AMERICAN FIDELITY
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**

Paid Family Leave Rider Claim 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 on page 2, 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. 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.

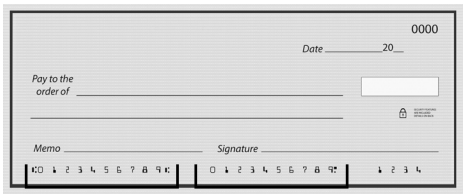
I authorize American Fidelity Assurance Company to initiate credit entries to my account as indicated. I also authorize American Fidelity to debit my account for any deposits made in error. This authorization remains effective and in full force until American Fidelity receives written notification from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

Bonding - Leave used to bond with an infant, adopted child or foster child during the first 12 months of birth, adoption, or placement.

Family Care Giving - Leave used to provide care for your family member with a serious health condition.

Qualifying Exigency - Leave for a need arising out of your family member's covered active duty service or notice of an impending call or order to covered active duty in a foreign country.

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: _____

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Verification Requirements

Bonding

One of the following is required:

- ☐ the child's birth certificate
- ☐ a statement from the child's health care provider stating the child's birth date
- ☐ a statement from the health care provider of the person who gave birth stating the child's birth date
- ☐ Declaration of Paternity
- ☐ Adoptive Placement Agreement
- ☐ Independent Adoption Placement Agreement
- ☐ foster care placement record or official letter from the foster care agency
- ☐ other evidence of a relationship

Family Care Giving

- ☐ Certification from a physician that includes:
  - a statement confirming the relationship between you and the family member
  - the name and address of the family member
  - a completed Health Care Provider Certification completed by the family member's treating physician

Qualifying Exigency

One of the following is required:

- ☐ a copy of the family member's active duty orders
- ☐ a letter of impending activation from the family member's commanding officer
- ☐ other documentation in circumstances where you are unable to produce the active duty orders or letter of impending activation. In addition, all claims must include the following:
  - ☐ a statement of the family relationship between the covered service member and you
  - ☐ the family member's name and address
  - ☐ the dates or period of time for which leave is requested
  - ☐ the underlying reason for the qualifying exigency
  - ☐ a completed attending physician statement

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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 ☐ Continuous
Approved leave period:	Annual salary:
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 physician.

This form should be completed by the treating physician 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 Leave for Family Care Giving include the following. Please check all that apply.

An illness, injury, impairment, or physical or mental condition of a Family Member that involves:

☐ Inpatient care in a hospital, hospice or residential medical facility; ☐ Continuing treatment or supervision by a Physician.

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: ☐ One to two days per month ☐ Two to three days per month ☐ Three to four days per month ☐ Other

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 Physician: _____ Date Signed: _____

Signature of Physician: _____ Type of Practice/Field of Specialization: _____

Phone Number: (with area code) _____

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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 confinement 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.