## Aflac Short Term Disability Claim Forms - Important Instructions

Enclosed you'll find the Aflac disability claim forms you requested. To ensure your claim is processed smoothly and efficiently, please follow these instructions carefully:

**Instructions:**

1. **Complete the Employee Section:** Please fill out the "employee" portion of the claim forms accurately and completely.
2. **Physician's Section:** Provide the forms to your physician to complete the "physician" section. *Please ensure your physician includes the ICD code and their Tax ID number, as these are the most common reasons for claim delays.*
3. **Return Completed Forms:** Once both sections are complete, please return the forms to *our* office via one of the following methods. *Do **NOT** send directly to Aflac.*
    - **Fax:** 631-991-6050
    - **Email:** claims@mybpc.com
    - **Mail:** Benefits Planning Corporation Attn: Claims Dept. 150 Motor Parkway Suite 125 Hauppauge, NY 11788
4. **Set up Direct Billing with Aflac:** To prevent a lapse in coverage, it is your responsibility to contact Aflac at 800-366-3436 to set up direct billing for your premium payments while you are out on disability and not receiving payroll deductions.
5. **Monitor Deductions Upon Return to Work:** When you return to work, please verify that your Aflac deductions have automatically restarted. If you do not see the Aflac deduction on your paycheck, contact us immediately at 631-991-6050.

If you have any questions or concerns, please don't hesitate to contact our office at 631-991-6050.

Sincerely,
BPC Claims Team

BPC | BENEFITS PLANNING CORPORATION

# INITIAL DISABILITY CLAIM FORM

**Thank you for trusting Aflac New York with your Initial Disability needs.**

- **To file your claim online, upload documentation on an existing claim, check claim status or get paid fast by signing up for direct deposit, register on Aflac.com or download the MyAflac mobile app.**

**To prevent delays, please provide documentation from your healthcare provider to support this claim. If you have additional bills or medical documentation that relates to this diagnosis other than the documentation defined, please submit them for review of additional benefits.**

- **Service related items can be obtained directly from the patient's healthcare provider(s) by requesting a UB04 hospital bill or HCFA 1500 non-hospital bill.**
- **Failure to complete all sections may result in a delay in processing this claim.**
- **Disclaimer: Some of the services listed may not be covered by your policy.**

***Policy Number:**

## Policyholder Information: This * denotes a required field.

*Last Name | Suffix | *First Name | MI

*Date of Birth (mm/dd/yy) | Telephone Number where we can reach you

*Home Address

*City | *State | *Zip Code

☐ *Check box if this is a permanent address change.*

## Patient Information:

*Last Name: SAME | *First Name | *Date of Birth (mm/dd/yy)

*Sex: ☐ Male ☐ Female

*Relationship: ☒ Primary Policyholder ☐ Spouse

### Initial Disability Checklist

Is disability due to a sickness? ☐ No ☐ Yes

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: _____
- Was this disability caused by an incident that occurred while performing the duties of the patient's employment? ☐ No ☐ Yes
- Was this a motor vehicle accident in which the patient was the driver? ☐ No ☐ Yes (If yes, please submit a copy of the Police Report)

**For all claims, please complete all remaining sections.**

- Was the patient confined to the hospital as a result of this condition? ☐ No ☐ Yes (If yes, please submit the itemized hospital bill, UB04, or HCFA 1500)
- Hospital name: _____
- City: _____ State: _____

**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.**

**POLICYHOLDER/PATIENT SIGNATURE** | **FAMILY RELATIONSHIP, IF NOT POLICYHOLDER** | **DATE**

**American Family Life Assurance Company of New York**
**ATTN: Claims Department • 1932 Wynnton Road • Columbus, GA 31999-7255**
**For information or to check claim status, visit aflac.com or call Benefits Planning at 631-991-6050**
**Claims may be faxed to 631-991-6050**

# INITIAL DISABILITY CLAIM FORM - PHYSICIAN'S STATEMENT

***Policy Number:**

**Policyholder Information:** This * denotes a required field.

*Last Name | Suffix | *First Name | MI

*Date of Birth (mm/dd/yy)

**Patient Information:**

*Last Name: SAME | *First Name | *Date of Birth (mm/dd/yy)

**Physician Information:**

*Phone Number | *Fax Number

*Physician's Name

*Address

*City | State | Zip Code

- Primary diagnosis for disability and ICD code: _____ Additional diagnoses: _____
- If due to an injury, please provide the date and details of the injury: _____
- Was this disability caused by an incident that occurred while performing the duties of his/her employment? ☐ No ☐ Yes
- Symptoms first occurred on: _____ If diagnosed with cancer, date of initial diagnosis: _____
- Patient first consulted you for this condition on: _____
- 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 two years of the policy, medical records may be requested.**

- Pregnancy claims: Date of delivery: _____ ☐ Vaginal ☐ Cesarean
- If not delivered, expected delivery date: _____
- Please advise of any complications: _____
- First date of disability: _____
- Date patient was last treated: _____
- 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: _____
- Is patient permanently disabled? ☐ No ☐ Yes (Medical records will be required if permanent disability is indicated; please provide medical records to patient.)

**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.**

**PHYSICIAN'S SIGNATURE** | **DATE** | **TAX ID**

**American Family Life Assurance Company of New York**
**ATTN: Claims Department • 1932 Wynnton Road • Columbus, GA 31999-7255**
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