USE FOR REIMBURSEMENT OF **IN HOSPITAL, OUTPATIENT & OFFICE VISITS UNDER MEDICAL GAP POLICY**

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

Medical/Supplement Dept.
ATTN: BENEFITS DIVISION
P.O. Box 25160
Oklahoma City, Oklahoma 73125-0160
Outside OK 1-800-662-1113
Local 523-5025
Fax 1-800-818-3453

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.

1. Complete statement of Insured.
2. Attach itemized charges with diagnosis.
3. ALL hospital charges, also submit EOB's from medical carrier.

STATEMENT OF INSURED

A. ABOUT YOU

Insured's Last Name | First Name | Initial | Date of Birth I I | Account Number

Insured's Address (City, State, Zip) | Insured's Social Security Number

Employer-Name/Address | Home Telephone #

B. ABOUT THE PATIENT

PATIENT INFORMATION (CHECK ONE)

FOR WHOM DO YOU MAKE THIS REQUEST? ☐ SELF ☐ WIFE ☐ HUSBAND ☐ SON ☐ DAUGHTER ☐ OTHER_____ IDENTIFY

Patient's Name | Patient's Birth Date | Patient's Social Security No.

If Claim is for a Dependent Child Under 19 is Such Child Living in Your Household? Yes ☐ No ☐

If Dependent Child is between age 19 and 23 years old is he/she a full-time student? Yes ☐ No ☐

If student:
Name of school _____
_____
Phone # of school _____

C. ABOUT THE CLAIM

Did the condition result from employment?_____yes_____no
If yes, are you filing or will you be filing for Worker's Compensation?_____yes_____no

If claim is due to an injury, explain how, where and when it happened.

Was treatment provided within 72 hours of injury?

If claim is due to an illness, give date of onset and nature of illness.

Have you had symptoms or treatment for this condition before?_____yes_____no If yes, when?

Give names, addresses and phone numbers of doctors consulted in the last 24 months.

D. HOSPITAL BENEFITS

Please ask your physician to complete the back of this form if you or your dependent incurred hospital expenses.

Have you been confined to a hospital? _____ yes _____ no

If so, when? From _____ to _____.
Name and address of hospital:

E. ABOUT THE INFORMATION RELEASE

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize the entities specified below to disclose any information about me or my dependents' health including my or my dependents' entire medical record 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. Colorado state law prohibits the redisclosure or reuse of information disclosed about a Colorado resident under this authorization.

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. For Maine residents, information authorized for release may include information on communicable or venereal diseases such as hepatitis, syphilis, gonorrhea, AIDS/ARC (Acquired Immune Deficiency Syndrome /AIDS Related Complex) 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 of the disease AIDS. Such test results shall not be discovered or published. Nothing in this caveat will prohibit this authorization from including the fact that you have AIDS. For Vermont residents, this authorization does not require disclosure of prior HIV-related tests. For Wisconsin residents, results of AIDS/HIV test do not need to be reported if they were done at any anonymous counseling and testing site, if the test was not an FDA-licensed blood test, or through the use of a home test kit. For Arizona residents, release of HIV/AIDS-related information can only be disclosed for a period not to exceed 180 days from the date shown below.

I understand that I may refuse to sign this authorization; however, if I do not sign the authorization, my failure to sign the authorization 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) | Date of Birth

_____
Relationship of Personal Representative to Patient | AFA Account# | 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 rquest a copy from our Company.

USE FOR
REIMBURSEMENT OF
IN HOSPITAL BENEFITS

Medical/Supplement Dept.
ATTN: BENEFITS DIVISION
P.O. Box 25160
Oklahoma City, Oklahoma 73125-0160
Outside OK 1-800-662-1113
Local 523-5025

The Attending Physician's Statement is required only when you or your dependent incur inpatient or outpatient hospital expenses.

ATTENDING PHYSICIAN'S STATEMENT

Warning: Any person who knowingly, and with intent to injure, defraud, or decieve 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.

1. Patient's name

   Date of Birth

2. Nature of sickness or injury

   ICDA9 Code:

3. When did symptoms first appear or accident happen? Date:

4. When did patient first consult you for this condition? Date:

5. Has patient ever had same or similar condition? Yes _____ No _____
   (If "Yes" state when and describe)

6. Was the patient referred to you by another physician? Yes _____ No _____
   If so, list name and address:
   Name:

   Address:

7. If patient hospitalized, give name and address of hospital.

   Admitted: _____ Discharged: _____
   Hospital name:

   Date: _____ Signed: _____
   (Attending Physician)

   TIN #: _____ _____
   (Street Address)

   _____
   (City or Town)

   _____
   (State) (Zip)

   Phone Number ( ) _____
   area code