Routine Pregnancy Claim Filing Instructions

Do not use this form for any benefit other than routine child birth.

1. Complete Employee's Disability Benefits Application in full.
2. Have the treating physician complete the Attending Physician's 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.** Employer's Report of Claim
   - **C.** Attending Physician's Statement

   to the address below or submit via our toll-free fax @ 1-800-818-3453.

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: 1-800-662-1113

American Fidelity Assurance Company
A member of the American Fidelity Group

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

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.

Hawaii - For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

REQUEST FOR ROUTINE PREGNANCY BENEFITS

American Fidelity Assurance Company
A member of the American Fidelity Group

ATTN: AFES BENEFITS DEPT.
P.O. Box 25160
Oklahoma City, Oklahoma 73125
Toll Free: 1-800-662-1113
Fax: 1-800-818-3453
www.afadvantage.com

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SECTION 1: EMPLOYEE'S DISABILITY BENEFITS APPLICATION

See page 1 for fraud statements.

Full Name: (last, first, middle initial) | Maiden Name | Account Number:

Social Security Number: - - | Date of Birth: / / | Telephone Number: (including area code) ( )

Mailing Address: (P.O. Box or street, city and zip code) | Occupation:

1. Full names and addresses of all treating physicians: (attach additional list if necessary)

_____
_____
_____

2. If hospitalized, give full name(s) and addresses of hospitals: (attach additional list if necessary)

Admit Date / / Discharge Date / /
Name(s) _____
Addresses _____

3. On what date did you last work?_____
Dates of total disability:
From _____ Thru _____
On what date did you return to work?
If not returned to work, when do you anticipate returning to work?_____

4. 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. **This authorization applies to benefits payable under all insurance policies held with AFAC.**

Bank/Credit Union Name: _____

Signature: _____

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

5. 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)

6. Are you receiving or eligible to receive other income during this period of disability? ☐ Yes ☐ No $ _____ Month

Sick Leave or Wage Continuation: ☐ Yes ☐ No $ _____ Month

Signature: _____ Date:_____

I certify this is true and correct information.

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize the entities specified below to disclose any information about my entire medical record or benefits payable 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 on the disease AIDS. Such test results shall not be discovered or published. Nothing in the 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 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.

SECTION 2: EMPLOYER'S REPORT OF CLAIM

Name of Employer: | Phone No.: ( ) | Fax No.: ( )

Mailing Address: (include street, city, state and zip code)

Name of Employee: | Social Security Number: | Occupation: | Date of Hire:

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

Have you withheld the employee's disability premium for the current month?

☐ Yes ☐ No

If not, what is the last month you deducted disability premiums? _____

CONTRACTED SALARY AT TIME OF DISABILITY ☐ 9 ☐ 10 ☐ 12 Month Work Schedule

Annual: $ _____ Effective Date: _____

Number of hours worked per week at time of disability _____.

Number of Contract days: _____ for _____ school year.

Date employee last worked:_____ Has employee returned to work? ☐ Yes ☐ No If Yes, date returned to work: Full Time: _____

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: _____

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PREGNANCY BENEFITS

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SECTION 3: ATTENDING PHYSICIAN'S STATEMENT

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

DIAGNOSIS

Diagnosis: | ICDA Code:

Type of delivery: _____

Date pregnancy was diagnosed? ____/____/____

Date of delivery: (if delivered) ___/___/_____

HISTORY

When did symptoms first appear? ____/____/____

Date patient first consulted you for this condition? ____/____/____

Was the patient referred to you? ❒ Yes ❒ No If yes, full name and address of referring physician: _____

_____

_____

TREATMENT

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.

Name: _____

Address:_____

PROGNOSIS

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

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

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

Signature: | Federal Tax ID #: | Date: