

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 Fat

STATEMENT OF CLAIMANT 1-800-662-1113 - Watts For Physician Expense For Injury or Sickness Only (Do NOT use this form when filing for disability)

Name(Palis table)	Date	of Birth		AFA Account	#	
(Policyholder)				O I I O with All-		
Residence Address(Street)	(Town)	(State)	(Zip)	_ Social Security No		
Mailing Address		· 				
(Street)	(Town)	(State)	(Zip)	•		
I am employed at(Employer)	(Address)	(Cit	ity)	(State)	(Zip)	
Telephone No. Home		•		, ,	,	
Date accident or illness began	$\overline{\top}$					
1. Date addition initials segan						
Nature of illness or accident						
3. Was accident or illness work related?4. If accident, where and how did it happen? (Explain fully)	Yes 🗓 No	-				
5. Dates of all Treatment What date(s) were you unable to work a full day?	Office					
	Hospital					
	Admit. Dat	Admit. Date: Discharge Date:				
6. Were you scheduled to work on the day of medical treatment?	Yes □ No	Yes □ No □ If no Explain (semester break, holiday, week-end, etc.):				
If yes, were you totally disabled and unable to work one full day on the date of medical treatment?	Yes □ No	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 Immune Deficiency Syndrome) or other conditions for which you may have to developed symptoms on the disease AIDS. Such test results shall n	ave been treated. This	s authorization excludes	s disclosure of the	result of a test for HIV if you have tes	sted HIV positive but have	
I understand that I may refuse to sign this authorization; however, revoke this authorization at any time by writing to AFES Benefits Depart revoke this authorization is limited to the extent that: AFAC has taken as my insurance coverage. A copy of this authorization will be as valid as the	tment, PO Box 25160, ction in reliance on the), Oklahoma Ćity, OK 73	3125-0160 or by ca	alling, toll-free, 1-800-662-1113. I und	lerstand that my right to	
I understand that if protected health information is disclosed to a person protected by the federal privacy regulations.	or organization that is	s not required to comply	y with federal priva	.cy regulations, the information may b	e redisclosed and no longer	
For health insurance coverage this authorization will expire twenty-four rother than health insurance, this authorization will expire twenty-four mo					For insurance coverage	
Signature (Patient) or Personal Representative (if applicable)		Print	ted Name (Patient)			

Date

Please retain a copy for your personal records, or you may request a copy from our company.

Relationship of Personal Representative to Patient
If authorization is supplied by a personal representative a description of the authority to act on behalf of the Insured must be included.