

Group Disability Claim Filing Instructions

(Not for use when filing for Physician's Expense Benefits)

Disability Claim form is to be completed after you become disabled.

1. Complete Employee's Disability Benefits Application in full.
2. Have the treating physician complete the Attending Physician's Statement and return to you.
3. Have your Employer complete the Employer's Report of Claim.
4. Submit the completed:
 - A. Employee's Disability Benefits Application
 - B. Employer's Report of Claim
 - C. Attending Physician's Statementto the address below or submit via our toll-free fax @ 1-800-818-3453
5. Please complete if you desire benefits deposited directly into your bank account.

I authorize AFAC to initiate credit entries to my account at the depository named below. This authorization is to remain in force and effect until AFAC receives written notification from me of its termination in such time and in such manner as to afford AFAC and the Depository opportunity to act on it.

Signature: _____

NOTE: You must attach a voided check to begin direct deposit.

All portions of this form package must be completed to avoid undue delay in processing claimant's request for benefits. If you have any questions regarding completion of this form please call:

Toll Free Phone # 1-800-662-1113

Local Phone # 405-523-5025

 **American Fidelity
Assurance Company**

A member of the American Fidelity Group®

Educational Services Division
Benefits Department
P.O. Box 25160
Oklahoma City, Oklahoma 73125-0160
www.afadvantage.com



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EMPLOYER'S REPORT OF CLAIM

E M P L O Y E E M E N T	Name of Employer: _____		Phone No.: _____ (____) _____
	Mailing Address: (include street, city, state and zip code) _____		Fax No.: _____ (____) _____
	Name of Employee: _____		Social Security Number: _____
	Address: (include street, city, state and zip code) _____		Phone No.: _____ (____) _____
	Date of Hire: _____	Effective date of employee's coverage: _____	Occupation: (please attach job description)
	Status of employment at time of disability: <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Leave of Absence <input type="checkbox"/> Terminated <input type="checkbox"/> Retired		
	Number of hours worked per week at time of disability: _____		In-house days: _____
Number of contract days: _____ for _____ school year.		First Day _____	
Has employee's status of employment changed? <input type="checkbox"/> Yes <input type="checkbox"/> No		Last Day _____	
If yes, current status and date of status-change? _____			
P R E M I U M S	Does employee participate in Social Security? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, hired after 4/1/86? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	Please furnish the percentage of the employee's AFA disability premium you pay:		Short Term _____%
	Are the AFA disability premiums withheld before or after taxes?		Long Term _____%
	Short Term Plan <input type="checkbox"/> Before <input type="checkbox"/> After Long Term Plan <input type="checkbox"/> Before <input type="checkbox"/> After		
S A L A R Y	CONTRACTED SALARY AT TIME OF DISABILITY		
	Annual: \$ _____	Effective Date: _____	<input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/> 12 Month Work Schedule <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/> 12 Month Pay Schedule
D I S A B I L I T Y	Date employee last worked: _____		Have AFA Disability premiums been withheld
	Has employee returned to work? <input type="checkbox"/> Yes <input type="checkbox"/> No		through the last date worked? <input type="checkbox"/> Yes <input type="checkbox"/> No
	If Yes, date returned to work: _____		If not, what is the last date disability premiums
Full Time: _____ Part Time: _____		were deducted? _____	
O T H E R I N C O M E	Did Employee's disability result from employment? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	If yes, name, address and phone number of Worker's Compensation carrier: _____		
	Has employee made a claim for or is entitled to Worker's Compensation? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	If yes, weekly rate of compensation: \$ _____		
	Provide:	The final date the employee is entitled to fully paid sick leave _____	
		The first date the employee is entitled to differential/sabbatical pay, if any _____	
	The last date the employee is entitled to differential/sabbatical pay _____		
	The daily rate of differential/sabbatical pay \$ _____		
Name, address and phone number of any other disability carrier: (include street, city, state and zip code) _____			
Is employee eligible for disability retirement benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No			

Remember - To attach a copy of the applicable school calendar for any contracted employee.

FAILURE TO DO SO COULD RESULT IN DELAYED BENEFITS

I hereby certify that the above named employee is a member of our Group Disability Program. The Information stated above is correct to the best of my knowledge and belief.

Authorized signature of employer firm or authorized official: _____

Title: _____ Date: _____

E-mail Address: _____



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EMPLOYEE'S DISABILITY BENEFITS APPLICATION

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.

Full Name: (last, first, middle initial)		Maiden Name		Account Number:	
Residence: (street, city, state and zip code)				Social Security Number: - -	
Mailing Address: (P.O. Box or street, city and zip code)				Date of Birth: / /	
Telephone Number: (including area code) ()		<input type="checkbox"/> Single		<input type="checkbox"/> Married	
		<input type="checkbox"/> Widowed		<input type="checkbox"/> Divorced	
Occupation:		Has your employment terminated?		If so, date:	
Names & birth dates of spouse & dependents:		Name _____ Birth date ____/____/____		Name _____ Birth date ____/____/____	
		Name _____ Birth date ____/____/____		Name _____ Birth date ____/____/____	
1. Date accident or illness began:		2. If accident, explain where and how it happened?			
3. Have you ever had the same or similar condition in the past? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, names and address of treating physicians and/or hospitals:					
4. Nature of illness or injury:			5. Dates of medical treatment: Date of next doctor's appointment:		
6. If hospitalized give full name(s) and addresses of hospitals: (attach additional list if necessary)		Admit Date: ____/____/____		Discharge Date: ____/____/____	
7. Full names and addresses of all treating physicians: (attach additional list if necessary)			8. Is your disability related to your employment/occupation? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, have you or do you intend to file for Worker's Compensation? <input type="checkbox"/> Yes <input type="checkbox"/> No		
9. On what date did you last work? _____		Dates of total disability: From _____		Thru _____	
On what date did you return to work? _____		Part Time ____/____/____		Full Time ____/____/____	
If not returned to work, when do you anticipate returning to work? _____					
10. If your request for benefits is approved, do you want us to withhold Federal Taxes from each benefit check? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, amount: \$ _____ (indicate amount per month \$86.00 minimum)					
11. Identify other income sources and amount of income for which you are receiving or may be entitled to receive during this disability					
Your Social Security: (disability or retirement) <input type="checkbox"/> Yes <input type="checkbox"/> No		\$ _____ Mo.		V.A. Benefits: <input type="checkbox"/> Yes <input type="checkbox"/> No \$ _____ Mo.	
Dependent Social Security: <input type="checkbox"/> Yes <input type="checkbox"/> No		\$ _____ Mo.		Worker's Compensation: <input type="checkbox"/> Yes <input type="checkbox"/> No \$ _____ Mo.	
Sick Leave or Wage Continuation: <input type="checkbox"/> Yes <input type="checkbox"/> No		\$ _____ Mo.		Other Disability Coverage: <input type="checkbox"/> Yes <input type="checkbox"/> No \$ _____ Mo.	
Retirement: (normal early or disability) <input type="checkbox"/> Yes <input type="checkbox"/> No		\$ _____ Mo.		(identify) _____	
State Disability Income <input type="checkbox"/> Yes <input type="checkbox"/> No		\$ _____ Mo.			
Signature: _____			Date: _____		
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.



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ATTENDING PHYSICIAN'S STATEMENT

	Name of Patient:	Date of Birth:	Account Number:
D I A G N O S I S	Diagnosis: (including complications)		ICDA Code:
	Is disability due to injury or sickness arising out of or in the course of patient's employment? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	Is disability the result of pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, type of delivery: _____ Date pregnancy was diagnosed? ____/____/____ Date of delivery:(if delivered) ____/____/____ Expected date of delivery? ____/____/____		
H I S T O R Y	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? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, indicate when and describe:		
	Was the patient referred to you? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, full name and address of referring physician:		
T R E A T M E N T	Frequency of treatment: <input type="checkbox"/> Monthly <input type="checkbox"/> Weekly <input type="checkbox"/> Other Date of next appointment : ____/____/____		
	Nature of treatment being rendered (including surgery and any medications being prescribed)		
	List all dates of treatment or medical attention since the disability began:		
	Is patient still under your regular care for this condition? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, please explain and provide name of the current treating physician:		
	Has the patient been confined to a hospital? <input type="checkbox"/> Yes <input type="checkbox"/> No Admitted: ____/____/____ Discharged: ____/____/____ If yes, give admit and discharge dates along with name and address of hospital. Admitted: ____/____/____ Discharged: ____/____/____ Name: _____ Address: _____		
P R O G N O S I S	Dates of total disability: (unable to work) From: _____ Through: _____ Disabled from: Patient's Job <input type="checkbox"/> Yes <input type="checkbox"/> No Any other work <input type="checkbox"/> Yes <input type="checkbox"/> No		
	Dates of partial disability? From: _____ Through: _____		
	If the patient is currently disabled, what is the anticipated length of disability? <input type="checkbox"/> 1-2 Months <input type="checkbox"/> 2-3 Months <input type="checkbox"/> 3-6 Months <input type="checkbox"/> 6-12 Months <input type="checkbox"/> More than 12 Months <input type="checkbox"/> Permanent		
	When, in your opinion, will the patient recover sufficiently to return to work?		
I M P A I R M E N T S	Functional Limitations that render your patient totally disabled:		
	Current Treatment Plan: Attention Physician: This form documents your verification that the above named individual is totally disabled from either their occupation or any other occupation. Your signature generates disbursement of disability benefits. You will be asked periodically for updates related to this individual's disability status and treatment plan.		
Attending Physician's Name: (print)		Specialty:	Telephone #: () - () - Fax #: () -
Street Address:		City:	State: Zip Code:
Signature:		Federal Tax ID #:	Date:
Email address:			