Group Disability Claim

Save Time and Paper – File Your Claim Online!

We offer two ways to file your Disability claim: online or by mail/fax.

Before you get started, don't forget to have your employer and attending physician complete the Employer's Report of Claim and Attending Physician's Statement. These forms can be found in this packet or when filing your claim online.

How to File Online:

1. Login to your secured Online Service Center (OSC) account at www.americanfidelity.com/MyAccount.
2. From the "My Claims" tab, click "File A Claim" to get started.
3. Conveniently upload your completed Attending Physician's Statement, Employer's Report of Claim and the Authorization to Disclose Protected Health Information during your claim filing process.
4. Follow the step-by-step instructions to complete your online claim filing process.
5. Check the status of your claim by selecting the "My Claims" tab at the top of the screen!

How to File By Mail or Fax:

1. Complete the Authorization to Disclose Protected Health Information and the Employee's Disability Benefit Application.
2. Have your employer and attending physician complete the Employer's Report of Claim and Attending Physician's Statement.
3. Mail the completed forms to American Fidelity:
   - **A.** Authorization to Disclose Protected Health Information
   - **B.** Employee's Disability Benefits Application
   - **C.** Employer's Report of Claim
   - **D.** Attending Physician's Statement
4. If you wish to fax your completed forms, please fax to 800-818-3453.

Whether completing this claim online or with the below packet, all portions must be completed to avoid undue delay in processing your request for benefits. If you have any questions regarding completion of your claim, please call:

Toll Free: 800-662-1113
Local: 405-523-5025

American Fidelity Assurance Company

Our Family, Dedicated To Yours.®

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

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize the entities specified below to disclose any information about my entire medical record, benefits payable, or benefit eligibility 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.

Warning: Any person who knowingly and with intent to injure, defraud, or deceive an 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.

California - For your protection, California law requires the following to appear on this form. Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

AR, DC, LA, MD, NJ, NM, TX, and WV - ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

DE, ID, IN, MN, OH, and OK - 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 is guilty of a felony.

Colorado - It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

New Hampshire - Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

Kentucky - Any person who knowingly and with intent to defraud any insurance company or other person files a 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.

Oregon - Any person who knowingly and with intent to defraud or solicit another to defraud an insurer: (1) by submitting an application, or (2) by filing a claim containing a false statement as to any material fact, may be guilty of insurance fraud.

Pennsylvania - 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.

Arizona - For your protection, Arizona law requires the following statement to appear on this form: Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

Florida - Any person who knowingly, and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Alabama - Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

Maryland - Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

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EMPLOYEE'S DISABILITY BENEFITS APPLICATION

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 so, when? _____

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? ☐ 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.**			
Unemployment	☐ Yes	☐ No	$_____Mo				

Signature: _____ **Date:** _____
I certify this information is true and correct.

I authorize AFA to initiate credit entries to my account at the depository named below. This authorization is to remain in force and effect until AFA receives written notification from me of its termination in such time and in such manner as to afford AFA and the Depository opportunity to act on it. This authorization applies to benefits payable under all insurance policies held with AFA.

Signature: _____

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

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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)

Status of employment at time employee last worked: ☐ Full-Time ☐ Part-Time ☐ Leave of Absence ☐ Terminated ☐ Retired

Number of hours worked per week at time of leave:_____

Number of contract days: _____ for _____ school year.

In-house days:
First Day _____
Last Day _____

Has employee's status of employment changed? ☐ Yes ☐ No If yes, current status and date of status-change? _____

PREMIUMS

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 paid by the employer:_____%

Are the AFA disability employee-paid premiums withheld before or after taxes?

Short Term Plan ☐ Before ☐ After **Long Term Plan** ☐ Before ☐ After

SALARY

CONTRACTED SALARY AT TIME OF DISABILITY

Annual: $_____ Effective Date: _____ ☐ 9 ☐ 10 ☐ 12 Month Work Schedule
☐ 9 ☐ 10 ☐ 12 Month Pay Schedule

DISABILITY

Date employee last worked:_____
Has employee returned to work? ☐ Yes ☐ No

If Yes, date returned to work:

Full Time: _____ Part Time: _____

Have AFA Disability premiums been withheld through the last date worked? ☐ Yes ☐ No

If not, what is the last date disability premiums were deducted? _____

OTHER INCOME

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 is 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 _____

Is this employee eligible to receive any other form of wage continuation? ☐ Yes ☐ No If so, please advise the amount and the final date the employee is entitled to receive this pay. _____

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 vested 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: _____

Title: _____ Date: _____

E-mail Address:_____ Extension: _____

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ATTENDING PHYSICIAN'S STATEMENT

Name of Patient: | Date of Birth: | Social Security Number: | Account Number:

DIAGNOSIS

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? ____/____/____

HISTORY

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? ☐ 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:

TREATMENT

Frequency of treatment: ☐ Monthly ☐ Weekly ☐ 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? ☐ Yes ☐ No If no, please explain and provide 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: _____

PROGNOSIS

Dates of total disability: (unable to work) From: _____ Through: _____

Disabled from: Patient's 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?

IMPAIRMENTS

Functional Limitations that render your patient totally disabled:

Current Treatment Plan:

Attending Physician's Name: (print) | Specialty: | Telephone #: ( ) - | Fax #: ( ) -

Street Address: | City: | State: | Zip Code:

Signature: | Federal Tax ID #: | Date:

Email address: