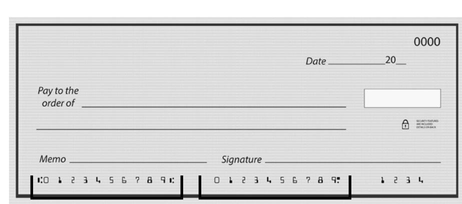
I authorize American Fidelity Assurance Company (AFA) to initiate credit entries to my account as indicated. I also authorize AFA to debit my account for any deposits made in error. This authorization remains effective and in full force until AFA receives written notification from me of its termination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

Full Name: (last, first, middle initial)	Account Number:
Mailing Address: (P.O. Box or street, city and zip code)	
Telephone Number: (including area code)	Date of Birth: / /
Email Address:	Social Security Number: / /
Employer Name and Address:	
What is the Critical Illness for which the claim is being made? o Heart Attack o Kidney Failure o Major Organ Failure o Paralysis o Stroke	
Have you ever had the same or similar condition? ❒ Yes ❒ No If yes, when?	
Provide names, addresses and telephone numbers for all attending physicians for the Critical Illness.	
If hospitalized, provide the name and address of the hospital.	

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Attending Physicians Statement Critical Illness Rider *To be completed by physician*

Name of Patient: Date of Birth: / / Social Security Number: / /

Please Indicate if Patient has been diagnosed with any of the following Critical Illnesses:
❒ Heart Attack ❒ Kidney Failure ❒ Major Organ Failure ❒ Paralysis ❒ Stroke
If Patient has been diagnosed with any of the above Critical Illnesses, please complete the portion below for the specified Critical Illness diagnosed, and attach office notes and objective testing from the date patient was first treated for symptoms associated with this condition to present.

MYOCARDIAL INFARCTION (HEART ATTACK)

Are new and serial electrocardiographic (EKG) findings consistent with Myocardial Infarction? ❒ Yes ❒ No (Attach EKG copy.)
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
Did the Patient have Chest Pain consistent with Myocardial Infarction? ❒ Yes ❒ No
Date the Patient met all of the above criteria for Myocardial Infarction? / /

KIDNEY (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 renal dialysis (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 Renal Disease?
When was Patient first treated for signs or symptoms of this condition? / /

MAJOR ORGAN FAILURE

Has the patient been placed on the UNOS (United Network for Organ Sharing) list, requiring transplantation of any of the following:
Liver, both lungs, pancreas, or heart? ❒ Yes ❒ No
Date patient was placed on UNOS list: / /
Specify organ transplantation required:
What condition caused the need for transplant?
When was patient first treated for signs or symptoms of this condition? / /

PARALYSIS (MUST BE COMPLETED BY A PHYSICIAN BOARD CERTIFIED IN NEUROLOGY)

Has the Patient experienced the complete loss of use of two or more limbs, as a result of a neurological disorder, for a period of 180 consecutive days or greater? ❒ Yes ❒ No
Is paralysis expected to be permanent in nature? ❒ Yes ❒ No
When was the Patient first diagnosed with paralysis? / /
What condition resulted in paralysis?
When was Patient first treated for signs or symptoms of this condition? / /

STROKE

Did the Patient have a stroke, meaning sudden neurological impairment of sensory and/or motor functions due to aneurysm rupture, acute cerebral occlusion, or acute hemorrhage from a cerebral artery which resulted in permanent damage to the nervous system? (A Stroke does not mean head injury, subdural hematoma, transient ischemic attack, multi-infarct dementia, or chronic cerebrovascular insufficiency) ❒ Yes ❒ No
Did the Patient's stroke produce neurological deficits persisting for a period of 30 days or greater? ❒ Yes ❒ No
Was the diagnosis of stroke confirmed by neuroimaging or other neurodiagnositc study consistent with an acute or subacute abnormality? ❒ Yes ❒ No
The date stroke occurred based on documented neurological deficits and neuroimaging or other neurodiagnostic study: / /

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 & Title) Signature: Date: / /

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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 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.

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Claim Form Fraud Statements

The following fraud language is attached to, and made part of, this claim form. **Please read and do not remove this page from this claim form.**

If you live in a jurisdiction not mentioned below, the following applies to you: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit is guilty of a crime and may be subject to fines and confinement in prison.

Alabama - Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution, fines, or confinement in prison, or any combination thereof.

Alaska - A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

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.

Arkansas, District of Columbia, Louisiana, Rhode Island and West Virginia - 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.

For your protection **California** law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confiment in state prison.

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.

Delaware, Idaho and Oklahoma - WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

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.

Indiana - A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

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.

Maine, Tennessee, Virginia and Washington - It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Maryland - Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Minnesota - A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

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.

New Jersey - Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New Mexico - 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 CIVIL FINES AND CRIMINAL PENALTIES.

Ohio - Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is 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.

Puerto Rico - Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances [be] present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

For your protection **Texas** 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.