CONTINENTAL AMERICAN INSURANCE
Post Office Box 84075 * Columbus, GA. 31993
Phone (800) 433-3036 * Fax (866) 849-2970
groupclaimfiling@aflac.com

ACCELERATED DEATH BENEFIT CLAIM FORM INSTRUCTIONS

To avoid delays in processing of your claim form, complete each section attaching documentation below when it applies.

Supporting Documentation Needed

- ✓ Physician's information and signatures
- ✓ Attach medical records pertaining to diagnosis
- ✓ Sign and return attached Authorization to Obtain Information form.
- ✓ Email form to groupclaimfiling@aflac.com or fax to 1.866.849.2970.

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ACCELERATED DEATH BENEFIT CLAIM FORM

SECTION A- INSURED'S INFORMATION			
Name:	Policy/Certificate:	Date of Birth:	Social Security Number:
Address:		Phone: ☐ Cell ☐ Home ☐ Work	Email Address:
Occupation:	Current Illness:		Date of Diagnosis:

SECTION B-ATTENDING PHYSICIAN'S STATEMENT (To be completed by the attending physician)	
Name of Patient:	Patient ID Number:
Please state diagnosis.	ICD-10 Code:
Describe nature and cause of injury or condition.	Date symptoms first occurred.
Has patient had same or similar condition? ☐Yes ☐No	
If no, what are the contributing factors?	
List all dates of treatment:	
List all prescribed treatment:	
List present medications:	
Is patient hospitalized? ☐ Yes ☐ No If yes, give dates:	

Hospital Name (s):	**Address**	**City, State, Zip**	**Phone**
Name of Referring Physician (if applicable):	**Address**	**City, State, Zip**	**Phone**

Prognosis:
After a thorough, extensive medical review, I have concluded that _____ is terminally ill. The current life expectancy is _____ months.

Physician Information			
Physician's Name (Please Print):		Specialty:	
Address:	City, State, Zip:	Phone:	Fax:
Physician's Signature:			Date:

AUTHORIZATION

DISCLOSURE AUTHORIZATION **The following disclosure is made pursuant to the Fair Credit Reporting Act:**

Please be notified that, as a result of our regular claims investigation procedures, an investigative consumer report may be prepared, whereby information received from third parties is obtained from an independent inspection company. You have the right to make a written request within a reasonable period of time to receive detailed information about the nature and scope of this investigation.

Authorization:

I authorize any physician, medical practitioner, hospital, clinic or other medical or medically related facility, Veterans Administration or government agency to furnish all information and copies of records regarding health care or treatment provided me, including but not limited to, admitting records, hospital records, test records, findings and diagnostics. Such information and records shall be provided to a representative of the Claims Department of Aflac. Information obtained by this authorization is for use solely to determine my eligibility of insurance benefits. This authorization includeds information about drugs, alcoholism or mental illness.

I authorize my present or past employers (s) to supply information covering the status of my employment, job duties, days absent from work and training provided. This information may be provided to a representative of Aflac and is to be used solely to determine my eligibility of insurance benefits. Any information obtained will not be released by Aflac to any person or organization.

I further authorize Aflac to release all copies of medical records collected during its investigation to a second physician (and third, if required). I further authorize this statement to be copied and the copy utilized as if it were an original. I understand that upon request I have a right to obtain a copy of this authorization. I understand this authorization will remain valid for one year from the date of signature.

I understand failure to sign this authorization may delay payment of benefits.

Owner's signature:_____ Date:_____

SIGNATURES REQUIRED

I have read the statement on this form and concur with them. I am of sound mind and have advised my beneficiaries, the executor of my estate, and my attorney of my action and have instructed that I alone am responsible for seeking this benefit. If the Accelerated Death Benefit is advanced to me, my executor, assignees, beneficiaries and I agree to hold Aflac harmless and free from all liability for having advanced this death benefit.

Insured/Claimant signature:_____ Date:_____

Spouse signature:_____ Date:_____

(If a Community Property state, I hereby forever waive all community property right and claims to any funds paid pursuant to the Accelerated Death Benefit and agree that said check should be made payable to the owner).

Owner signature:_____ Date:_____

(if other than insured)

Joint Owner signature:_____ Date:_____

(if applicable)

Irrevocable Beneficiary signature:_____ Date:_____

(If applicable, I hereby forever waive all rights and claims to any funds paid pursuant to the Accelerated Death Benefit and agree that said check should be made payable to the owner.)

Notarized signature:_____ Date:_____

INSURED STATEMENT OF CLAIM-COMMUNICATION

CONSENT FOR USE OF ELECTRONIC COMMUNICATIONS (EMAIL, SMS/MMS)
To ensure the best and fastest communication, we would like to communicate with you using either email or text messaging. Please complete this section to authorization electronic communications regarding your claim, benefits, policy, premium or condition.

May we communicate with you electronically?
☐ No
☐ Yes, by Text Messages to (authorized cell phone number):
☐ Yes, by Email to (authorized email address):

When choosing to communicate electronically, you should be aware that electronic communications are not secure unless it is encrypted. We strongly encourage you to use encrypted communication when sending sensitive and/or confidential information. By sending sensitive or confidential electronic messages that are not encrypted, you accept the risks of absence of security and possible risk of confidentiality. If you choose to communicate from your workplace computer, you should be aware that your employer and its agents may have access to electronic communication between you and Aflac.

I understand by choosing text messaging, regular test messaging rates may apply for any texts I receive from Aflac. I assume responsibility for any costs associated with these text messages. This consent shall remain in effect unless revoked in writing.

To ensure a smooth email experience, ensure your computer has the most recent version of Adobe Reader. Add our email address to your address book contact list and to your email server or spam filter's approved list. If you do not see an email from us in your email inbox, check your spam, clutter, junk or bulk email folders. You can choose to stop electronic communication at any time by revoking this authorization in writing. If you no longer wish to communicate through electronically, we will correspond with you by US mail. If you require copies of any communication sent to you by email/text in paper form, you may contact us 1.866.849.2970.There is no cost to obtain copies of electronic communication in paper format.

AUTHORIZATION

I may revoke or update this authorization in writing at any time or by email to groupclaimfiling@aflac.com. Aflac may rely on the information I provide for the adjudication of my claim as a result of this authorization until receipt of my revocation notice. This authorization is valid for two (2) years. I may request a copy of this authorization and a copy is as valid as the original.

Policy Owner signature:_____ Date:_____

Printed Name:_____ Social Security Number:_____

INSURED STATEMENT OF CLAIM-COMMUNICATION (CONTINUED)

THIRD PARTY COMMUNICATION AUTHORIZATION
Complete this authorization if you would like us to discuss, to release or to provide information to a family member, friend or other third party such as your agent or employer.

My Spouse or Partner: (Name):
☐ All Information (All policy and claim information)
☐ All information ***EXCEPT*** Medical Information (diagnosis, medical condition, reason for claim, treatment, physicians)

My Family Member (Name and Relationship)
☐ All Information (All policy and claim information)
☐ All information ***EXCEPT*** Medical Information (diagnosis, medical condition, reason for claim, treatment, physicians)

Other Third Party
☐ My Agent (Name):
☐ My Employer (Name):
☐ Other Third Party (Name and Relationship):
☐ All Information (All policy and claim information)
☐ All information ***EXCEPT*** Medical Information (diagnosis, medical condition, reason for claim, treatment, physicians)

I agree that if I authorize release of all claim information this may include healther information which may be related to disorders of the immune system including but not limited to HIV and AIDS, use of alcohol or drugs, mental and physical condition, history or treatment.

I understand that any information shared may be subject to re-disclosure and might not be protected by certain federal regulations governing the privacy of health information relative to my condition.

AUTHORIZATION

I may revoke or update this authorization in writing at any time or by email to groupclaimsfiling@aflac.com.
Aflac may rely on this information I provide for the adjudication of my claim as a result of this authorization until receipt of my revocation notice. This authorization is valid for two (2) years. I may request a copy of this authorization and a copy is valid as the original.

Policy Owner Signature:_____ Date:_____

Printed Name:_____ Social Security Number:_____

CONTINENTAL AMERICAN INSURANCE
Post Office Box 84075 * Columbus, GA. 31993
Phone (800) 433-3036 * Fax (866) 849-2970
groupclaimfiling@aflac.com

AUTHORIZATION TO OBTAIN INFORMATION

MAIL TO: Continental American Insurance Company
P.O. Box 84075
Columbus, Georgia 31993

CALL: 1.800.433.3036 (toll-free)
CLAIM FAX: 1.866.849.2970

Primary Certificateholder's Name:	**SSN**(optional):	**Date of Birth:**
Certificate Number(s):		
Address:		
Name of Individual Subject to Disclosure (If not the primary Certificateholder):		**Date of Birth:**
Relationship to Primary Certificateholder: ☐ Self ☐ Spouse ☐ Domestic Partner ☐ Child ☐ Stepchild ☐ Grandchild		

I. Authorization:
For the purpose of evaluating my *eligibility for insurance and for benefits* under an existing certificate, including checking for and resolving any issues that may arise regarding incomplete or incorrect information on my application for coverage and/or claim form, I hereby authorize the disclosure of the following information(defined below) about me and, if applicable, my dependents, from the sources listed below to Continental American Insurance Company (CAIC), or any person or entity acting on its part, to include American Family Life Assurance Company of Columbus and American Family Life Assurance Company of New York (collectively, "Aflac).

II. Disclosure of Health Information:
Health information may be disclosed by any health care provider, health plan (including CAIC or Aflac, with respect to other CAIC or Aflac coverages) or health care clearinghouse that has any records or knowledge about me. Health care provider includes, but is not limited to, any licensed physician, medical or nurse practitioner, nurse, pharmacist, osteopath, psychologist, physical or occupational therapist, chiropractor, dentist, audiologist or speech pathologist, podiatrist, hospital, medical clinic or laboratory, pharmacy, rehabilitation facility, nursing home or extended care facility, prescription drug database or pharmacy benefit manager, or ambulance or other medical transport service. Health information may also be disclosed by any insurance company or the Medical Information Bureau (MIB). Health information includes my entire medical record, but does not include psychotherapy notes. Some information obtained may not be protected by certain federal regulations governing the privacy of health information, but the information is protected by state privacy laws and other applicable laws. CAIC will not disclose the information unless permitted or required by those laws.

III. Rights and Expiration:
I understand that I may revoke this authorization at any time, except to the extent that CAIC or Aflac has taken action in reliance on this authorization. If I revoke this authorization, CAIC may not be able to evaluate my application for coverage and/or claim. To revoke this authorization, I must provide a written and signed revocation to CAIC at the address or fax number above. Unless otherwise revoked, this authorization shall remain in effect for two (2) years from the date signed or upon my death, whichever occurs first. I agree that a copy of this authorization is as valid as the original and that I or an authorized representative may request a copy of this authorization.

IV. Notice:
I understand that CAIC is not conditioning payment, enrollment, or eligibility for benefits on whether I sign this authorization. I understand that if the information disclosed is protected health information relating to a health plan and the person or entity receiving the information is a not a health care provider or health plan covered by federal privacy regulations, the information disclosed may be redisclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.

- **If records are on an adult dependent, (e.g. spouse, child over 18), the dependent must sign this form**
- **If records are on a minor child the natural parent or legal guardian must sign on their behalf.**

_____ _____
Signature of Individual Subject to Disclosure Date Signed

_____ _____ _____ _____
Legal Representative's Printed Name Legal Representative's Signature Legal Relationship Date Signed

If signed by a legal representative (e.g. Legal Guardian, Estate Administrator, Power of Attorney)

Electronic Funds Transaction Authorization

Send to: **Continental American Insurance Company**
Post Office Box 84075
Columbus, Georgia 31993

Phone: (800) 433-3036 Fax (866) 849-2970
Email: groupclaimfiling@aflac.com

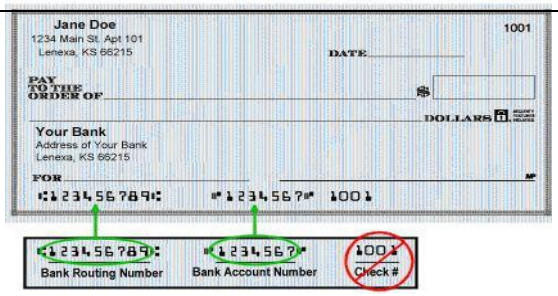
Authorization Agreement for Direct Deposit

I would like to: ☐ Start ☐ Stop ☐ Change direct deposit of my claim payment(s).

Account Type:

☐ Checking ☐ Savings

****** Please provide a blank voided check or direct deposit form from your financial institution. Incomplete or inaccurate information will not be processed.**



9-Digit Routing Number:		Account Number:
Name of Financial Institution:		
Address:		City:
State:	Zip:	Phone:

I authorize Continental American Insurance Company (CAIC) to initiate credit entries, and, if errors occur, I authorize the correction of entries to my account as indicated. This authorization remains effective and in full force until CAIC receives written notification from me of its termination in such time and in such manner to afford CAIC a reasonable opportunity to act on it. Please notify CAIC immediately if your financial institution information has changed by sending notification to the address indicated above. Should you have any questions, please contact us at 1-800-433-3036.

Policy/Certificate Holder's Name (*Print*):	
Address:	City/State/Zip:
Phone #:	E-mail Address:
Employer Name or Group #:	Certificate #:

****By providing your e-mail address above, you consent to the use of electronic transactions in connection with your CAIC policies, contracts, and/or accounts to the extent available and permitted by law (which may include, but not limited to: invoices, claim correspondence, contracts, surveys, and other materials that CAIC is, or may be, legally required to deliver to you)*

Note: Forms received without signature will not be processed. Electronic signatures not accepted.

Policy/Certificate Holder Signature *(Required)* **Date Signed:**

Continental American Insurance Company (CAIC), a proud member of the Aflac family of insurers, is a wholly-owned subsidiary of Aflac Incorporated and underwrites group coverage. Aflac is not licensed to solicit business in New York, Guam, Puerto Rico, or the Virgin Islands. For groups situsedin California, coverage is underwritten by Continental American Life Insurance Company. For groups situsedin New York, coverage is underwritten by American Family Life Assurance Company of New York.
Continental American Insurance Company • 1600 Williams St • Columbia, South Carolina 29201 • 1-800-433-3036 toll-free • 1-866-849-2970 fax

FRAUD WARNING NOTICES

For use with Claim Forms

PLEASE READ THE FRAUD WARNING NOTICE FOR YOUR STATE

ALASKA: A person who knowingly and with intent to injury, defraud or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.	**IDAHO:** Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.
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.	**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.
ARKANSAS: 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.	**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.
CALIFORNIA: For your protection California law requires the following to appear on this form: Any person who knowingly presents a 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.	**LOUISIANA:** 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.
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.	**MAINE:** 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 and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
DELAWARE: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.	**MINNESOTA:** A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilt of a crime.
DISTRICT OF COLUMBIA: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.	**NEW HAMPSHIRE:** Any person who, with a purpose toinjure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, ormisleading information is subject to prosecution andpunishment for insurance fraud, as provided in RSA638:20.
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.	**NEW JERSEY:** Any person who knowingly files astatement of claim containing any false or misleading information is subject to criminal and civil penalties.

FRAUD WARNING NOTICES (CONT.)

For use with Claim Forms

PLEASE READ THE FRAUD WARNING NOTICE FOR YOUR STATE

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.	**TENNESSEE:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.
NEW YORK: 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.	**TEXAS:** Any person who knowingly presents a 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.
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.	**VIRGINIA**: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.
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.	**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 include imprisonment, fines, and denial of insurance benefits.
OREGON: 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 may be guilty of insurance fraud.	**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.
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.	**ALL OTHER STATES:** 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 with the penalty of 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 are 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.	