PROOF OF DEATH - BENEFICIARY'S STATEMENT

TO FILE A CLAIM UNDER AN AFLAC LIFE INSURANCE OR ACCIDENT POLICY, PLEASE MAIL YOUR COMPLETED BENEFICIARY'S STATEMENT ALONG WITH VERIFIABLE PROOF OF DEATH. PLEASE NOTE, ADDITIONAL INFORMATION MAY BE REQUESTED FROM THE INSURED'S ESTATE, NEXT OF KIN OR PERSONAL REPRESENTATIVE.

INFORMATION ON DECEASED			
LAST NAME	FIRST NAME	MIDDLE INITIAL	MAIDEN/ALIAS/NICKNAME
ADDRESS			
CITY	COUNTY	STATE	ZIP
SOCIAL SECURITY NUMBER			DATE OF BIRTH
RELATIONSHIP TO POLICYHOLDER: ❒ SPOUSE ❒ DEPENDENT ❒ OTHER _____			

The undersigned hereby applies to Aflac or payment of said insurance and agrees that the written statements and affidavits of all the physicians who attended or treated the insured, and all other papers called for by the instructions hereon, will constitute, and they are hereby made a part of these verifiable Proofs of Death and further agrees that the furnishing of this form, or of any other forms supplemental thereto, by said company will not constitute nor be considered an admission by it that there was any insurance in force on the life in question, nor a waiver of any of its rights or defense.

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.

Signed at _____ Dated _____
City, County, State

_____ _____ ___/___/___
Beneficiary's Signature Beneficiary's SSN Beneficiary's DOB

_____ _____
Print Beneficiary's Name Witnessed by

_____ (____)_____
Beneficiary's Mailing Address City County State/Zip Home Telephone

American Family Life Assurance Company of Columbus (Aflac)
Attn: Claims Department • Worldwide Headquarters • 1932 Wynnton Road • Columbus, GA 31999
For information, call toll-free 1-800-99-AFLAC (1-800-992-3522) or visit aflac.com.
Toll-free fax number: 1.877.44.AFLAC (1.877.442.3522)

Claims Authorization to Obtain Information

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Instructions for completing this Health Insurance Portability and Accountability Act of 1996 (HIPAA) compliant form:

1. **All areas of this form should be completed.**
2. **This form must be signed and dated by the claimant/patient below.**
3. **IMPORTANT: If you are filing a claim on behalf of a deceased, please check here**
4. **If you are the Authorized Representative, please sign below and indicate your relationship to the claimant/patient/deceased. In addition, include a copy of the legal document(s) authorizing you to act on their behalf.**
5. **Fax this form to 1-877-442-3522 or return the form to Aflac, Attn: Claims Department, Worldwide Headquarters, 1932 Wynnton Road, Columbus, GA 31999, as soon as possible in order to expedite claim review.**

Policyholder Name:	**Policy Number(s):**	**Date of Birth:**
Policyholder Address:		
Claimant/Patient Name (if different from named policyholder listed above):		**Date of Birth:**

This authorization shall be valid for a period of two years from the sign date unless a lesser time frame is indicated. Alternate Expiration Date:	**Name and Address of health care provider(s), company, or individual authorized to release the requested information:** (this section will be completed by Aflac):
Purpose of Disclosure: Evaluate claims for benefits during the time this authorization is valid.	

I, or my authorized representative, request that information regarding my past, present, or future physical or mental health condition (excluding psychotherapy notes), employment, other insurance coverage, or any other nonmedical facts be released to **American Family Life Assurance Company of Columbus (Aflac)** or any person or entity acting on its part. This could include, but is not limited to, any medical professional, medical care institution, insurer (including Aflac, with respect to other Aflac coverages), reinsurer, government agency (including departments of public safety and motor vehicle departments), consumer reporting agency or employer.

I understand that:

1. Protected health information may include information and records protected under Federal and State Law such as: alcohol, drug abuse, mental health, AIDS or HIV testing or treatment, or the presence of a communicable or noncommunicable disease.
2. My treatment, payment or eligibility for benefits may not be conditioned on signing this authorization.
3. I understand that I may revoke this authorization at any time by writing to **Aflac, Claims Department, Worldwide Headquarters, 1932 Wynnton Road, Columbus, GA 31999**, except to the extent that:
   a. Aflac has taken action in reliance to this authorization, or
   b. Other law provides Aflac with the right to contest a claim under the policy or the policy itself.
4. If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. It is recommended I retain a copy of this signed form for my records, understanding that a copy is as valid as the original.

Signature of claimant/patient, guardian or authorized representative **Date**

Printed name of claimant/patient, guardian or authorized representative **Relationship**