

**CONTINENTAL AMERICAN INSURANCE COMPANY**

Post Office Box 84075 \* Columbus,  
GA. 31993 Phone (800) 433-3036 \*  
Fax (866) 849-2970



**SHORT TERM DISABILITY CLAIM FORM INSTRUCTIONS**

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

Note: This form is for initial filing of a disability claim. If your disability is being extended, you will need to complete the listed Supplemental Claim form.

Supporting Documentation Needed

- ✓ Chart Note to include admission and discharge paperwork if there was a hospital stay
- ✓ Surgical Report if surgery took place
- ✓ Receipts for follow up visits or physical therapy with dates and charges if applicable
- ✓ Email form to [groupclaimfiling@aflac.com](mailto:groupclaimfiling@aflac.com) or fax to 1.866.849.2970.

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**SHORT TERM DISABILITY CLAIM FORM**

**\*Please attach paperwork for any additional income you are receiving during this period of disability.\***

**\*\*Please sign and return the attached Authorization.**

**PART A: POLICYHOLDER'S STATEMENT (FORMS ARE TO BE COMPLETED ON OR AFTER DISABILITY DATE TO AVOID PROCESSING DELAYS)**

POLICY HOLDER'S NAME		POLICY/CERTIFICATE NUMBER		SOCIAL SECURITY/ ID		DATE OF BIRTH		GENDER		
POLICY HOLDER MAJOR MEDICAL INSURANCE PROVIDER						POLICY HOLDER MAJOR MEDICAL ID#				
POLICY HOLDER'S ADDRESS, CITY, STATE, ZIP						Check Box if This is a Permanent Address Change				
PHONE NUMBER (Please include area code)										
E-MAIL ADDRESS				*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 delivery to you)						
EMPLOYERNAME					OCCUPATION					
IS YOUR ACCIDENT OR SICKNESS RELATED TO YOUR OCCUPATION? YES NO					HAS A WORKER'S COMPENSATION CLAIM BEEN FILED? YES NO					
DATE REPORTED TO YOUR EMPLOYER					STATUS APPROVED PENDING DENIED					
DATE SYMPTOM FIRST APPEARED					IF DENIED, HAS AN APPEAL BEEN FILED? YES NO					
TREATING PHYSICIAN NAME		ADDRESS								
IF HOSPITALIZED: (NAME/ADDRESS)										
DATES HOSPITALIZED										
PLEASE PROVIDE DESCRIPTION OF SICKNESS OR INJURY										
DATES YOU DID NOT WORK AT ALL			DATES YOU WORKED LESS THAN FULL TIME.				DATE YOU RETURNED OR EXPECT TO RETURN TO WORK.			
FROM		THROUGH		FROM		THROUGH		FULL-TIME		PART-TIME
PRIMARY DOCTOR NAME			TREATING DOCTOR NAME				REFERRING DOCTOR NAME			
ADDRESS, CITY, STATE, ZIP CODE			ADDRESS, CITY, STATE, ZIP CODE				ADDRESS, CITY, STATE, ZIP CODE			
PHONE NUMBER			PHONE NUMBER				PHONE NUMBER			
<b>AUTHORIZATION</b>										
<p>Several states require that the following statement appear on the claim forms:                  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.</p> <p>For the purpose of evaluating my <i>eligibility for insurance and eligibility for benefits</i> under an existing policy/certificate including checking for and resolving any issues that may arise regarding incomplete or incorrect information on my application or claim form, I hereby authorize the disclosure of the following information about me and, if applicable, my dependents, from the sources listed below to Continental American Insurance Company (CAIC) and its duly authorized representatives.</p> <p><b>Disclosure of Health Information</b>                  Health information may be disclosed by any health care provider, health plan 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.</p> <p>Financial or credit history, earnings, or employment history may be disclosed by any entity, person or organization that has these records about me, including but not limited to my employer, employer representative and compensation sources, insurance company, financial institution or any consumer reporting agency.</p> <p>Federal, state and local government organizations including but not limited to the Veteran's Administration, Internal Revenue Service, Social Security Administration, Medicare or Medicaid agencies, may disclose health or financial information or records about me.</p> <p>Any information CAIC obtains pursuant to this authorization will be used for the purpose of evaluating and administering my claim for benefits. 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.</p> <p>This authorization is valid for two (2) years from its execution or the duration of my claim, whichever is later. A copy of this authorization is as valid as the original. I know that I or my authorized representative may request a copy of this authorization and access to this information.</p> <p>This authorization may be revoked by me or my authorized representative at any time except to the extent CAIC has relied on the authorization prior to notice of revocation or has a legal right to contest coverage under the contract or the contract itself. If I revoke this authorization, CAIC may not be able to evaluate my claim or eligibility for benefits. I may revoke this authorization by sending written notice to: Continental American Insurance Company, Claims Department, and P.O. Box 84075, Columbus, Georgia 31993.</p> <p>You may refuse to sign this form; however, CAIC may not be able to evaluate and administer your claim without this authorization.                  I am the individual to whom this authorization applies or that person's legal Guardian, Power of Attorney Designee, Conservator, Beneficiary or personal representative.</p>										
<b>POLICYHOLDER'S SIGNATURE:</b>						<b>DATE:</b>				

Post Office Box 84075 \* Columbus, GA. 31993

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



### SHORT TERM DISABILITY CLAIM FORM

**PART B: EMPLOYER'S STATEMENT: (To be completed by your Benefits Department unless self-employed)**

EMPLOYEE'S NAME	EMPLOYEE ID NUMBER	DATE OF BIRTH	DATE OF HIRE
OCCUPATION AT TIME LAST WORKED: _____ EMPLOYEE'S JOB TITLE DUTIES: (Please mark selection in each category)			
<b>LIFTING</b> LESS THAN 15LBS      15 TO 44      OVER 45 <b>REPETITIVE</b> NONE      SELDOM      FREQUENT <b>REACHING/PULLING/PUSHING</b> NONE      SELDOM      FREQUENT SITTING (NUMBER OF HOURS EACH DAY)	<b>STOOPING/BENDING</b> NONE      SELDOM      FREQUENT <b>CRAWLING/CLIMBING/KNEELING</b> NONE      SELDOM      FREQUENT <b>MANAGEMENT DUTIES</b> NONE      SELDOM      FREQUENT STANDING/WALKING (HOURS EACH DAY)		
DATE EMPLOYEE WAS ACTUALLY LAST PRESENT AT WORK?		WORK SCHEDULE AT TIME LAST WORKED:	
DATES EMPLOYEE DID NOT WORK AT ALL		DATES EMPLOYEE WORKED LESS THAN FULL-TIME HOURS	
FROM _____ THROUGH _____		FROM _____ THROUGH _____	
DATE THE EMPLOYEE RETURNED TO FULL-TIME WORK		IF THE EMPLOYEE HAS NOT RETURNED, IS LIGHT DUTY AVAILABLE? YES NO	
LIGHT DUTY/PART-TIME		IF THE EMPLOYEE RETURNED TO WORK LIGHT DUTY/ PART TIME PLEASE PROVIDE HOURS WORKED AND EARNINGS	
DID THE CLAIM RESULT FROM JOB ACTIVITY?		HAS A WORKER'S COMPENSATION CLAIM BEEN FILED?	
HAS THE EMPLOYEE RECEIVED ANY OTHER INCOME AS A RESULT OF DISABILITY? NO YES		NO YES <b>STATUS</b> APPROVED      PENDING      DENIED	
SALARY CONTINUANCE, SICK PAY VACATION WEEKLY BENEFIT:      DATE CEASED		IF DENIED, HAS AN APPEAL BEEN FILED? YES NO	
IS ANY PORTION OF THE EMPLOYEE'S POLICY PAID FOR BY THE EMPLOYER? NO YES		IS THE EMPLOYEE'S POLICY PAID FOR WITH PRE-TAX DOLLARS (SECTION 125)? NO YES	
		WHAT ARE THE EMPLOYEE'S BASIC MONTHLY EARNINGS? IF WORKING THE EMPLOYEE IS WORKING LIGHT DUTY OR PART-TIME, PLEASE PROVIDE EARNINGS AND HOURS WORKED	
<b>AUTHORIZED EMPLOYER'S SIGNATURE</b>			
EMPLOYER'S COMPANY NAME		TELEPHONE NUMBER	FAX NUMBER
ADDRESS		NAME AND TITLE OF PERSON COMPLETING THIS FORM	
SIGNATURE OF AUTHORIZED EMPLOYER REPRESENTATIVE		DATE	

\* IF SELF-EMPLOYED, PLEASE SUBMIT 1099 FORM FOR VERIFICATION

\* IF EMPLOYEE IS RECEIVING ANY OTHER INCOME, PLEASE SPECIFY TYPE AND AMOUNT OF INCOME



**SHORT TERM DISABILITY CLAIM FORM**

**PART C: ATTENDING PHYSICIAN'S STATEMENT (To be completed by physician certifying disability on or after disability date to avoid processing delays)**

PATIENT'S NAME		DATE OF BIRTH
DATE PATIENT BECAME DISABLED DUE TO PRESENT DIAGNOSIS	WHEN DID SYMPTOMS FIRST APPEAR OR ACCIDENT OCCUR?	HAS THE PATIENT EVER HAD SAME OR SIMILAR CONDITION/ DIAGNOSIS? YES NO
IS THIS A WORKER'S COMPENSATION INJURY? YES NO	DATE	NAMES/ADDRESSES ANY ADDITIONAL PHYSICIAN TREATING PATIENT FOR CURRENT DIAGNOSIS
<b>DIAGNOSIS</b> (INCLUDING COMPLICATIONS)	ICD CODE (S)	SUBJECTIVE SYMPTOMS  <b>OBJECTIVE FINDINGS</b> (INCLUDING CURRENT X-RAYS, EKG'S, LABORATORY DATA AND ANY CLINICAL FINDINGS.)

**DIAGNOSIS**

<b>PREGNANCY</b>	<b>DATE OF DELIVERY</b>	<b>METHOD OF DELIVERY</b>	PLEASE LIST ANY PREGNANCY COMPLICATIONS
EDC _____  LMP _____		VAGINAL  CESAREAN	

**TREATMENT**

DATE FIRST TREATED FOR THIS CONDITION	LAST DATE TREATED FOR THIS CONDITION
NATURE OF TREATMENT (SURGERY AND MEDICATIONS PRESCRIBED, IF ANY.)	DID PATIENT HAVE SURGERY? YES NO IF YES, <b>DATE OF SURGERY</b> <b>TYPE OF SURGERY:</b>
HAS THE PATIENT RECOVERED RETROGRESSED UNCHANGED IMPROVED	IS THE PATIENT AMBULATORY HOUSE CONFINED BED CONFINED HOSPITAL CONFINED
IF CONFINED TO HOSPITAL, PLEASE PROVIDE DATES CONFINED FROM: TO:	NAME AND ADDRESS OF HOSPITAL: (IF CONFINED)
WHEN DO YOU EXPECT A FUNDAMENTAL CHANGE IN THE PATIENT'S CONDITION? (Please circle selection) 1 MO. 1-3 MO. 3-6 MO. 6-9 MO. 9-12 MO. NEVER	WHEN DO YOU ANTICIPATE A RETURN TO WORK FULL DUTY <u>WITHOUT RESTRICTIONS</u> ?
WHEN COULD A TRIAL EMPLOYMENT COMMENCE? (IF PATIENT RELEASED TO RETURN TO WORK WITH RESTRICTIONS) DATE (PATIENT'S JOB):  <b>CAPACITY:</b> FULL-TIME PART-TIME LIGHT DUTY	

**PHYSICAL IMPAIRMENTS (AS DEFINED IN THE FEDERAL DICTIONARY OF OCCUPATIONAL TITLES)**

CLASS 1 – NO LIMITATION OF FUNCTIONAL CAPACITY; CAPABLE OF HEAVY WORK. NO RESTRICTIONS (0-10%)  
 CLASS 2 – MEDIUM MANUAL ACTIVITY. (15-30%)  
 CLASS 3 – SLIGHT LIMITATION OF FUNCTIONAL CAPACITY; CAPABLE OF LIGHT WORK. (35-55%)  
 CLASS 4 – MODERATE LIMITATION OF FUNCTIONAL CAPACITY; CAPABLE OF CLERICAL/ADMINISTRATIVE (SEDENTARY) ACTIVITY. (60-70% (75-100%)  
 CLASS 5 – SEVERE LIMITATION OF FUNCTIONAL CAPACITY; INCAPABLE OF MINIMUM (SEDENTARY) ACTIVITY

**RESTRICTIONS AND LIMITATIONS: (What specific activities/ work duties is the patient incapable of performing)**

**REMARKS:** (Additional comments regarding the patient's condition)

NAME: (ATTENDING PHYSICIAN)	FAX NUMBER	TELEPHONE NUMBER	MEDICAL ID NUMBER
PHYSICIAN ADDRESS, CITY, STATE, ZIP CODE			

**AUTHORIZED SIGNATURE OF PHYSICIAN**

"I hereby certify that the above described information is based upon reasonable medical probability, and is true and correct to the best of my knowledge and belief."

<b>SIGNATURE</b>	<b>DATE</b>
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**FRAUD WARNING NOTICES**

For use with Claim Forms

**PLEASE READ THE FRAUD WARNING NOTICE FOR YOUR STATE**

<b>ALASKA:</b> 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.	<b>IDAHO:</b> 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.
<b>ARIZONA:</b> 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.	<b>INDIANA:</b> 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.
<b>ARKANSAS:</b> 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.	<b>KENTUCKY:</b> 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.
<b>CALIFORNIA:</b> 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.	<b>LOUISIANA:</b> 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.
<b>COLORADO:</b> 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 <u>regulatory agencies</u> .	<b>MAINE:</b> 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.
	<b>MARYLAND:</b> 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.
<b>DELAWARE:</b> 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.	<b>MINNESOTA:</b> A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.
<b>DISTRICT OF COLUMBIA: WARNING:</b> 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.	<b>NEW HAMPSHIRE:</b> 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 RSA638:20.
<b>FLORIDA:</b> 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.	<b>NEW JERSEY:</b> Any person who knowingly files a statement 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**

<p><b>NEW MEXICO:</b> 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.</p>	<p><b>TENNESSEE:</b> 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.</p>
<p><b>NEW YORK:</b> 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 <u>value of the claim for each such violation.</u></p>	<p><b>TEXAS:</b> 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 <u>instate prison.</u></p>
<p><b>OHIO:</b> 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.</p>	<p><b>VIRGINIA:</b> 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.</p>
<p><b>OKLAHOMA: WARNING:</b> 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 <u>is guilty of a felony.</u></p>	<p><b>WASHINGTON:</b> 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.</p>
<p><b>OREGON:</b> 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 <u>deceptive statement may be guilty of insurance fraud.</u></p>	<p><b>RHODE ISLAND and WEST VIRGINIA:</b> 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 <u>crime and may be subject to fines and confinement in prison.</u></p>
<p><b>PENNSYLVANIA:</b> 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.</p>	<p><b>ALL OTHER STATES:</b> 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.</p>
<p><b>PUERTO RICO:</b> 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.</p>	



## HIPAA-AUTHORIZATION TO OBTAIN INFORMATION

**Send to:**

Continental American Insurance Company  
Post Office Box 84075  
Columbus, GA 31993

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

<b>Primary Certificate Holder Name:</b>	<b>SSN(optional):</b>	<b>Date of Birth:</b>	
<b>Certificate Number(s):</b>			
<b>Address:</b>	<b>City:</b>	<b>State:</b>	<b>Zip:</b>
<b>Name of Individual Subject to Disclosure (If not the primary Certificate Holder):</b>		<b>Date of Birth:</b>	
<b>Relationship to Primary Certificate Holder:</b> <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> 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 re-disclosed 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.**

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Signature of Individual Subject to Disclosure Date Signed

---

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

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



# Electronic Funds Trans action Authorization

Mail To: Continental American Insurance Company

PO Box 84075, Columbus, GA 31993

Phone: 800.433.3036 Fax: 866.849.2970

Email: groupclaimfiling@aflac.com

**Important: Do not** complete this form if your policy number has both letters and numbers (e.g. 0Y123B45). Policies containing both letters and numbers are administered by Aflac and not Aflac Group (CAIC). Direct deposit registration for Aflac is located at <https://phs.aflac.com/aflac.phs.app/account/login>. Aflac Group (CAIC) cannot process direct deposit requests for Aflac.

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 ( <i>Print</i> ):		
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 situated in California, coverage is underwritten by Continental American Life Insurance Company. For groups situated in 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