CONTINENTAL AMERICAN INSURANCE COMPANY
Post Office Box 427* Columbia, South Carolina 29202
Phone (800) 433-3036 Fax (866) 849-2970

INITIAL DISABILITY CLAIM FORM

Policyholder's Statement

Failure to complete all sections may result in a delay in processing this claim.

AUTHORIZATION

Several states require that the following statement appear on the claim forms:

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.

For the purpose of evaluating my *eligibility for insurance and eligibility for benefits* under an existing certificate including checking for and resolving any issues that may arise regarding incomplete or incorrect information on my application or claim form, I hereby authorize the disclosure of the following information about me and, if applicable, my dependents, from the sources listed below to Continental American Insurance Company (CAIC) and its duly authorized representatives.

Disclosure of Health Information

Health information may be disclosed by any health care provider, health plan or health care clearinghouse that has any records or knowledge about me. Health care provider includes, but is not limited to, any licensed physician, medical or nurse practitioner, nurse, pharmacist, osteopath, psychologist, physical or occupational therapist, chiropractor, dentist, audiologist or speech pathologist, podiatrist, hospital, medical clinic or laboratory, pharmacy, rehabilitation facility, nursing home or extended care facility, prescription drug database or pharmacy benefit manager, or ambulance or other medical transport service. Health information may also be disclosed by any insurance company or the Medical Information Bureau (MIB). Health information includes my entire medical record, but does not include psychotherapy notes.

Financial or credit history, earnings, or employment history may be disclosed by any entity, person or organization that has these records about me, including but not limited to my employer, employer representative and compensation sources, insurance company, financial institution or any consumer reporting agency.

Federal, state and local government organizations including but not limited to the Veteran's Administration, Internal Revenue Service, Social Security Administration, Medicare or Medicaid agencies, may disclose health or financial information or records about me.

Any information CAIC obtains pursuant to this authorization will be used for the purpose of evaluating and administering my claim for benefits. Some information obtained may not be protected by certain federal regulations governing the privacy of health information, but the information is protected by state privacy laws and other applicable laws. CAIC will not disclose the information unless permitted or required by those laws.

This authorization is valid for two (2) years from its execution or the duration of my claim, whichever is later. A copy of this authorization is as valid as the original. I know that I or my authorized representative may request a copy of this authorization and access to this information.

This authorization may be revoked by me or my authorized representative at any time except to the extent CAIC has relied on the authorization prior to notice of revocation or has a legal right to contest coverage under the contract or the contract itself. If I revoke this authorization, CAIC may not be able to evaluate my claim or eligibility for benefits. I may revoke this authorization by sending written notice to: Continental American Insurance Company, Claims Department, P.O. Box 427, Columbia, SC 29202.

You may refuse to sign this form; however, CAIC may not be able to evaluate and administer your claim without this authorization.

I am the individual to whom this authorization applies or that person's legal Guardian, Power of Attorney Designee, Conservator, Beneficiary or personal representative

Policyholder's Signature: _____ Date: _____ Patient's Signature: _____ Date: _____

PART A POLICYHOLDER/PATIENT'S INFORMATION

1	EMPLOYER'S NAME	POLICYHOLDER'S NAME	POLICY NO.	DATE OF BIRTH	GENDER
2	POLICYHOLDER'S ADDRESS CITY STATE ZIP CODE			SOCIAL SECURITY NO.	
3	POLICYHOLDER'S PREFERRED EMAIL ADDRESS	PREFERRED METHOD OF CONTACT ❑ MAIL ❑ EMAIL		POLICYHOLDER'S TELEPHONE NO. (WITH AREA CODE)	
4	PATIENT'S NAME	DATE OF BIRTH	GENDER	PATIENT'S OCCUPATION	
5	DATES YOU DID NOT WORK AT ALL. FROM THROUGH	DATES YOU WORKED LESS THAN FULL TIME. FROM THROUGH		DATE YOU RETURNED OR EXPECT TO RETURN TO WORK. FULL-TIME PART-TIME	
	PRIMARY DOCTOR NAME	TREATING DOCTOR NAME		REFERRING DOCTOR NAME	
	ADDRESS	ADDRESS		ADDRESS	
	CITY, STATE, ZIP CODE	CITY, STATE, ZIP CODE		CITY, STATE, ZIP CODE	
	PHONE NUMBER	PHONE NUMBER		PHONE NUMBER	

INITIAL DISABILITY CLAIM FORM

Policyholder's Statement

Please sign the attached HIPAA Form and return it with the completed claim form.

- Is disability due to a sickness? ☐ No ☐ Yes
  - If yes, please provide the date symptoms first appeared: _____
- Is disability due to an injury? ☐ No ☐ Yes
  - If yes, please complete the following questions related to the injury.
    - Date of the Injury: _____
    - Describe how the injury occurred: _____

      _____
    - Location of the injury? ☐ On the job ☐ Off the job
      - If on the job, please provide the date the employer was notified:_____
      - Has a worker's compensation claim been filed?
        - If yes, please provide status: ☐ Approved ☐ Pending ☐ Denied* ☐ Appealing

          **If denied, please submit a copy of workers' compensation denial letter.*
      - Was the injury due to a motor vehicle accident? ☐ No ☐ Yes (If yes, please submit a copy of the Police Report)

- Please indicate any additional income you are currently receiving:
-
  - Social Security: Date Began:_____ Date Ceased:_____
  - State Disability: Date Began:_____ Date Ceased:_____
- Was the patient confined to the hospital as a result of this condition? ☐ No ☐ Yes
  Admission date _____ Discharge Date _____

  Hospital name:_____ Telephone Number: _____

  Address: _____

  City: _____ State: _____ Zip Code: _____

PART B	EMPLOYER'S STATEMENT (To be completed by your Benefits Department unless self-employed)			
1	EMPLOYEE'S NAME:	EMPLOYEE ID NUMBER	DATE OF BIRTH	DATE OF HIRE
2	OCCUPATION AT TIME LAST WORKED _____ EMPLOYEE'S JOB TITLE DUTIES INCLUDE LIFTING ❑LESS THAN 15LBS. ❑15 TO 44 ❑OVER 45 STOOPING/BENDING ❑NONE ❑SELDOM ❑FREQUENT REPETITIVE ❑NONE ❑SELDOM ❑FREQUENT CRAWLING/CLIMBING/KNEELING ❑NONE ❑SELDOM ❑FREQUENT REACHING/PULLING/PUSHING ❑NONE ❑SELDOM ❑FREQUENT MANAGEMENT DUTIES ❑NONE ❑SELDOM ❑FREQUENT SITTING (NUMBER OF HOURS EACH DAY) _____ STANDING/WALKING (HOURS EACH DAY) _____			

- First date of Disability _____
- Was this disability caused by an incident that occurred while performing the duties of his/her employment?
  ☐ No ☐ Yes (If yes, please attach the first report of injury – accident report.)
  - If yes, has a worker's compensation claim been filed? ☐ No ☐ Yes
    - If yes, please provide the status: ☐ Approved ☐ Pending ☐ Denied ☐ Appealed
      If approved, please provide the worker's compensation weekly amount: _____
- Prior to this disability, number of hours worked per week: _____ Basic monthly earnings: _____
- Gross annual income prior to disability: _____***Income is subject to verification at time of claim.**
  Self-employed? ☐ No ☐ Yes (If yes, your gross annual income is the average of your net earnings for the past two years. Please submit tax records for the past two years.)
- Has the employee returned to work? ☐No ☐ Yes
  If no, expected return to work date: _____ If yes, date returned to work: _____
- If the employee has returned to work is he or she working: ☐ Full-Time ☐ Part-Time ☐Light Duty
  - If working part time or light duty, please provide the number of working hours per week: _____
  - Is light duty available? ☐ No ☐ Yes
    - If yes, can you accommodate the employee for light duty? ☐ No ☐ Yes
  - If part-time/light duty, date expected to return to work to full-time:_____
  - If part-time/light duty, is/was the employee earning at least 80% of his/her pre-disability salary? ☐ No ☐ Yes
- Has the employee received any other income as a result of disability? ☐ No ☐ Yes
  - Is the employee currently using salary continuance, sick pay or vacation pay? ☐ No ☐ Yes
    - If yes, weekly benefit:_____ Date Ceased: _____
  - Is the employee received any other type of income? ☐ No ☐ Yes
    - If yes, weekly benefit:_____ Date Ceased: _____

Please complete this section only for Contract 1099 and W-2 Employees. (Please contact payroll and/or check the policyholder's Salary Redirection Agreement/Premium Deduction Authorization card for the answer to these questions.)

- Are Disability Rider or Short-Term Disability premiums deducted from the policyholder's paycheck on a pre-tax basis?
  ☐ No ☐ Yes
- Does the employer pay a portion of the disability premium for the policyholder? ☐No ☐ Yes
  - If yes, what percent? _____%
- Is the person still employed? ☐ No ☐ Yes
  - If no, last date of employment: _____
  - If no, please provide the reason for separation:_____

Please note:
The employer is required to report disability benefits paid on pre-tax plans on Form 941 and the employee's Form W-2.

AUTHORIZED EMPLOYER'S SIGNATURE			
9	EMPLOYER'S COMPANY NAME:	TELEPHONE NUMBER:	FAX NUMBER:
10	ADDRESS:	NAME AND TITLE OF PERSON COMPLETING THIS FORM:	
11	SIGNATURE OF AUTHORIZED EMPLOYER REPRESENTATIVE:	DATE:	

PART C	ATTENDING PHYSICIAN'S STATEMENT (To be completed by your current treating physician)	
1	PATIENT'S NAME	DATE OF BIRTH

Diagnosis:

- Primary diagnosis for disability and ICD code: _____ Additional diagnoses:_____
- Objective findings (including current x-rays, EKG's, laboratory data and any clinical findings: _____
  _____
- If due to an injury, please provide the date, details of the injury: _____
  _____
- Location of the injury? ☐ On the job ☐ Off the job
- Symptoms first occurred on: _____ If diagnosed with cancer, date of initial diagnosis: _____
- Patient first consulted you for this condition on: _____
- Has the patient ever had the same or similar condition? ☐ No ☐ Yes
- Was the patient treated for the primary diagnosis by another physician? ☐ No ☐ Yes
  - If yes, physician's name: _____
  - Treating physician's address: _____ Phone Number: _____

*** If filing for disability within the first year of the policy, medical records may be requested.**

Pregnancy claims:

- Date of delivery: _____ ☐ Vaginal ☐ Cesarean
- EDC: _____ LMP: _____
- If not delivered, expected delivery date: _____
- Please list any complications: _____

Prognosis:

- First date of disability: _____
- Date patient was last treated: _____ Frequency of visits: ☐ Weekly ☐ Monthly ☐ Other
  - Nature of treatment (surgery and medications prescribed, if any):_____
- Have you released the patient to return to work? ☐ No ☐ Yes (Date released: _____)
  Patient released to work: ☐Full Time ☐Part Time ☐Light Duty
  If part time/light duty, please provide the date the patient is expected to return to full duty: _____
- If patient has not been released, please provide the next appointment date: _____
  - Please also provide the date of expected release: _____

Physical Impairments (As defined in the Federal Dictionary of Occupational Titles):

☐ Class 1 – No limitation of functional capacity; capable of heavy work. No restrictions (0-10%)
☐ Class 2 – Medium manual activity (15-30%)
☐ Class 3 – Slight limitation of functional capacity; capable of light work. (35-55%)
☐ Class 4 – Moderate limitation of functional capacity; capable of clerical/administrative (sedentary) activity. (60-70%).
☐ Class 5 – Severe limitation of functional capacity; incapable of minimum (sedentary) activity. (75-100%).

- Restrictions and Limitations: (What specific activities is the patient incapable of performing?) _____
  _____

Activities of Daily Living:

- Which Activities of Daily Living (ADLs) is the patient unable to perform?*
  - Check all that apply: ☐ Continence ☐ Transferring ☐ Dressing ☐ Bathing ☐ Toileting ☐ Eating

  ***Medical records will be requested if ADLs are indicated.**
- Does this patient require direct personal assistance to perform these ADLs **each and every time**? ☐Yes ☐No
  - If yes, how many days will the patient require direct personal assistance?

Permanent Disability:

- Is patient permanently disabled? ☐ No ☐ Yes (Medical records will be requested if permanent disability is indicated.)

"I hereby certify that the above described information is based upon reasonable medical probability, and is true and correct to the best of my knowledge and belief."

NAME (Attending Physician) PLEASE PRINT	FAX NUMBER	TELEPHONE NUMBER	
ADDRESS	CITY	STATE	ZIP CODE
SIGNATURE	DATE	MEDICAL ID#	

FRAUD WARNING NOTICES

For use with Claim Forms

PLEASE READ THE FRAUD WARNING NOTICE FOR YOUR STATE

ALABAMA: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

ALASKA: A person who knowingly and with intent to injure, defraud or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

ARIZONA: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

ARKANSAS: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

CALIFORNIA: For your protection California law requires the following to appear on this form: Any person who knowingly presents 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.

COLORADO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

DELAWARE: 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 is guilty of a felony.

DISTRICT OF COLUMBIA: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

FLORIDA: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

IDAHO: Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement containing any false, incomplete, or misleading information is guilty of a felony.

INDIANA: A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

KANSAS: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement **may** be guilty of insurance fraud as determined by a court of law.

KENTUCKY: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

LOUISIANA: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

MAINE: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

MARYLAND: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

MINNESOTA: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

FRAUD WARNING NOTICES (CONT.)

For use with Claim Forms

PLEASE READ THE FRAUD WARNING NOTICE FOR YOUR STATE

NEW MEXICO: any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

NEW YORK: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

OHIO: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

OKLAHOMA: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

OREGON: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

PENNSYLVANIA: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

PUERTO RICO: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances are present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

TENNESSEE: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

TEXAS: 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.

VIRGINIA: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

WASHINGTON: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

RHODE ISLAND and WEST VIRGINIA: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

ALL OTHER STATES: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

CONTINENTAL AMERICAN INSURANCE COMPANY
Post Office Box 427* Columbia, South Carolina 29202
Phone (800) 433-3036 Fax (866) 849-2970

INSURED_____ POLICY NUMBER_____

AUTHORIZATION TO OBTAIN INFORMATION
CONTINENTAL AMERICAN INSURANCE COMPANY

For the purpose of evaluating my *eligibility for insurance and eligibility for benefits* under an existing policy/certificate, including checking for and resolving any issues that may arise regarding incomplete or incorrect information on my application for coverage and/or claim form, I hereby authorize the disclosure of the following information about me and, if applicable, my dependents, from the sources listed below to Continental American Insurance Company (CAIC) and its duly authorized representatives.

Disclosure of Health Information

Health information may be disclosed by any health care provider, health plan (including CAIC or Aflac, with respect to other CAIC or Aflac coverages) or health care clearinghouse that has any records or knowledge about me. Health care provider includes, but is not limited to, any licensed physician, medical or nurse practitioner, nurse, pharmacist, osteopath, psychologist, physical or occupational therapist, chiropractor, dentist, audiologist or speech pathologist, podiatrist, hospital, medical clinic or laboratory, pharmacy, rehabilitation facility, nursing home or extended care facility, prescription drug database or pharmacy benefit manager, or ambulance or other medical transport service. Health information may also be disclosed by any insurance company or the Medical Information Bureau (MIB). Health information includes my entire medical record, but does not include psychotherapy notes.

Financial or credit history, earnings, or employment history may be disclosed by any entity, person, or organization that has these records about me, including but not limited to my employer, employer representative and compensation sources, insurance company, financial institution, or any consumer reporting agency.

Federal, state, and local government organizations including but not limited to the Veteran's Administration, Internal Revenue Service, Social Security Administration, and Medicare or Medicaid agencies, may disclose health or financial information or records about me.

Any information CAIC obtains pursuant to this authorization will be used for the purpose of evaluating and administering my application for coverage and/or claim for benefits. Some information obtained may not be protected by certain federal regulations governing the privacy of health information, but the information is protected by state privacy laws and other applicable laws. CAIC will not disclose the information unless permitted or required by those laws.

I understand that if the information disclosed is protected health information relating to a health plan and the person or entity receiving the information is a not a health care provider or health plan covered by federal privacy regulations, the information disclosed may be redisclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.

This authorization may be revoked by me or my authorized representative at any time except to the extent CAIC has relied on the authorization prior to notice of revocation or has a legal right to contest coverage under the contract or the contract itself. If I revoke this authorization, CAIC may not be able to evaluate my application for coverage and/or claim. I may revoke this authorization by sending written notice to: Continental American Insurance Company, ATTN: New Business Department (for applications) or ATTN: Claims Department (for claims), P.O. Box 427, Columbia, SC 29202.

You may refuse to sign this form; however, CAIC may not be able to evaluate and administer your application for coverage and/or your claim without this authorization.

This authorization is valid for two (2) years from its execution or for the duration of my claim, whichever is later. A copy of this authorization is as valid as the original. I know that I or my authorized representative may request a copy of this authorization and access to this information.

I am the individual to whom this authorization applies or that person's legal Guardian, Power of Attorney Designee, Conservator, Beneficiary or personal representative.

_____ _____
(Printed Name of Individual Subject to Disclosure) (Date of Birth)

_____ _____
(Signature) (Date Signed)

If applicable, I signed on behalf of the insured as _____.
(Indicate relationship, legal Guardian, Power of Attorney Designee, Conservator, Beneficiary or personal representative.)

_____
(Printed Name of Legal Representative)

_____ _____
(Signature of Legal Representative) (Date Signed)

Electronic Funds Transaction Authorization

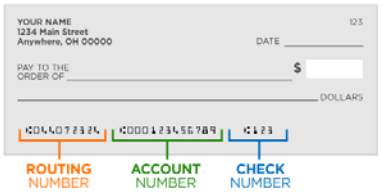
Send to: **Continental American Insurance Company**
Mail: Post Office Box 427 Columbia, South Carolina 29202
Phone: (800) 433-3036 Fax (866) 849-2970
Email: groupclaimfiling@aflac.com

I would like to:

☐ Start ☐ Stop ☐ Change direct deposit of my claim payment(s).

Account Type:

☐ Checking ☐ Savings ☐ Other



9-Digit Routing Number:	Account Number:
Remember: The 9-digit number on a deposit slip is not a routing number. You can obtain the routing number from a check or from your financial institution. *See example above.*	
Name of Financial Institution:	
Address:	City:
State: / Zip:	Phone:

Authorization Agreement for Direct Deposit

I authorize Continental American Insurance Company (CAIC) to initiate credit entries, and, if errors occur, I authorize the correction of entries to my account as indicated. This authorization remains effective and in full force until CAIC receives written notification from me of its termination in such time and in such manner to afford CAIC a reasonable opportunity to act on it. Please notify CAIC immediately if your financial institution information has changed by sending notification to the address indicated above. Should you have any questions, please contact us at 1-800-433-3036.

Certificateholder's Name (*Print*):	
Address:	City/State:
Zip:	Phone #:
Employer Name or Group #:	Certificate #:
Certificateholder's Signature:	Date: