American Fidelity Assurance Company
A member of the American Fidelity Group

www.afadvantage.com
Local Phone # **(405) 523-5025**
Toll Free # **(800) 662-1113**
Fax Toll Free # **(800) 818-3453**

ACCIDENT ONLY WELLNESS BENEFIT
RETURN THIS BENEFIT FORM AND ATTACHMENTS TO:
AMERICAN FIDELITY ASSURANCE COMPANY
American Fidelity Educational Services
ATTN: BENEFITS DEPARTMENT
P.O. BOX 25160
OKLAHOMA CITY, OK 73125

INSTRUCTION TO INSURED

1. Complete **STATEMENT OF INSURED**
2. Please attach **bill, receipt, or evidence of the test**
3. **Be sure to include your account number or Social Security number on all documents.**

STATEMENT OF INSURED

1. INSURED FULL NAME_____ Account No. _____
(Please Print) (Last) (First) (M.I)

Date of Birth _____/_____/_____ Insured Social Sec. # _____-_____-_____
(MO) (Day) (YR)

2. Address _____
(Street) (City) (State) (Zip Code)

3. If claim is for dependent, give name of dependent_____ Relationship_____

Date of Birth _____/_____/_____
(Mo) (Day) (YR)

AA. WELLNESS BENEFIT: After coverage has been in force for 12 months if, due to routine examinations or preventive testing, you or any other Covered Person has an annual physical exam, including immunization(s), we will pay the amount shown in the Schedule of Benefits. This benefit does not cover dental exams or eye exams. The amount shown in the Schedule of Benefits is the total amount that will be paid for this benefit once per Calendar Year per policy. Services must be under the supervision of a Physician and a charge must be incurred for the service.

MAIL TO:
American Fidelity Assurance Company
American Fidelity Educational Services
Attn: Benefits Dept - Supplemental Medical Claim
P.O. Box 25160
Oklahoma City, OK 73125-0160

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.

For Residents of California
Warning: For your protection California 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.

For Residents of Pennsylvania:
Warning: Any person who knowingly and with intent to defraud any insurance company or other people files an application for insurance or statment 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.

For Residents of Florida:
Warning: 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.

For Residents of Arizona:
Warning: 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.