VISION CLAIM FORM

FILING CLAIM FOR (check all that apply)**:**

Disease/Disorder of the Eye   Impairment due to Accident   Hospitalization   Deceased -- Date Deceased:_____/_____/_____

Vision Policy Number	Accident Policy Number	Short-Term Disability / Sickness Disability Rider Policy Number	Hospital Indemnity Policy Number	Hospital Intensive Care Policy Number

Failure to complete this form in its entirety may result in a delay in processing this claim.

INSTRUCTIONS:
- Complete **Section A: Policyholder/Patient Information**.
- Be sure to sign your claim form at the bottom of Page 1.
- Have your doctor complete Section B: Physician's Statement.
- If you are filing for the Eye Exam benefit or the Vision Correction benefit please use form S-00222 (Vision Now[SM] Eye Exam/Vision Correction Materials Claim Form). **Obtain a form by calling 1-800-99-Aflac (1-800-992-3522).**
- If you are filing for disability due to a sickness, please complete the Sickness Claim Form (S-2029) as well. If you are filing for disability due to an accident, please complete the Accident Claim Form (S-00198). **Forms are available on our website at www.aflac.com.**

ADDITIONAL NOTES:
- Submit all bills related to this claim such as hospital, surgery, etc. All bills should be itemized and should include the diagnosis, services rendered and actual charges for the service.
- If hospitalized and/or confined to an intensive care unit, please send a copy of your hospital bill that shows charges and the number of days you were confined. If confined to an intensive care unit, the bill must specify the number of days you spent in the intensive care unit.
- **Be sure to include your policy number(s) on all documents.**

SECTION A: POLICYHOLDER/PATIENT INFORMATION

POLICYHOLDER INFORMATION

LAST NAME	FIRST NAME	MIDDLE INITIAL
SOCIAL SECURITY NUMBER (optional)	BIRTH DATE	PHONE NUMBER ( )
ADDRESS		CHECK BOX IF THIS IS A NEW PERMANENT ADDRESS
CITY	STATE	ZIP
PLACE OF EMPLOYMENT		PHONE NUMBER ( )
ADDRESS		
CITY	STATE	ZIP

PATIENT INFORMATION

LAST NAME	FIRST NAME	MIDDLE INITIAL
SOCIAL SECURITY NUMBER (optional)	BIRTH DATE	
MALE FEMALE SINGLE MARRIED OTHER	RELATIONSHIP: SELF SPOUSE DEPENDENT - CHECK IF DEPENDENT IS FULL-TIME STUDENT	

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.

CLAIMANT SIGNATURE   **FAMILY RELATIONSHIP, IF NOT POLICYHOLDER**   **DATE**

American Family Life Assurance Company of Columbus (Aflac)
Claims Department: 1932 Wynnton Road, Columbus, GA 31999-7251
1-800-99-Aflac (1-800-992-3522) - www.aflac.com - 1-800-SI-Aflac (1-800-742-3522) en espanol

VISION CLAIM FORM – PHYSICIAN'S STATEMENT

Failure to complete this form in its entirety may result in a delay in processing this claim.

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Policy Number: _______________ Policyholder Name: ____

Patient Name: ____ Birth Date: _____________________ Patient Is: Male Female

Patient's Relationship to Policyholder: Self Spouse Dependent -- Check here if dependent is full-time student

SECTION B: PHYSICIAN'S STATEMENT

PHYSICIAN'S NAME	PHONE NUMBER ( )	FAX NUMBER ( )	
ADDRESS	CITY	STATE	ZIP

Diagnosis: Macular Degeneration Retinal Detachment Glaucoma (excluding preglaucoma and/or borderline glaucoma)

Proliferative Diabetic Retinopathy Retinitis Pigmentosa

ICD-9 Diagnosis Code: _______________ If not listed above, please indicate diagnosis here: ____

Permanent Visual Impairment - Please indicate level of visual impairment below (check one):

Left Right **LEVEL 1 - SEVERE VISUAL IMPAIRMENT:** Maximal visual acuity, after correction, of 20/200 or less, or a total diameter of the visual field in that eye of 20 degrees or less.

Left Right **LEVEL 2 - PROFOUND VISUAL IMPAIRMENT:** Maximal visual acuity, after correction, of 20/500 or less, or a total diameter of the visual field in that eye of 10 degrees or less.

Left Right **LEVEL 3 - NEAR-TOTAL VISUAL IMPAIRMENT:** Maximal visual acuity, after correction, of less than 20/1000, or a total diameter of the visual field in that eye of 5 degrees or less.

Left Right **LEVEL 4 - TOTAL VISUAL IMPAIRMENT:** Complete loss of vision with no remaining perception of light, or loss of the natural eye.

Symptoms first occurred on: ______/______/______ Date of initial diagnosis: ______/______/______

Patient first consulted you for this condition on: ______/______/______

Did patient undergo surgery for this diagnosis? Yes No

Date	CPT/HCPCS Code	Description	Eye	Charge

Was patient hospitalized for this diagnosis? Yes No If yes, admission date: ______/______/______ Date of discharge: ______/______/______

Hospital Name: ____ City: ______________________________ State: _______

PHYSICIAN'S SIGNATURE DATE TAX ID NUMBER

Policy #: [ ][ ][ ][ ][ ][ ][ ][ ]

AUTHORIZATION TO OBTAIN INFORMATION

I authorize the following to give information (as defined below) to American Family Life Assurance Company of Columbus (Aflac) or any person or entity acting on its part: any medical professional, medical care institution, insurer (including Aflac, with respect to other Aflac coverages), reinsurer, government agency (including departments of public safety and motor vehicle departments), consumer reporting agency or employer. "Information" means facts or opinions relating to my past, present, or future physical or mental health or condition (excluding psychotherapy notes), employment, other insurance coverage, or any other non-medical facts that Aflac deems appropriate to evaluate claims for benefits during the time this authorization is valid. I understand that any disclosure of information to Aflac for the purpose of evaluating claims for benefits for coverage other than health plan coverage means the information may no longer be protected by federal privacy regulations. I further understand, however, that such information may be re-disclosed only in accordance with other applicable laws or regulations.

I understand that this information will be used by Aflac to evaluate claims for benefits.

I understand that I may revoke this authorization at any time, except to the extent that (1) Aflac has taken action in reliance on this authorization, or (2) other law provides Aflac with the right to contest a claim under the policy or the policy itself. My revocation must be submitted in writing to Aflac, Claims Department, Worldwide Headquarters, 1932 Wynnton Road, Columbus, GA 31999.

Unless otherwise revoked, I agree that this authorization will expire two years from the date indicated below.

I agree that a copy of this authorization is as valid as the original.

______________________________ ______________________________

Signature Date Printed Name

Individual/Guardian/Personal Representative

____

Printed Name

If this authorization has been signed by a personal representative on behalf of an individual, his/her authority to act on behalf of the individual must be set forth here:

Policy #: | | | | | | | | |

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______________________________ ______________________________

Signature Date Printed Name

Individual/Guardian/Personal Representative

____

Printed Name

If this authorization has been signed by a personal representative on behalf of an individual, his/her authority to act on behalf of the individual must be set forth here:

RETAIN THIS COPY FOR YOUR RECORDS