



## Routine Pregnancy Claim Filing Instructions

This form should be used for routine childbirth without complications.

## Faster, Easier Online Claim Filing

Through your online or mobile account, you can file your claim, check claim status, sign up for notifications, update personal information, enroll in direct deposit, view your detailed policy, and much more!



Two Easy Ways  
to Register

Online at **americanfidelity.com**

Download AFmobile® from the  
**Apple App Store** or **Google Play**

SB-32082-0219

**! Stop here! Paper claim filing is not the fastest option.** Receive your money faster when you file online or through AFmobile.

### Claim Filing Instructions for Mail or Fax:

Please complete this packet in full to avoid delays in your claim processing.

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.

To receive updates on the status of your claims, log in or register for an account at **americanfidelity.com** and select your communication preferences.

### Your Money Direct, Your Money Faster. Enroll in Direct Deposit.

To set up direct deposit with American Fidelity, provide all required information below with your submitted claim. You may also enroll in direct deposit through your online account.

I authorize American Fidelity Assurance Company (AFA) to initiate credit entries to my account as indicated. I also authorize AFA to debit my account for any deposits made in error. This authorization remains effective and in full force until AFA receives written notification from me of its termination in such time and in such manner as to afford AFA and the Depository a reasonable opportunity to act on it. Please notify AFA immediately if your depository information has changed. This authorization applies to benefits payable under all benefit plans with AFA.

Signature: \_\_\_\_\_

You must provide the following information:

Routing Number: \_\_\_\_\_

Account Number: \_\_\_\_\_



Routing Number    Account Number



**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? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No    If so, please describe:                    |  |
| If hospital confined, please provide:  |  |
| Hospital(s): _____   | Admitted: _____ Discharged: _____  |
| Hospital(s): _____   | Admitted: _____ Discharged: _____  |
| Type of Delivery: <input type="checkbox"/> Normal <input checked="" type="checkbox"/> C-Section  |  |
| Date of Delivery: _____  |  |
| On what date did you last work?    /    /  | Dates of total disability: From    /    /    Through    /    /               |
| On what date did you return to work?    /    /   | If not returned to work, when do you anticipate returning to work?    /    / |
| If your request for benefits is approved do you want us to withhold Federal Taxes from each benefit check? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| If yes, amount/month: \$<br>(minimum is \$88/month)  |  |
| Are you receiving or eligible to receive other income during this period of disability? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                    |  |

Identify other income sources and amount of income which you are receiving or may be entitled to receive during this disability.

|   |  |  |  |
|---|--|--|--|
| Other Group Disability:   | Begins:            Ends:<br>Amount: \$<br><input type="checkbox"/> Daily <input checked="" type="checkbox"/> Weekly <input type="checkbox"/> Monthly | Differential/Sabbatical :  | Begins:            Ends:<br>Amount: \$<br><input type="checkbox"/> Daily <input checked="" type="checkbox"/> Weekly <input type="checkbox"/> Monthly |
| Wage Continuation:  | Begins:            Ends:<br>Amount: \$<br><input type="checkbox"/> Daily <input checked="" type="checkbox"/> Weekly <input type="checkbox"/> Monthly | Union:   | Begins:            Ends:<br>Amount: \$<br><input type="checkbox"/> Daily <input checked="" type="checkbox"/> Weekly <input type="checkbox"/> Monthly |
| Sick Leave:   | Begins:            Ends:<br>Amount: \$<br><input type="checkbox"/> Daily <input checked="" type="checkbox"/> Weekly <input type="checkbox"/> Monthly | State Disability:  | Begins:            Ends:<br>Amount: \$<br><input type="checkbox"/> Daily <input checked="" type="checkbox"/> Weekly <input type="checkbox"/> Monthly |
| PTO/PPT:  | Begins:            Ends:<br>Amount: \$<br><input type="checkbox"/> Daily <input checked="" type="checkbox"/> Weekly <input type="checkbox"/> Monthly | For Union Benefits or Other Group Disability, please list provider's:<br>Name: _____<br>Phone: _____ |  |
| <b>Include a copy of your award or denial letter for any source in which one has been received.</b> |  |  |  |
| I certify this information is true and correct.    Signature: _____                                 |  |  | Date: _____  |



## Employer's Report of Claim

|   |   |
|---|---|
| Name of Employer:   | Phone Number:                               |
| Mailing Address: (P.O. Box or Street, City, State and Zip Code)   |   |
| Fax Number:   |   |
| Name of Employee:   | Social Security Number:     /     /         |
| Mailing Address: (P.O. Box or street, city and zip code)  |   |
| Date of Hire:     /     /   | Occupation (please attach job description): |
| Employment Status at time of Disability: <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Leave of Absence <input type="checkbox"/> Terminated <input type="checkbox"/> Retired |   |

### DISABILITY

|  |   |
|--|---|
| Date employee last worked:     /     /     | Has employee returned to work? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| If yes, date returned to work:     /     / | <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time                   |

### PREMIUMS

|   |  |
|---|--|
| Does the employee participate in Social Security? <input type="checkbox"/> Yes <input type="checkbox"/> No                                      | If no, hired after 4/1/86? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| Does employer pay a portion of the disability premium? <input type="checkbox"/> Yes <input type="checkbox"/> No                                 | If yes, what percent?     %  |
| Are disability premiums deducted from employee's pay on a pre-tax (section 125) basis? <input type="checkbox"/> Yes <input type="checkbox"/> No |  |
| Have AFA disability premiums been withheld through the last date worked? <input type="checkbox"/> Yes <input type="checkbox"/> No               | If not, what is the last date disability premiums were deducted?     /     /                   |

### SALARY AT TIME OF DISABILITY FOR EDUCATION EMPLOYERS

|  |                                       |
|--|---------------------------------------|
| Number of Contract Days _____ for _____ school year. | In-house days: First Day:     /     / |
| Annual Salary: \$ _____ Effective Date:     /     /  | Last Day:     /     /                 |

### SALARY AT TIME OF DISABILITY FOR ALL OTHER EMPLOYERS

|  |  |
|--|--|
| Hourly: \$ _____ Monthly: \$ _____   |  |
| Gross salary for previous calendar year: \$ _____ Year-to-date, gross salary: \$ _____ |  |

### OTHER INCOME

|   |   |
|---|---|
| Did Employee's disability result from employment? <input type="checkbox"/> Yes <input type="checkbox"/> No  | Has employee made a claim for Workers' Compensation? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| If yes provide the name, address, and phone number of Workers' Compensation carrier: _____  |   |
| Is the employee entitled to Workers' Compensation for this disability? <input type="checkbox"/> Yes <input type="checkbox"/> No                     |   |
| Please indicate if the employee is receiving or eligible to receive any of the following:   |   |
| Other Group Disability: <input type="checkbox"/> Yes <input type="checkbox"/> No   Amount: \$ _____ Start Date: _____ End Date: _____               | <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input checked="" type="checkbox"/> Monthly    |
| Salary Continuation/Other Paid Leave: <input type="checkbox"/> Yes <input type="checkbox"/> No   Amount: \$ _____ Start Date: _____ End Date: _____ | <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly               |
| Sick Leave: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   Amount: \$ _____ Start Date: _____ End Date: _____                | <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly               |
| Differential/Sabbatical: <input type="checkbox"/> Yes <input type="checkbox"/> No   Amount: \$ _____ Start Date: _____ End Date: _____              | <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly               |
| Union Benefits: <input type="checkbox"/> Yes <input type="checkbox"/> No   Amount: \$ _____ Start Date: _____ End Date: _____                       | <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly               |
| State Disability: <input type="checkbox"/> Yes <input type="checkbox"/> No   Amount: \$ _____ Start Date: _____ End Date: _____                     | <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly               |
| For Union Benefits or Other Group Disability, please list provider's: Name: _____   |   |
| Phone: _____  |   |

### EMPLOYER SIGNATURE

|   |                     |                   |
|---|---------------------|-------------------|
| The above named employee may qualify for benefits under the American Fidelity 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: _____ |                     |                   |
| Printed Name: _____   | Title: _____        | Date: _____       |
| Email Address: _____  | Phone: (____) _____ | Fax: (____) _____ |
| How do you prefer to be contacted? <input checked="" type="checkbox"/> Email <input type="checkbox"/> Phone <input type="checkbox"/> Fax  |                     |                   |



**Attending Physicians Statement** Routine Pregnancy Claim Form to be completed by physician

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

**DIAGNOSIS**

|   |                                      |
|---|--------------------------------------|
| Disabling Diagnoses (including complications):                                      | ICD Code:                            |
| Type of delivery: <input type="checkbox"/> Normal <input type="checkbox"/> Cesarean |                                      |
| Date pregnancy was diagnosed: / /   | Date of delivery (if delivered): / / |
| Expected date of delivery: / /  |                                      |

**HISTORY**

|  |
|--|
| Date patient first consulted you for this condition? / /   |
| Was the patient referred to you? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide full name, address, and phone number of referring physician: |

**TREATMENT**

|  |               |                 |               |                 |
|--|---------------|-----------------|---------------|-----------------|
| Has the patient been confined to a hospital? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>If yes, give admit and discharge dates along with name and address of hospital. | Admitted: / / | Discharged: / / | Admitted: / / | Discharged: / / |
| Name:  | Address:      |                 |               |                 |

**PROGNOSIS**

|                                  |              |
|----------------------------------|--------------|
| Date total disability: From: / / | Through: / / |
|----------------------------------|--------------|

**PHYSICIAN INFORMATION**

|   |            |
|---|------------|
| Attending Physician's Name & Title: (print)                     | Specialty: |
| Phone:  | Fax:       |
| Mailing Address: (P.O. Box or Street, City, State and Zip Code) |            |
| Form Completed By: (Name & Title)                               | Signature: |
| Date: / /   |            |

**If you require completion of your own authorization for the release of medical records please submit the form along with the physician statement.**



## AUTHORIZATION TO DISCLOSE INFORMATION INCLUDING PROTECTED HEALTH INFORMATION

The purpose of this form is to allow American Fidelity Assurance Company (AF), or business partners acting on behalf of AF in the administration of AF products and to obtain data including but not limited to employment information, financial information, and protected health information about me, from any party holding that information. Once obtained, AF may use this data to review or process benefits, confirm policy information, or otherwise review or process information related to my Customer relationship with them.

I hereby authorize the entities specified below to disclose any information about me or my dependents' health or financial 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 AF 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, k) banks or financial institutions and l) Workers' Compensation Carrier. AF will only disclose any data collected pursuant to this authorization as necessary for our legitimate business purposes, and only to the extent allowed by law.

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.

I understand that AF may not condition payment of claims, enrollment, or eligibility for benefits on whether I sign this authorization. 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 an inability to pay benefits under my policy if my failure to sign results in AF not having enough information to process my benefits. 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: AF has taken action in reliance on the authorization; or, the law provides AF 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 financial 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 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.

\_\_\_\_\_  
AF 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 benefit is guilty of a crime and may be subject to fines and confinement in prison.

**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.

**Alaska** - A person who knowingly and with intent to injure, defraud, or deceive an insurance company files 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 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.

**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 fines and confinement 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, 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.

**Delaware, Idaho and Oklahoma** - WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

**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.

**Indiana** - A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

**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.

**Maine, Tennessee, Virginia and Washington** - It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

**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.

**Minnesota** - A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

**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.

**New Jersey** - Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

**New Mexico** - 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 CIVIL FINES AND CRIMINAL PENALTIES.

**Ohio** - Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is 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.

**Puerto Rico** - Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars (\$5,000) and not more than ten thousand dollars (\$10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances [be] present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.