PHYSICIAN'S VISIT BENEFIT CLAIM FORM

Your Aflac Hospital Indemnity policy pays a Physician's Visit Benefit for services rendered under the supervision of a physician, after the effective date of your policy (see policy schedule).

- **Please complete all sections of the form, sign, date, and mail form to the address shown below.**
- **Submit only one treatment date per claim form.**
- **Each additional treatment date should be on a separate claim form.**
- **Claims for all other benefits covered under this policy should be filed separately.**
- **Do not fax or photocopy this document.**
- **Incomplete forms will be returned for completion.**
- **Do not attach receipts, statements or other documentation to this form.**
- **Use blue or black ink only**

Policyholder Information:

Policy Number:

First Name:

Last Name:

Policyholder Birth Date: M M D D Y Y Y Y

Patient Information:

Patient First Name:

Middle Initial:

Patient Last Name:

Sex:
- Male
- Female

Patient Birth Date: M M D D Y Y Y Y

Relationship:
- Primary Policyholder
- Spouse
- Dependent Child
- Check if dependent is full-time student

Date of Physician's Visit: M M D D Y Y Y Y

Physician's Phone Number: - -

Physician's Name:

Physician's Street Address:

Physician's City:

State:

ZIP:

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.

Policyholder Signature **Printed Name** **Date**

American Family Life Assurance Company of Columbus (Aflac)
Worldwide Headquarters • 1932 Wynnton Road • Columbus, GA 31999
1-800-99-AFLAC (1-800-992-3522) • aflac.com
1-800-SI-AFLAC (1-800-742-3522) en español