Reduce your claim processing time and receive your money faster when you file online or through AFmobile®.

1. Complete the Statement of Insured.
2. Complete the Authorization to Disclose Protected Health Information.
3. Have your employer complete the Employer's Report of Claim.
4. Have your treating physician complete the Attending Physician Statement.
5. Mail or fax the completed forms to American Fidelity at the address or fax number listed above.

ROUTINE PREGNANCY

Do not use this form for any benefit other than routine child birth with no complications.

STATEMENT OF INSURED

To be completed by Employee.

Full Name: (last, first, middle initial)	Date of Birth:
Social Security Number:	Account Number:
Mailing Address: (P.O. Box or street, city and zip code)	
Telephone Number (including area code)	Email Address:

DISABILITY

Provide all current treating physicians' full name(s) and contact information (attach additional list if necessary):

Physician's Full Name(s): _____ Physician's Phone Number(s): _____

Physician's Full Name(s): _____ Physician's Phone Number(s): _____

Have you become disabled for any new illnesses or accidents? ^ Yes ^ No If so, please describe:

If hospital confined, please provide:

Hospital(s): _____ _____ _____

^ _____ _____ _____

AUTHORIZATION TO DISCLOSE INFORMATION INCLUDING PROTECTED HEALTH INFORMATION

The purpose of this form is to allow American Fidelity Assurance Company (AFAC) to obtain data including but not limited to employment information, nancial information, and protected health information about me, from any party holding that information.

I hereby authorize the entities speci ed below to disclose any information about me or my dependents' health or nancial situation including my or my dependents' entire medical record and history of treatment for physical and/or emotional illness to include psychological testing, except psychotherapy notes, to individuals representing AFAC who are involved in determining whether I am eligible for bene ts 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, k) banks or nancial institutions and l) Workers' Compensation Carrier. Colorado state law prohibits the redisclosure or reuse of information disclosed about a Colorado resident under this authorization.

NOTICE: Information authorized for release may include information on communicable or venereal diseases such as hepatitis, syphilis, gonorrhea, HIV/AIDS (Human Immunode ciency Virus/Acquired Immune De ciency Syndrome) or other conditions for which you may have been treated.

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 bene ts. I understand that I may revoke this authorization at any time by writing to American Fidelity Assurance Company, 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. In addition to the types of information described above, I also authorize American Fidelity to access any other type of information deemed necessary to investigate my claim. This information includes but is not limited to nancial information, information submitted or related to insurance claim(s) or insurance coverage(s) and employment records. Any party holding this information is hereby authorized to release it to American Fidelity.

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 rst. 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 bene ts, whichever occurs rst.

AFA Account# | Printed Name of Patient | Patient's Date of Birth

Signature (Patient) or Personal Representative (if applicable) | Date Signed

Relationship of Personal Representative to Patient (if applicable)

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.

Claim Form Fraud Statements

The following fraud language is attached to, and made part of, this claim form. Please read and do not remove this page from this claim form.

If you live in a jurisdiction not mentioned below, the following applies to you: Any person who knowingly presents a false or fraudulent claim for payment of a loss or bene t is guilty of a crime and may be subject to nes and con nement in prison.

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

Alaska - A person who knowingly and with intent to injure, defraud, or deceive an insurance company les a claim containing false, incomplete, or misleading information may be prosecuted under state law.

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.

Arkansas, District of Columbia, Louisiana, Rhode Island and West Virginia - Any person who knowingly presents a false or fraudulent claim for payment of a loss or bene t or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to nes and con nement in prison.

California and Texas - For your protection California and Texas 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 nes and con nement in state prison.

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, nes, 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

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