American Fidelity Assurance Company
A member of the American Fidelity Group
www.afadvantage.com

Benefits Division
ATTN: Disability Dept.
P.O. Box 25160
Oklahoma City, OK 73125
405-523-5025 - Local
1-800-662-1113 - Watts
1-800-818-3453 - Toll-free Fax

STATEMENT OF CLAIMANT
For Physician Expense For Injury or Sickness Only
(Do NOT use this form when filing for disability)

Name_____ Date of Birth_____ AFA Account #_____
(Policyholder)

Residence Address_____ Social Security No._____
(Street) (Town) (State) (Zip)

Mailing Address_____
(Street) (Town) (State) (Zip)

I am employed at_____
(Employer) (Address) (City) (State) (Zip)

Telephone No. Home_____ Work_____ Occupation_____

1. Date accident or illness began	_____
2. Nature of illness or accident	_____
3. Was accident or illness work related?	Yes ❑ No ❑
4. If accident, where and how did it happen? (Explain fully)	_____ _____ _____
5. Dates of all Treatment What date(s) were you unable to work a full day?	Office_____ Hospital_____ Admit. Date:_____ Discharge Date:_____
6. Were you scheduled to work on the day of medical treatment? If yes, were you totally disabled and unable to work one full day on the date of medical treatment?	Yes ❑ No ❑ If no Explain (semester break, holiday, week-end, etc.): Yes ❑ No ❑ Date unable to work _____

PLEASE ATTACH DIAGNOSIS AND ITEMIZED CHARGES FROM THE DOCTOR

Warning: 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 may be guilty of insurance fraud and subject to criminal and civil penalties.

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize the entities specified below to disclose any information about my entire medical record or benefits payable for this disability and history of treatment for physical and/or emotional illness to include psychological testing except psychotherapy notes, to individuals representing American Fidelity Assurance Company (AFAC), 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; 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; and k) Workers' Compensation Carrier.

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. This authorization excludes disclosure of the result of a test for HIV if you have tested HIV positive but have not developed symptoms on the disease AIDS. Such test results shall not be discovered or published. Nothing in the caveat will prohibit this authorization from including the fact that you have AIDS.

I understand that I may refuse to sign this authorization; however, if I do not sign the authorization, my failure to sign may result in a denial or a delay of benefits. I understand that I may revoke this authorization at any time by writing to AFES Benefits Department, PO Box 25160, Oklahoma City, OK 73125-0160 or by calling, toll-free, 1-800-662-1113. I understand that my right to revoke this authorization is limited to the extent that: AFAC has taken action in reliance on the authorization; or, the law provides AFAC 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 the federal privacy regulations.

For health insurance coverage this authorization will expire twenty-four months from the date it is signed or upon 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.

_____ _____
Signature (Patient) or Personal Representative (if applicable) Printed Name (Patient)

_____ _____
Relationship of Personal Representative to Patient Date
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.