CANCER SCREENING BENEFIT CLAIM FORM

If you are interested in filing your claim online, register using aflac.com/smartclaim.

Benefits of filing your claim online include faster claim processing time and receiving claim communications by email.

Please read all instructions.
Failure to follow these instructions could delay the processing of your claim.

- Do not include receipts, statements or other claim documentation with this form.
- Do not write on form except as instructed.
- Sign, date and fax or mail the completed form to the Aflac New York fax number/address shown below.
- Use black or blue ink only and print legibly when completing this form in its entirety.
- Mark only wellness exam boxes for test(s) and/or treatment(s) received.
- Failure to complete all sections may result in a delay in processing this claim.
- Some types of tests and/or treatment listed may not be covered by your policy.

Please keep a copy of this completed form for your records. Please print a separate form for each additional family member or call 1-800-366-3436 to request additional forms. Claims for all other benefits covered under this policy must be filed separately using the claim forms available at aflac.com or by calling 1-800-366-3436.
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Policy Number: __________________________ All Fields are required.

Policyholder Information:

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 permanent address change.

Patient Information:

Last Name ___________________________ First Name ___________________________ Date of Birth (mm/dd/yy) ___________________________ ___________________________

Sex: ☐ Male ☐ Female

Relationship: ☐ Primary Policyholder ☐ Spouse ☐ Dependent Child

Treatment Date: ___________________________ M M D D Y Y Y Y ___________________________ M M D D Y Y Y Y ___________________________ M M D D Y Y Y Y

☐ Genetic Testing ☐ Chest X-ray ☐ Scopes (Oscopies) ☐ Scans/MRI ☐ Pap Smear/Pap Smear-ThinPrep ☐ HPV Screening ☐ Bone Marrow Screening

Mammogram Date: ___________________________ M M D D Y Y Y Y ___________________________ M M D D Y Y Y Y ___________________________ M M D D Y Y Y Y

☐ Serum Protein Electrophoresis ☐ Hemocult Stool Specimen ☐ CEA (blood test for colon cancer) ☐ CA125 (blood test for ovarian cancer) ☐ Mammogram ☐ Cervical Cancer Screening ☐ P32 Uptake Test

Pap Smear Date: ___________________________ M M D D Y Y Y Y ___________________________ M M D D Y Y Y Y ___________________________ M M D D Y Y Y Y

☐ CA153 (blood test for breast cancer monitoring) ☐ Thermography ☐ PSA (blood test for prostate cancer) ☐ Ultrasounds ☐ Biopsy ☐ Cancer Vaccine

Actual Cost of Mammogram ___________________________ ___________________________

Physician's Name ___________________________ ___________________________

Physician's Street Address ___________________________ ___________________________

Physician's City ___________________________ State: ___________________________ Zip: ___________________________

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.

The Physician listed above is authorized to validate the information I have provided.