

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 Physicians 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. Employers 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



A member of the American Fidelity Group®

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



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Oklahoma City, OK 73125-0160
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EMPLOYER'S REPORT OF CLAIM

EMPLOYMENT	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)	
PREMIUMS	Status of employment at time of disability: ☐ Full-Time ☐ Part-Time ☐ Leave of Absence ☐ Terminated ☐ Retired	
	Number of hours worked per week at time of disability: _____ Inhouse days: _____	
	Number of contract days: _____ for _____ school year. First Day _____ Last Day _____	
	Has employee's status of employment changed? ☐ Yes ☐ No If yes, current status and date of status-change? _____	
SALARY	Does employee participate in Social Security? ☐ Yes ☐ No If no, hired after 4/1/86? ☐ Yes ☐ No	
	Please furnish the percentage of the employee's AFA disability premium you pay: _____%	
	Are the AFA disability premiums withheld before or after taxes? ☐ Before ☐ After	
DISABILITY	CONTRACTED SALARY AT TIME OF DISABILITY	
	Monthly: \$ _____ Effective Date: _____ ☐ 9 ☐ 10 ☐ 12 Month Work Schedule	
	Annual: \$ _____ Effective Date: _____ ☐ 9 ☐ 10 ☐ 12 Month Work Schedule	
OTHER INCOME	Date employee last worked: _____ Have AFA Disability premiums been withheld through the last date worked? _____	
	Has employee returned to work? ☐ Yes ☐ No	
	If Yes, date returned to work: _____	
OTHER INCOME	Full Time: _____ Part Time: _____	
	Did Employee's disability result from employment? ☐ Yes ☐ No	
	If yes, name, address and phone number of Worker's Compensation carrier: _____	
	Has employee made a claim for or entitled to Worker's Compensation? ☐ Yes ☐ 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? ☐ Yes ☐ 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:

Date: _____ Signature: _____ Title: _____

E-mail Address: _____



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Oklahoma City, OK 73125-0160
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Toll Free Fax # 1-800-818-3453
www.afadvantage.com

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) ()		☐ Single	☐ Married	☐ Widowed ☐ 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? ☐ Yes ☐ 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 Doctors 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? ☐ Yes ☐ No If yes, have you or do you intend to file for Worker's Compensation? ☐ Yes ☐ 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? ☐ Yes ☐ 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) ☐ Yes ☐ No \$ Mo. V.A. Benefits: ☐ Yes ☐ No \$ Mo.				
Dependent Social Security: ☐ Yes ☐ No \$ Mo. Worker's Compensation: ☐ Yes ☐ No \$ Mo.				
Sick Leave or Wage Continuation: ☐ Yes ☐ No \$ Mo. Other Disability Coverage: ☐ Yes ☐ No \$ Mo.				
Retirement: (normal early or disability) ☐ Yes ☐ No \$ Mo. (identify) _____				
State Disability Income ☐ Yes ☐ No \$ Mo. Include a copy of your award or denial letter for any source in which one has been received.				
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 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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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? ☐ Yes ☐ No				
	Is disability the result of pregnancy? ☐ Yes ☐ 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 appeared or accident happen? _____ Date patient first consulted you for this condition? _____/_____/_____ Has the patient ever had the same or similar condition? ☐ Yes ☐ No If yes, indicate when and describe: _____				
	Was the patient referred to you? ☐ Yes ☐ No If yes, full name and address of referring physician: _____				
	Frequency of treatment: ☐ Monthly ☐ Weekly ☐ Other If not under your regular care and attendance please explain. 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 care for this condition? ☐ Yes ☐ No If no, please provide the name of the current treating physician: _____ Has the patient been confined to a hospital? ☐ Yes ☐ 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: Patients Job ☐ Yes ☐ No Any other work ☐ Yes ☐ No Dates of partial disability? From: _____ Through: _____ If the patient is currently disabled, what is the anticipated length of disability? ☐ 1-2 Months ☐ 2-3 Months ☐ 3-6 Months ☐ 6-12 Months ☐ More than 12 Months ☐ 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 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:	