CONTINENTAL AMERICAN INSURANCE COMPANY
Post Office Box 427* Columbia, South Carolina 29202
Phone (800) 433-3036 Fax (866) 849-2970

SUPPLEMENTAL CLAIM FORM (CONTINUING DISABILITY)

(Please have completed for support of continued disability) **Claim Number:**

PART A: POLICYHOLDER'S STATEMENT

NAME:	SOCIAL SECURITY/ ID #:	DOB:
PHONE #: (INCLUDING AREA CODE)	ADDRESS: Please include apartment/unit number if applicable ☐ **PLEASE CHECK BOX IF PERMANENT ADDRESS CHANGE**	EMAIL ADDRESS:
DATES YOU WERE CONSIDERED TOTALLY DISABLED: FROM: THROUGH:	DATES YOU WERE CONSIDERED PARTIALLLY DISABLED: FROM: THROUGH:	DATE YOU RETURNED OR EXPECT TO RETURN TO WORK: FULL TIME: PART TIME/ LIGHT DUTY:

* By providing your e-mail address above, you consent to the use of electronic transactions in connection with your CAIC policies, contracts, and/or accounts to the extent available permitted by law (which may include, but not limited to: invoices, claim correspondence, contracts, surveys, and other materials that CAIC is, or may be, legally required to deliver to you).

I, the undersigned, do hereby warrant the foregoing answers and statements to be complete and true

POLICYHOLDER'S SIGNATURE: ***DATE:***

PART B: EMPLOYER'S STATEMENT

DATES EMPLOYEE WAS CONSIDERED TOTALLY DISABLED: FROM: THROUGH:	**DATES EMPLOYEE WAS CONSIDERED PARTIALLLY DISABLED:** FROM: THROUGH: **If working light duty or part time, was the employee earning more than 80% of the pre-disability salary?** **Please provide dates, hours worked, and earnings if the employee returned working part-time/light duty:**	DATE EMPLOYEE RETURNED OR EXPECT TO RETURN TO WORK FULL DUTY: ☐ FULL-TIME ☐ PART-TIME

COMPANY NAME:	TELEPHONE NUMBER:	NAME/TITLE OF REPRESENTATIVE COMPLETING THIS FORM:	EMPLOYEE'S OCCUPATION AT LAST DATE WORKED:
ADDRESS:			

EMPLOYER REPRESENTATIVE AUTHORIZED SIGNATURE: ***DATE:***

PART C: ATTENDING PHYSICIAN STATEMENT (To be completed by physician assessing return to work capability)

DIAGNOSIS:	PROVIDE ALL DATES YOU HAVE TREATED THE PATIENT FOR THIS CONDITION:

NATURE OF SICKNESS OR INJURY; COMPLICATIONS PREVENTING THE PATIENT FROM RETURNING TO WORK:

IF PREGNANCY RELATED, HAS THE PATIENT DELIVERED? **DELIVERY DATE**: _____ METHOD OF DELIVERY: ☐ VAGINAL ☐ C-SECTION	**PLEASE LIST ANY COMPLICATIONS RELATED TO THIS PREGNANCY THAT WOULD EXTEND DISABILITY**: (PREVENT PATIENT FROM PERFORMING NORMAL JOB FUNCTIONS)

WAS THE PATIENT TREATED BY OR REFERRED TO FOR ANY OTHER PHYSICIANS FOR THIS CONDITION?	IF YES, PLEASE PROVIDE PHYSICIAN NAMES, ADDRESSES, AND TELEPHONE NUMBERS:

DATES PATIENT WAS CONSIDERED TOTALLY DISABLED: FROM: THROUGH:	DATES PATIENT WAS CONSIDERED PARTIALLLY DISABLED: FROM: THROUGH:	DATE PATIENT RELEASED TO RETURN TO WORK: **(Please give estimate if not able to determine at this time)**

HAS THE PATIENT: (Please circle selection) RECOVERED IMPROVED UNCHANGED RETROGRESSED WHEN DO YOU EXPECT A FUNDAMENTAL OR MARKED CHANGE IN THE FUTURE: 1 MO. 1-3 MO. 3-6 MO. 6-12 MO. NEVER	DISABILITY RELATES TO: ☐ PATIENT'S JOB ☐ ANY OTHER WORK

WHAT ARE THE **SPECIFIC RESTRICTIONS AND LIMITATIONS** AS IT RELATES TO THE PATIENT'S OCCUPATION AND DISABLING CONDITION?

WILL THE PATIENT BE ABLE TO PERFORM THE REGULAR DUTIES OF HIS/ HER OCCUPATION WITH THE ABOVE RESTRICTIONS IN PLACE?

AUTHORIZED SIGNATURE OF PHYSICIAN

Name (Please Print):	**Telephone Number:**
Address:	**Medical ID #:**

"I hereby certify that the above described information is based upon reasonable medical probability, and is true and correct to the best of my knowledge and belief."

SIGNATURE OF PHYSICIAN: ***DATE:***

FRAUD WARNING NOTICES

For use with Claim Forms

PLEASE READ THE FRAUD WARNING NOTICE FOR YOUR STATE

ALASKA: A person who knowingly and with intent to injury, 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: 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: For your protection California law requires the following to appear on this form:
Any person who knowingly presents a 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: 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.

DISTRICT OF COLUMBIA: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

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.

IDAHO: Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

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.

LOUISIANA: 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.

MAINE: 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 and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and 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.

FRAUD WARNING NOTICES (CONT.)

For use with Claim Forms

PLEASE READ THE FRAUD WARNING NOTICE FOR YOUR STATE

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.

NEW YORK: 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

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.

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.

OREGON: 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 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.

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 with the penalty of 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 are 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.

TENNESSEE: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

TEXAS: Any person who knowingly presents a 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.

VIRGINIA: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

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 include imprisonment, fines, and denial of insurance benefits.

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.

ALL OTHER STATES: 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.

Electronic Funds Transaction Authorization

Send to: **Continental American Insurance Company**
Post Office Box 427
Columbia, South Carolina 29202

Phone: (800) 433-3036 Fax (866) 849-2970
Email: groupclaimfiling@aflac.com

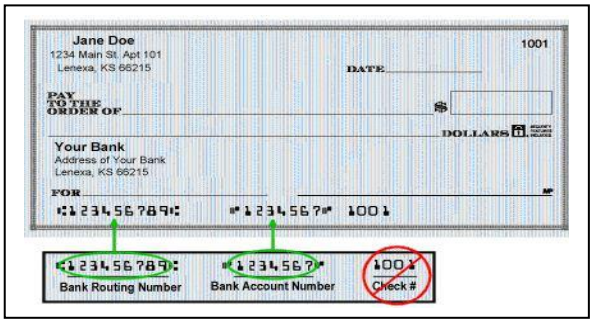
I would like to:

☐ Start ☐ Stop ☐ Change direct deposit of my claim payment(s).

Account Type:

☐ Checking ☐ Savings

****** Please provide a blank voided check or direct deposit form from your financial institution. Incomplete or inaccurate information will not be processed.**



9-Digit Routing Number:		Account Number:
Name of Financial Institution:		
Address:		City:
State:	Zip:	Phone:

Authorization Agreement for Direct Deposit

I authorize Continental American Insurance Company (CAIC) to initiate credit entries, and, if errors occur, I authorize the correction of entries to my account as indicated. This authorization remains effective and in full force until CAIC receives written notification from me of its termination in such time and in such manner to afford CAIC a reasonable opportunity to act on it. Please notify CAIC immediately if your financial institution information has changed by sending notification to the address indicated above. Should you have any questions, please contact us at 1-800-433-3036.

Policy/Certificate Holder's Name (*Print*):

Address:	City/State/Zip:
Phone #:	E-mail Address:
Employer Name or Group #:	Certificate #:

By providing your e-mail address above, you consent to the use of electronic transactions in connection with your CAIC policies, contracts, and/or accounts to the extent available and permitted by law (which may include, but not limited to: invoices, claim correspondence, contracts, surveys, and other materials that CAIC is, or may be, legally required to deliver to you)

_____ _____
Policy/Certificate Holder Signature ***(Required)*** Date

Note: Forms received without signature will **not** be processed.

CONTINENTAL AMERICAN INSURANCE COMPANY
Post Office Box 427* Columbia, South Carolina 29202
Phone (800) 433-3036 Fax (866) 849-2970

AUTHORIZATION TO OBTAIN INFORMATION

MAIL TO: Continental American Insurance Company
P.O. Box 427
Columbia, South Carolina 29202

CALL: 1.800.433.3036 (toll-free)
CLAIM FAX: 1.866.849.2970

Primary Certificateholder's Name:	**SSN**(optional):	**Date of Birth:**
Certificate Number(s):		
Address:		
Name of Individual Subject to Disclosure (If not the primary Certificateholder):		**Date of Birth:**
Relationship to Primary Certificateholder: □Self □ Spouse □ Domestic Partner □ Child □ Stepchild □ Grandchild		

I. Authorization:
For the purpose of evaluating my *eligibility for insurance and for benefits* under an existing certificate, including checking for and resolving any issues that may arise regarding incomplete or incorrect information on my application for coverage and/or claim form, I hereby authorize the disclosure of the following information(defined below) about me and, if applicable, my dependents, from the sources listed below to Continental American Insurance Company (CAIC), or any person or entity acting on its part, to include American Family Life Assurance Company of Columbus and American Family Life Assurance Company of New York (collectively, "Aflac).

II. Disclosure of Health Information:
Health information may be disclosed by any health care provider, health plan (including CAIC or Aflac, with respect to other CAIC or Aflac coverages) or health care clearinghouse that has any records or knowledge about me. Health care provider includes, but is not limited to, any licensed physician, medical or nurse practitioner, nurse, pharmacist, osteopath, psychologist, physical or occupational therapist, chiropractor, dentist, audiologist or speech pathologist, podiatrist, hospital, medical clinic or laboratory, pharmacy, rehabilitation facility, nursing home or extended care facility, prescription drug database or pharmacy benefit manager, or ambulance or other medical transport service. Health information may also be disclosed by any insurance company or the Medical Information Bureau (MIB). Health information includes my entire medical record, but does not include psychotherapy notes. Some information obtained may not be protected by certain federal regulations governing the privacy of health information, but the information is protected by state privacy laws and other applicable laws. CAIC will not disclose the information unless permitted or required by those laws.

III. Rights and Expiration:
I understand that I may revoke this authorization at any time, except to the extent that CAIC or Aflac has taken action in reliance on this authorization. If I revoke this authorization, CAIC may not be able to evaluate my application for coverage and/or claim. To revoke this authorization, I must provide a written and signed revocation to CAIC at the address or fax number above. Unless otherwise revoked, this authorization shall remain in effect for two (2) years from the date signed or upon my death, whichever occurs first. I agree that a copy of this authorization is as valid as the original and that I or an authorized representative may request a copy of this authorization.

IV. Notice:
I understand that CAIC is not conditioning payment, enrollment, or eligibility for benefits on whether I sign this authorization. I understand that if the information disclosed is protected health information relating to a health plan and the person or entity receiving the information is a not a health care provider or health plan covered by federal privacy regulations, the information disclosed may be redisclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.

- **If records are on an adult dependent, (e.g. spouse, child over 18), the dependent must sign this form**
- **If records are on a minor child the natural parent or legal guardian must sign on their behalf.**

_____ _____
Signature of Individual Subject to Disclosure Date Signed

_____ _____ _____ _____
Legal Representative's Printed Name Legal Representative's Signature Legal Relationship Date Signed

If signed by a legal representative (e.g. Legal Guardian, Estate Administrator, Power of Attorney)