American Fidelity Assurance Company
A member of the American Fidelity Group

Local Phone # 405-523-5025
Toll Free # 1-800-662-1113
Fax # 1-800-818-3453
www.afadvantage.com

SPOUSAL DISABILITY RIDER

AMERICAN FIDELITY EDUCATIONAL SERVICES
BENEFITS DEPARTMENT
P.O. Box 25160
Oklahoma City, OK 73125

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.

INSTRUCTIONS TO INSURED AND SPOUSE

1. Complete STATEMENT OF INSURED. 2. Statement of Spouse 3. Ask your physician to complete the ATTENDING PHYSICIAN'S STATEMENT.

SECTION 1- STATEMENT OF INSURED

1. Full Name _____ Date of Birth ____/____/____ Account No. _____
   Please Print (Last) (First) (M.I.) (Mo) (Day) (YR)

2. Address _____ Social Security No. _____
   (Street) (City) (State) (Zip Code)

3. Telephone number Work _____ Home _____ Employer _____

SECTION 2- COMPLETE STATEMENT OF SPOUSE

1. Patient Information- Spouse Full Name _____ Spouse SS# _____ Date of Birth: _____
   Last First MI (Mo) (Day) (YR)

2. Spouse's employer _____ Address _____ Telephone # _____

3. Illness Condition _____

4. Date accident or illness began: _____ _____ 5. Have you been confined to a hospital? ❑ Yes ❑ No

6. Have you ever had the same or similar condition in the past? ❑ Yes ❑ No

7. If yes, names and addresses of all treating physicians and/or hospitals: _____

_____

8. "Activities of Daily Living" means the basic human functions required for the spouse to remain independent.

	Can Perform	Cannot Perform	Dates Unable to Perform
(a) Continence: Maintaining control of bladder and/or functions of the bowel, including the ability to use ostomy supplies or other devices such as catheters;	a _____	_____	From_____To_____
(b) Transferring: Moving between the bed and the chair; or the bed and a wheelchair, with or without assistive device;	b _____	_____	From_____To_____
(c) Dressing: Putting on and taking off all necessary items of clothing; and/or medically necessary braces and artificial limbs usually worn;	c _____	_____	From_____To_____
(d) Toileting: Getting to and from the toilet; getting on and off the toilet; and performing associated personal hygiene; and	d _____	_____	From_____To_____
(e) Eating: Performing all major tasks of getting food into the body, with or without assistive device.	e _____	_____	From_____To_____

Date _____ Signature _____ I certify this information is true and correct

AUTHORIZATION TO 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 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.

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)

_____ _____
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.

American Fidelity Assurance Company
A member of the American Fidelity Group®

American Fidelity Educational Services
Mail to: AFES Benefits Department
P.O. Box 25160
Oklahoma City, OK 73125-0160
Local Phone # (405) 523-5025
Toll Free Phone # 1-800-662-1113
Toll Free Fax # 1-800-818-3453

SECTION 3 - ATTENDING PHYSICIAN'S STATEMENT

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.

Name of Patient: Date of Birth: Account Number:

Diagnosis: (including complications) ICDA Code:

When did symptoms first appear or accident happen? Date patient first consulted you for this condition?

_____/_____/_____ _____/_____/_____

Has the patient ever had the same or similar condition? ❒ Yes ❒ No If yes, indicate when and describe.

Was the patient referred to you? ❒ Yes ❒ No If yes, full name and address of referring physician:

Frequency of treatment: ❒ Monthly ❒ Weekly ❒ Other

If not under your regular care and attendance please explain.

Date of next appointment : _____/_____/_____

Nature of treatment being rendered (including surgery and any medications being prescribed) and the current treatment plan:

List all dates of treatment or medical attention since the disability began:

Dates unable to perform the Activity of Daily Living. From: Through:

Physician Please Note:
To meet disability criteria insured must be unable to perform two or more of their ADL's as defined below or be considered terminally ill.
The inability to perform a task must be generally recognized by the medical profession as a consequence of the disabling accident or illness.

"Activities of Daily Living" means the basic human functions required for the spouse to remain independent.

(a) Continence: Maintaining control of bladder and/or functions of the bowel, including the ability to use ostomy supplies or other devices such as catheters; From _____ To_____

(b) Transferring: Moving between the bed and the chair; or the bed and a wheelchair, with or without assistive device; From _____ To_____

(c) Dressing: Putting on and taking off all necessary items of clothing; and/or medically necessary braces and artificial limbs usually worn; From _____ To_____

(d) Toileting: Getting to and from the toilet; getting on and off the toilet; and performing associated personal hygiene; and From _____ To_____

(e) Eating: Performing all major tasks of getting food into the body, with or without assistive device. From _____ To_____

A spouse is considered unable to perform an Activity of Daily Living if the task cannot be performed safety without another person's stand-by assistance or verbal cueing. The inability to perform a task must be generally recognized by the medical profession as a consequence of the disabling Accident or Sickness.

OR:
Does this patient have a terminal illness? _____ yes _____ no
(life expectancy of less than 12 months)

Do you agree that the inability for your patient to perform their ADL's would be recognized by the medical profession as a consequence of their current disabling diagnosis? _____ yes _____ no

When, in your opinion, will the patient recover sufficiently to return to his or her Daily Living Activities?
❒ 1-2 Months ❒ 2-3 Months ❒ 3-6 Months ❒ 6-12 Months ❒ More than 12 Months ❒ Permanent

Attending Physician's Name: (print) Specialty: Telephone #: ( ) - Fax #: ( ) -

Street Address: City: State: Zip Code:

Signature: Federal Tax ID #: Date: