

Cancer Screening Wellness Benefit Claim Form

Please read all instructions.

Failure to follow these instructions will delay the processing of your claim.

Do not include receipts, statements, or other documentation with this form.

Your Aflac policy provides one Wellness Benefit per covered person, per calendar year, and this form is designed specifically for this benefit. To receive your Wellness Benefit, complete the form by following the instructions provided. Please print a separate form for each additional covered family member or call 1-800-99-AFLAC (1-800-992-3522) to request additional forms. Claims for all other benefits covered under your Cancer policy must be filed separately, using the Cancer Claim Form.

If any of your wellness tests resulted in a diagnosis of cancer, please submit your claim for cancer treatment separately, using the Cancer Claim Form.

If your Aflac policy also provides one Mammogram Benefit per calendar year, please mark the appropriate box and indicate the date the mammogram was performed. Please check your policy for specific benefits covered under your policy.

If your Aflac policy also provides one Pap Smear Benefit per calendar year, please mark the appropriate box and indicate the date the Pap smear was performed. Please check your policy for specific benefits covered under your policy.

- **Do not write on the form except as instructed.**
- **Incomplete forms cannot be processed and will be returned.**
- **Please do not fax this completed form to Aflac.**
- **Mark only wellness exam box(es) for test(s) that you had performed.**

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Some of the tests listed may not be covered under the Wellness Benefit of your policy. Please check your policy for a list of covered wellness procedures or call 1-800-99-AFLAC (1-800-992-3522) for a Wellness Form specifically tailored for your policy.

Please use black or blue ink only and print legibly when completing this form in its entirety. Keep a copy of the supporting documentation and this completed form for your records. Sign, date, and mail the completed form to the Aflac address shown below.

Policyholder Information

Policyholder's First Name:
Middle Initial:
Policyholder's Last Name:
M M D D Y Y Y Y ZIP of mailing address:
Policyholder's Birth Date:

Patient Information

First Name:
Middle Initial:
Last Name:
Relationship: Primary Policyholder Spouse Dependent Child
Sex: Male Female
Patient's Birth Date:
Policy Number:

Wellness Exam

Treatment Date:
 Colonoscopy
 Virtual colonoscopy
 Pap smear - ThinPrep
 Pap smear
 Cancer Prevention Vaccine
 Hemocult stool specimen
 CEA (blood test for colon cancer)
 CA 125 (blood test for ovarian cancer)
 Mammogram
 Flexible sigmoidoscopy
 Thermography
 Chest X-ray
 PSA (blood test for prostate cancer)
 Breast ultrasound/Breast sonogram
 Biopsy
M M D D Y Y Y Y
Pap Smear Date:
M M D D Y Y Y Y
Mammogram Date:
Provide Actual Cost for Mammogram:

Physician Information

Phone Number:

Name:
Street Address:
City:
State:
ZIP:

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.

I certify that the information provided is true and correct:

POLICYHOLDER'S SIGNATURE

DATE

American Family Life Assurance Company of Columbus (Aflac)
Attn: Claims Department • 1932 Wynnton Road • Columbus, GA 31999-7251
1-800-99-AFLAC (1-800-992-3522) • aflac.com • 1-800-SI-AFLAC (1-800-742-3522) en español