CANCER SCREENING BENEFIT CLAIM FORM

If you are interested in filing your claim online, register using aflac.com/smartclaim.

➢ **Benefits of filing your claim online include faster claim processing time and receiving claim communications by email.**

Please read all instructions.
Failure to follow these instructions could delay the processing of your claim.

- Do not include receipts, statements or other claim documentation with this form.
- Do not write on form except as instructed.
- Sign, date and fax or mail the completed form to the Aflac fax number/address shown below.
- Use black or blue ink only and print legibly when completing this form in its entirety.
- Mark only wellness exam boxes for test(s) and/or treatment(s) received.
- Failure to complete all sections may result in a delay in processing this claim.
- Some types of tests and/or treatment listed may not be covered by your policy.

Please keep a copy of this completed form for your records. Please print a separate form for each additional family member or call 1-800-99-AFLAC (1-800-992-3522) to request additional forms. Claims for all other benefits covered under this policy must be filed separately using the claim forms available at aflac.com or by calling 1-800-99-AFLAC (1-800-992-3522).

American Family Life Assurance Company of Columbus (Aflac)
ATTN: Claims Department • 1932 Wynnton Road • Columbus, GA 31999
For information or to check claim status, visit aflac.com or call 1-800-99-AFLAC (1-800-992-3522)
Claims may be faxed to 1-877-44-AFLAC (1-877-442-3522)

CANCER SCREENING BENEFIT CLAIM FORM

Policy Number:

All Fields are required.

Policyholder Information:

Last Name | Suffix | First Name | MI

Date of Birth (mm/dd/yy) / /

Telephone Number where we can reach you - -

Home Address

City | State | Zip Code

☐ *Check box if this is permanent address change.*

Patient Information:

Last Name | First Name | Date of Birth (mm/dd/yy) / /

Sex: ☐ Male ☐ Female

Relationship: ☐ Primary Policyholder ☐ Spouse ☐ Dependent Child

Treatment Date: M M D D Y Y Y Y

Mammogram Date: M M D D Y Y Y Y

Pap Smear Date: M M D D Y Y Y Y

- ☐ Genetic Testing
- ☐ Chest X-ray
- ☐ Scopes (Oscopies)
- ☐ Scans/MRI
- ☐ Pap Smear/Pap Smear-ThinPrep
- ☐ HPV Screening
- ☐ Bone Marrow Screening
- ☐ Serum Protein Electrophoresis
- ☐ Hemocult Stool Specimen
- ☐ CEA (blood test for colon cancer)
- ☐ CA125 (blood test for ovarian cancer)
- ☐ Mammogram
- ☐ Cervical Cancer Screening
- ☐ P32 Uptake Test
- ☐ CA153 (blood test for breast cancer monitoring)
- ☐ Thermography
- ☐ PSA (blood test for prostate cancer)
- ☐ Ultrasounds
- ☐ Biopsy
- ☐ Cancer Vaccine

Actual Cost of Mammogram .

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.

The Physician listed above is authorized to validate the information I have provided.

POLICYHOLDER/PATIENT SIGNATURE | **FAMILY RELATIONSHIP, IF NOT POLICYHOLDER** | **DATE**

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