American Fidelity Assurance Company
A member of the American Fidelity Group®

American Fidelity Assurance Company
Mail to: AFES Benefits Department
P.O. Box 25160
Oklahoma City, OK 73125-0160
Toll Free Phone # 1-800-662-1113
Toll Free Fax # 1-800-818-3453

ATTENDING PHYSICIAN'S STATEMENT

Name of Patient: | Date of Birth: | Account Number:

DIAGNOSIS

Diagnosis: (including complications) | ICDA Code:

Is disability due to injury or sickness arising out of or in the course of patient's employment? ❑ Yes ❑ No

Is disability the result of pregnancy? ❑ Yes ❑ No If yes, type of delivery: _____

Date pregnancy was diagnosed? ____/____/____ Date of delivery:(if delivered) ____/____/____ Expected date of delivery? ____/____/____

HISTORY

When did symptoms first appeared or accident happen? _____/_____/_____ Date patient first consulted you for this condition? _____/_____/_____

Has the patient ever had the same or similar condition? ❑ Yes ❑ No If yes, indicate when and describe:

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

TREATMENT

Frequency of treatment: ❑ Monthly ❑ Weekly ❑ Other
If not under your regular care and attendance please explain.

Date of next appointment : _____/_____/_____

Nature of treatment being rendered (including surgery and any medications being prescribed)

List all dates of treatment or medical attention since the disability began:

Is patient still under your care for this condition? ❑ Yes ❑ No If no, please provide the name of the current treating physician:

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. Admitted: _____/_____/_____ Discharged: _____/_____/_____

Name:_____ Address: _____

PROGNOSIS

California Physicians: Please answer the following question with respect to your patient's disability:

Patient was continuously totally disabled (unable to work)

1. Own occupational ❑ Yes ❑ No From: _____ thru _____
   Total Disability from own occupation is defined as a disability that renders one unable to perform with reasonable continuity the substantial and material acts necessary to pursue his usual occupation in the usual and customary ways.

2. Any occupation ❑ Yes ❑ No From: _____ thru _____
   Total Disability from any occupation is defined as: disability that renders one unable to engage with reasonable continuity in another occupation in which he could reasonably be expected to perform satisfactorily in light of his age, education, training, experience, station in life, physical and mental capacity.

Dates of partial disability? From: _____ Through: _____

If the patient is currently disabled, what is the anticipated length of disability?

❑ 1-2 Months ❑ 2-3 Months ❑ 3-6 Months
❑ 6-12 Months ❑ More than 12 Months ❑ Permanent

When, in your opinion will the patient recover sufficiently to return to work?

IMPAIRMENTS

Functional Limitations that render your patient totally disabled:

Current Treatment Plan:

Attention Physician: This form documents your verification that the above named individual is totally disabled from either their or any other occupation. Your signature generates disbursement of disability benefits. You will be asked periodically for updates related to this individual's disability status and treatment plan.

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

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

Signature: | Federal Tax ID #: | Date:

Group Disability Claim Filing Instructions

(Not for use when filing for Physician's Expense Benefits)

CALIFORNIA

Disability claim forms should be completed after you become disabled.

1. Complete Employee's Disability Benefits Application in full.
2. Have the treating physician complete the Attending Physicians 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. Employers Report of Claim
   C. Attending Physician's Statement
   to the address below or submit via our toll-free fax @ 1-800-818-3453
5. 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.

   Signature: _____

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

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 Phone # 1-800-662-1113

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Benefits Department
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EMPLOYER'S REPORT OF CLAIM

EMPLOYMENT

Name of Employer: Phone No.: ( )

Mailing Address: (include street, city, state and zip code) Fax No.: ( )

Name of Employee: Social Security Number: - -

Address: (include street, city, state and zip code) Phone No.: ( )

Date of Hire: Effective date of employee's coverage: Occupation: (please attach job description)

Status of employment at time of disability: ❑ Full-Time ❑ Part-Time ❑ Leave of Absence ❑ Terminated ❑ Retired

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

Number of contract days: _____ for _____ school year.

Inhouse days:
First Day _____
Last Day _____

Has employee's status of employment changed? ❑ Yes ❑ No If yes, current status and date of status-change? _____

PREMIUMS

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: Short Term Plan _____

Are the AFA disability premiums withheld before or after taxes? On Long Term Plan _____

Short Term Plan ❑ Before ❑ After Long Term Plan ❑ Before ❑ After

SALARY

CONTRACTED SALARY AT TIME OF DISABILITY

Monthly: $_____ Effective Date: _____ ❑ 9 ❑ 10 ❑ 12 Month Work Schedule

Annual: $_____ Effective Date: _____ ❑ 9 ❑ 10 ❑ 12 Month Work Schedule

DISABILITY

Date employee last worked:_____ Have you withheld the employee's disability premium for the current month?

Has employee returned to work? ❑ Yes ❑ No ❑ Yes ❑ No

If Yes, date returned to work: If not, what is the last month you deducted disability premiums?

Full Time: _____Part Time: _____ _____

OTHER INCOME

Did Employee's disability result from employment? ❑ Yes ❑ No

If yes, name, address and phone number of Worker's Compensation carrier: _____

Has employee made a claim for or entitled to Worker's Compensation? ❑ Yes ❑ No

If yes, weekly rate of compensation: $_____

Provide: The final date the employee is entitled to fully paid sick leave _____

The **first** date the employee is entitled to differential/sabbatical pay, if any _____

The **last** date the employee is entitled to differential/sabbatical pay _____

The daily rate of differential/sabbatical pay $ _____

Name, address and phone number of any other disability carrier: (include street, city, state and zip code)

Is employee eligible for disability retirement benefits? ❑ Yes ❑ No

Remember - To attach a copy of the applicable school calendar for any contracted employee.
FAILURE TO DO SO COULD RESULT IN DELAYED BENEFITS

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:

Date: _____ Signature: _____ Title: _____

E-mail address: _____

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EMPLOYEE'S DISABILITY BENEFITS APPLICATION

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.

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

Residence: (street, city, state and zip code) | Social Security Number: - -

Mailing Address: (P.O. Box or street, city and zip code) | Date of Birth: /____/

Telephone Number: (including area code) ( ) | ❒ Single ❒ Married ❒ Widowed ❒ Divorced

Occupation: | Has your employment terminated? | If so, date:

Names & birth dates of spouse & dependents:
_____/____/____ Name Birth date | _____/____/____ Name Birth date
_____/____/____ Name Birth date | _____/____/____ Name Birth date

1. Date accident or illness began:

2. If accident, explain where and how it happened?

3. Have you ever had the same or similar condition in the past? ❒ Yes ❒ No
If yes, names and address of treating physicians and/or hospitals:

4. Nature of illness or injury:

5. Dates of medical treatment:
Date of next Doctors appointment:

6. If hospitalized give full name(s) and addresses of hospitals: (attach additional list if necessary)
Admit Date: _____/_____/_____ Discharge Date: _____/_____/_____

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

8. Is your disability related to your employment/occupation? ❒ Yes ❒ No
If yes, have you or do you intend to file for Worker's Compensation? ❒ Yes ❒ No

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

10. 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)

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

Your Social Security: (disability or retirement)	❒ Yes	❒ No	$_____Mo.	V.A. Benefits:	❒ Yes	❒ No	$_____Mo.
Dependent Social Security:	❒ Yes	❒ No	$_____Mo.	Worker's Compensation:	❒ Yes	❒ No	$_____Mo.
Sick Leave or Wage Continuation:	❒ Yes	❒ No	$_____Mo.	Other Disability Coverage:	❒ Yes	❒ No	$_____Mo
Retirement: (normal early or disability)	❒ Yes	❒ No	$_____Mo.	(identify)_____			
State Disability Income	❒ Yes	❒ No	$_____Mo.				

Include a copy of your award or denial letter for any source in which one has been received.

Signature: _____ **Date:** _____

I certify this information is true and correct.

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize the entities specified below to disclose any information about my entire medical record 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 practicioners; 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 of the disease AIDS. Such test results shall not be discovered or published. Nothing in this 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 the authorization 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.