CALIFORNIA

American Fidelity Assurance Company
A member of the American Fidelity Group
Toll Free # 1-800-662-1113
Fax # 1-800-818-3453
afadvantage.com

INDIVIDUAL CANCER , INTENSIVE CARE OR DREAD DISEASE BENEFIT STATEMENT

AMERICAN FIDELITY ASSURANCE COMPANY
ATTN: Benefit Department
P.O. Box 25160
Oklahoma City, OK 73125

Warning: 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.

INSTRUCTIONS TO INSURED

1. **Complete STATEMENT OF INSURED.**
2. **Attach ITEMIZED BILLS.**
3. **Have physician complete ATTENDING PHYSICIAN'S STATEMENT.**
4. **If claim is for CANCER BENEFIT, include PATHOLOGIST'S REPORT.**

STATEMENT OF INSURED

1. FULL NAME_____ Date of Birth_____/_____/_____ Account No. _____
(Please Print (Last) (First) (M.I.) (Mo) (Day) (YR) Social Sec. # _____
2. Address _____
(Street) (City) (State) (Zip Code)
3. Telephone number Work _____ Home _____
4. If claim is for dependent, give name of dependent_____ Relationship_____ Date of Birth:_____
Mo Day Yr
5. **For dependent child between 21-25 years of age:**
School _____ Hours Enrolled: _____
Address of School: _____
ID number or Social Security number of student: _____

Is this claim for ❑ Cancer Benefits ❑ Intensive Care Benefits ❑ Dread Disease Benefits

6. Illness Condition _____
7. Has this condition caused previous trouble?_____ If so, when?_____
8. Date first treated _____
9. Have you been confined to a hospital? ❑ Yes ❑ No If yes, when From:_____ To:_____

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize the entities specified below to disclose any information about me or my dependents' health including my or my dependents' 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 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. Colorado state law prohibits the redisclosure or reuse of information disclosed about a Colorado resident under this authorization.

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. For Maine residents, information authorized for release may include information on communicable or venereal diseases such as hepatitis, syphilis, gonorrhea, AIDS/ARC (Acquired Immune Deficiency Syndrome /AIDS Related Complex) 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. For Vermont residents, this authorization does not require disclosure of prior HIV-related tests. For Wisconsin residents, results of AIDS/HIV test do not need to be reported if they were done at any anonymous counseling and testing site, if the test was not an FDA-licensed blood test, or through the use of a home test kit. For Arizona residents, release of HIV/AIDS-related information can only be disclosed for a period not to exceed 180 days from the date shown below.

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)

_____ _____
Date of Birth Date Signed

I certify this information is true and correct.

Relationship of Personal Representative to Patient _____

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.

ATTENDING PHYSICIAN'S STATEMENT

Warning: For your protection, California law requires the following to appear on this form. Any person who knowingly presents false or fraudulent statement claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

1. Patient's Name_____Age_____ Date of Birth_____
2. Diagnosis _____ (ICDA Code)_____
3. When did symptoms first appear? _____ Date_____
4. When did patient first consult you for this condition? _____ Date_____
5. Has patient ever had same or similar condition? ☐ Yes ☐ No (If "Yes" state when and describe)

   _____
6. Was patient referred to you by another physician? ☐ Yes ☐ No If yes, list name and address of referring physician

   Name _____ Address_____
7. If patient hospitalized, give name and address of hospital. _____

   Admit Date_____ Discharge Date_____

   Date_____ Signed_____
   Degree

   _____
   (Street Address) (City or Town) (State) (Zip Code)

   Tax ID Number_____