

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 Statementto 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



A member of the American Fidelity Group®

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



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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
www.afadvantage.com

EMPLOYER'S REPORT OF CLAIM

E M P L O Y E R S R E P O R T	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)
P R E M I U M S	Status of employment 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
	Number of hours worked per week at time of disability: _____ Inhouse days: _____
	Number of contract days: _____ for _____ school year. First Day _____
	Has employee's status of employment changed? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, current status and date of status-change? _____ Last Day _____
S A L A R Y	CONTRACTED SALARY AT TIME OF DISABILITY
	Monthly: \$ _____ Effective Date: _____ <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/> 12 Month Work Schedule
	Annual: \$ _____ Effective Date: _____ <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/> 12 Month Work Schedule
D I S A B I L I T Y	Date employee last worked: _____ Have you withheld the employee's disability premium for the current month? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Has employee returned to work? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
	If Yes, date returned to work: _____ If not, what is the last month you deducted disability premiums? _____
O T H E R I N C O M E	Full Time: _____ Part Time: _____
	Did Employee's disability result from employment? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, weekly rate of compensation: \$ _____
O T H E R I N C O M E	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 \$ _____
O T H E R I N C O M E	Name, address and phone number of any other disability carrier: (include street, city, state and zip code)
	Is employee eligible for disability retirement benefits? <input type="checkbox"/> Yes <input type="checkbox"/> 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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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
www.afadvantage.com

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.

Form with fields for: Full Name, Maiden Name, Account Number, Residence, Social Security Number, Mailing Address, Date of Birth, Telephone Number, Marital Status, Occupation, Employment Termination, Names & birth dates of spouse & dependents, Date accident or illness began, Nature of illness or injury, Dates of medical treatment, Hospitalization details, Treating physicians, Disability related to employment, Return to work dates, Federal Taxes, Other income sources, and Signature.

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.

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.

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 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. Includes footer: 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.



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ATTENDING PHYSICIAN'S STATEMENT

Name of Patient:	Date of Birth:	Account Number:		
D I A G N O S I S	Diagnosis: (including complications) ICDA Code:			
	Is disability due to injury or sickness arising out of or in the course of patient's employment? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
	Is disability the result of pregnancy? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If yes, type of delivery: _____ Date pregnancy was diagnosed? ___/___/___ Date of delivery:(if delivered) ___/___/___ Expected date of delivery? ___/___/___			
H I S T O R Y	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? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If yes, indicate when and describe:			
	Was the patient referred to you? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If yes, full name and address of referring physician:			
T R E A T M E N T	Frequency of treatment: <input checked="" type="checkbox"/> Monthly <input checked="" type="checkbox"/> Weekly <input type="checkbox"/> 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? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If no, please provide the name of the current treating physician:			
	Has the patient been confined to a hospital? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Admitted: ___/___/___ Discharged: ___/___/___ If yes, give admit and discharge dates along with name and address of hospital. Admitted: ___/___/___ Discharged: ___/___/___ Name: _____ Address: _____			
P R O G N O S I S	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 <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No From: _____ thru _____ 2. Any occupation <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No From: _____ thru _____ <small>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.</small> <small>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.</small>			
	Dates of partial disability? From: _____ Through: _____			
	If the patient is currently disabled, what is the anticipated length of disability? <input checked="" type="checkbox"/> 1-2 Months <input checked="" type="checkbox"/> 2-3 Months <input type="checkbox"/> 3-6 Months <input checked="" type="checkbox"/> 6-12 Months <input checked="" type="checkbox"/> More than 12 Months <input type="checkbox"/> Permanent When, in your opinion will the patient recover sufficiently to return to work?			
I M P A I R M E N T S	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:	