American Fidelity Assurance Company
A member of the American Fidelity Group

Local Phone # 416-7750
Toll Free # 1-800-267-2322
Fax # 1-888-243-3453

INDIVIDUAL CANCER, INTENSIVE CARE OR DREAD DISEASE BENEFIT STATEMENT

AMERICAN FIDELITY ASSURANCE COMPANY
ATTN: AWD Benefits Department
P.O. Box 268898
Oklahoma City, OK 73126-8898

Warning: Any person who knowingly, and with intent to injure, defraud, or deceive any insurer files a statement of claim containing any false, incomplete, or misleading information may be guilty of insurance fraud and subject to criminal and civil penalties.

INSTRUCTIONS TO INSURED

1. **Complete STATEMENT OF INSURED.**
2. **Attach ITEMIZED BILLS with DIAGNOSIS.**
3. **If claim is for CANCER BENEFIT, include PATHOLOGIST'S REPORT.**

STATEMENT OF INSURED

1. FULL NAME (Please Print) (Last) (First) (M.I.) Date of Birth (Mo) / (Day) / (Yr) Account # 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)
   Dependent Social Sec. #

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

5. Illness/Condition
6. Has this condition caused previous trouble? If so, when?
7. Date first treated
8. Have you been confined to a hospital? ☐ Yes ☐ No If yes, when From To
   Name and address of hospital
   (Complete if diagnosis was made within the first year of coverage.)
9. Names, addresses and phone numbers of any doctors the patient has consulted in the past five years

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize the entities specified below to disclose any information about my or my dependants' 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.

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 of benefits. *I understand that I may revoke this authorization at any time by writing to American Fidelity Assurance Company, AWD Benefits Department, P.O. Box 268898, Oklahoma City, Oklahoma 73126-8898 or calling toll free 1-800-267-2322. 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 re-disclosed and no longer protected by 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. **For Arizona residents,** release of HIV/AIDS - released information can only be disclosed for a period not to exceed 180 days from the date shown below.

Print Insured's/Patient Name

Signature Date:

Please retain a copy for your personal records, or you may request a copy from our company.