

Group Disability Claim Filing Instructions

1. Complete Employee's Disability Benefits Application in full.
2. Have the physician treating you complete the Attending Physician's Statement and return to you.
3. Have your Employer complete the Employer's Report of Claim and return to you.
4. Complete the Direct Deposit Authorization Agreement if applicable
Submit the completed:
 - A. Employee's Disability Benefits Application
 - B. Employer's Report of Claim
 - C. Attending Physician's Statement
 - D. Direct Deposit Authorization Agreement if elected to the address below or submit via our toll free fax @ 1-888-243-3453

All portions of this claim form must be completed to avoid undue delay in processing claimant's request for benefits. If you have any questions when completing this form, please call:

Local Phone # (405) 416-7750
Toll Free Phone # (800) 267-2322

DIRECT DEPOSIT INSTRUCTIONS

If you want your benefits to be directly deposited into your checking account, complete the **AUTHORIZATION AGREEMENT** below and attach a voided/cancelled check. Please keep in mind, funds from direct deposits will **NOT** become available for use any earlier than 3- 4 business days following the date the benefits are approved and the credit entry is initiated to your account.

If you have already filed an **AUTHORIZATION AGREEMENT** do not complete another, unless your Bank or Credit Union account information has changed.

() Yes () No Do you want to continue the **AUTHORIZATION AGREEMENT** to initiate credit entries from your checking account? If you do not answer this question American Fidelity will assume that you are continuing to authorize credit entries into your account.

AUTHORIZATION AGREEMENT FOR AUTOMATIC DEPOSITS

I authorize American Fidelity Assurance Company to initiate credit entries to my checking account at the depository named below. This authorization is to remain in full force and effect until the Company has received written notification from me of its termination in such time and in such a manner as to afford the Company and the Depository opportunity to act on it.

BANK/CREDIT UNION NAME: _____

MAIL ADDRESS: _____

CITY, STATE, ZIP CODE: _____ **BANK TELE.# ()** _____

YOUR NAME: _____ **S.S.#:** _____

SIGNED: _____ **DATE:** _____

IMPORTANT: You must attach a voided/cancelled check to begin direct deposit. A deposit slip is NOT acceptable.



A member of the American Fidelity Group®

ASSOCIATION and WORKSITE DIVISION

BENEFITS DEPARTMENT

P.O. Box 268898

Oklahoma City, Oklahoma 73126-8898

ATTENDING PHYSICIAN'S STATEMENT

	Name of Patient	Date of Birth / /	SS#
D I A G N O S I S	Diagnosis: (including complications)		ICDA Code
	Is disability due to injury or sickness arising out of or in the course of patient's employment? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	Disability result of pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No If delivered, type of delivery: _____ Date Pregnancy diagnosed: _____		
Date of delivery (if delivered) ____/____/____ Expected date of delivery (if not delivered) ____/____/____			
H I S T O R Y	When did symptoms first appear or accident happen? Date patient first consulted you for this condition? If accident, date of accident / / / / / /		
	Has the patient ever had the same or similar condition? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, indicate when and describe:		
	Was the patient referred to you? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide the full name and address of referring physician:		
T R E A T M E N T	Frequency of treatment: <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Other If not under your regular care and attendance please explain how, in your opinion, the condition is considered disabling but does not require regular care and attendance.		
	Nature of treatment being rendered (including surgery and any medications being prescribed) and the current treatment plan:		
	List all dates of treatment or medical attention since the disability began:		
	Is patient still under your care for this condition? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, please provide the name of the current treating physician:		
	Has the patient been confined to a hospital: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, give admit and discharge dates along with name and address of hospital: Admitted: ____/____/____ Discharged: ____/____/____ Name: _____ Address: _____		
P R O G N O S I S	Dates of total disability: (unable to work) From: ____/____/____ Through: ____/____/____ Currently disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	Disabled from: Patients job? <input type="checkbox"/> Yes <input type="checkbox"/> No Any other work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	If currently disabled, what is the anticipated length of disability: <input type="checkbox"/> 1-2 Months <input type="checkbox"/> 2-3 Months <input type="checkbox"/> 3-6 Months <input type="checkbox"/> 6-12 Months <input type="checkbox"/> More than 12 Months <input type="checkbox"/> Permanent		
	Dates of partial disability: From: ____/____/____ Through: ____/____/____ When, in your opinion, will the patient recover sufficiently to return to work?		
I M P A I R M E N T	Physical Impairments (*As defined in 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* activity (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%)		
DSM-IV Diagnosis (if applicable)			
Axis I: _____			
Axis II: _____			
Axis III: _____			
Axis IV: _____			
Axis V: _____			
Do you believe patient is competent to endorse checks and direct the use of the proceeds thereof? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Attending Physician's Name: (print)		Degree: Telephone #: (including area code) _____ ext. # _____	
Street Address: _____		City: _____ State: _____ Zip Code: _____ Fax# (including area code) _____	
Signature of Physician: _____		Federal Tax ID #: _____ Date: ____/____/____	
Form Completed by: _____		Title: _____	



A member of the American Fidelity Group®

American Fidelity Assurance Company
Mail to: AWD Benefits Department
 P.O. Box 268898
 Oklahoma City, OK 73126-8898
Local Phone # (405)416-7750
Toll Free Phone # 1-800-267-2322
Local Fax# (405)523-5762
Toll Free Fax # 1-888-243-3453

EMPLOYER'S REPORT OF CLAIM

EMPLOYMENT	Name of Employer:	Fax No.: ()
	Mailing Address: (include street, city, state and zip code)	Phone No.: (including extension) () ext. #
	Name of Employee:	Social Security Number: - -
	Date of Hire: Effective date of employee's coverage:	Occupation:
	Status of employment at time of disability: <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Leave of Absence <input type="checkbox"/> Terminated <input type="checkbox"/> Retired Date: _____ Date: _____	
Has employee's status of employment changed? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, current status: _____		
PREMIUMS	Does employee participate in Social Security? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, hired after 4/1/86? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Please furnish the percentage of the employee's AFA disability premium you pay: _____%	
	Are the AFA disability premiums withheld before or after taxes? <input type="checkbox"/> Before <input type="checkbox"/> After	
SALARY	SALARY AT TIME OF DISABILITY	
	GIVE ANNUAL SALARY FOR COMMISSIONED EMPLOYEES	
	Weekly \$ _____	
	Monthly \$ _____	
Annual \$ _____	\$ _____	
	W-2, previous calendar year	year-to-date
DISABILITY	Date employee last worked: _____	
	Has employee returned to work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	If yes, date returned to work: _____ Full Time: _____ Part Time: _____	
OTHER INFORMATION	Did employee make a claim for, or are they entitled to Workers' Compensation? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	If yes, name, address and phone number of Workers' Compensation carrier:	
	Provide the final date the employee is entitled to fully paid sick leave:	
	Name, address and phone number of any other disability carrier: (include street, city, state and zip code)	
	Is employee eligible for disability retirement benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No	

I hereby certify that the above named employee is a member of our Group Disability Program and was actively at work in his usual occupation on the effective date of coverage. The information stated above is correct to the best of my knowledge and belief.

Authorized signature of employer firm or authorized official:

Signature: _____ Date: _____

Print Name: _____



A member of the American Fidelity Group

American Fidelity Assurance Company
Mail to: AWD Benefits Department
P.O. Box 268898
Oklahoma City, OK 73126-8898

Local Phone # (405)416-7750
Toll Free Phone # 1-800-267-2322
Local Fax# (405)523-5762
Toll Free Fax # 1-888-243-3453

EMPLOYEE'S DISABILITY BENEFITS APPLICATION

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 may be guilty of insurance fraud.

Form with 11 numbered sections for personal information, medical history, and authorization. Includes fields for name, address, birth date, employer, and medical treatment details.

FAILURE TO SIGN & DATE FORM WILL DELAY BENEFITS