Cancer Screening Wellness Benefit Claim Form

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

Do not include receipts, statements, or other documentation with this form.

Your Aflac New York policy provides one Wellness Benefit per covered person, per calendar year, and this form is designed specifically for this benefit. To receive your Wellness Benefit, complete the form by following the instructions provided. Please print a separate form for each additional covered family member or call (1-800-366-3436) to request additional forms. Claims for all other benefits covered under your Cancer policy must be filed separately, using the Cancer Claim Form.

If any of your wellness tests resulted in a diagnosis of cancer, please submit your claim for cancer treatment separately, using the Cancer Claim Form.

If your Aflac New York policy also provides one Mammogram Benefit per calendar year, please mark the appropriate box and indicate the date the mammogram was performed. Please check your policy for specific benefits covered under your policy.

If your Aflac New York policy also provides one Pap Smear Benefit per calendar year, please mark the appropriate box and indicate the date the Pap smear was performed. Please check your policy for specific benefits covered under your policy.

- **Do not write on the form except as instructed.**
- **Incomplete forms cannot be processed and will be returned.**
- **Please do not fax this completed form to Aflac.**
- **Mark only wellness exam box(es) for test(s) that you had performed.**

American Family Life Assurance Company of New York (Aflac New York)
Attn: Claims Department • 1932 Wynnton Road • Columbus, GA 31999-7251
(1-800-366-3436) • aflacny.com

Cancer Screening Wellness Benefit Claim Form

Aflac New York

Some of the tests listed may not be covered under the Wellness Benefit of your policy. Please check your policy for a list of covered wellness procedures or call (1-800-366-3436) for a Wellness Form specifically tailored for your policy.

Please use black or blue ink only and print legibly when completing this form in its entirety. Keep a copy of the supporting documentation and this completed form for your records. Sign, date, and mail the completed form to the Aflac New York address shown below.

Policyholder Information

Policyholder's First Name: | Middle Initial: | Policyholder's Last Name:

Policyholder's Birth Date: M M D D Y Y Y Y | ZIP of mailing address:

Policy Number

Patient Information

First Name: | Middle Initial: | Last Name:

Relationship: ☐ Primary Policyholder ☐ Spouse ☐ Dependent Child

Sex: ☐ Male ☐ Female

Patient's Birth Date: M M D D Y Y Y Y

Wellness Exam

Treatment Date: M M D D Y Y Y Y

- ☐ Colonoscopy
- ☐ Virtual colonoscopy
- ☐ Pap smear - ThinPrep
- ☐ Pap smear

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

- ☐ Hemocult stool specimen
- ☐ CEA (blood test for colon cancer)
- ☐ CA 125 (blood test for ovarian cancer)
- ☐ Mammogram

Mammogram Date: M M D D Y Y Y Y

Provide Actual Cost for Mammogram:

- ☐ Flexible sigmoidoscopy
- ☐ Thermography
- ☐ Chest X-ray
- ☐ PSA (blood test for prostate cancer)
- ☐ Breast ultrasound
- ☐ Biopsy

Physician Information

Phone Number: ___ - ___ - ____

Name:

Street Address:

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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

I certify that the information provided is true and correct:

_____ _____

POLICYHOLDER'S SIGNATURE **DATE**

American Family Life Assurance Company of New York (Aflac New York)
Attn: Claims Department • 1932 Wynnton Road • Columbus, GA 31999-7251
(1-800-366-3436) • aflacny.com

NYZ06197CA NY