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American Fidelity Assurance Company | Mail to: Worksite Group Benefits Department
P.O. Box 25160 | Oklahoma City, Oklahoma | 73125-0160
Toll Free Phone # 1-800-662-1113
Toll Free Fax # 1-800-818-3453
americanfidelity.com

Group Disability Claim Filing Instructions

Account Number

DISABILITY CLAIM FORM

To be completed ***AFTER*** you become disabled. (Not for use when filing for Physician's Expense Benefits) (Please Print)

Save Time and Paper – File Your Claim Online! Login to your secured Online Service Center (OSC) account at www.americanfidelity.com/MyAccount. From the "My Benefits" tab, click "File a Claim" to get started and follow the online instructions.

Tip! Once filed, you can check the status of your claim by selecting the "My Benefits" tab at the top of the screen.

Instructions for Mail or Fax:

1. Complete the Statement of Insured.
2. Complete the Authorization to Disclose Protected Health Information.
3. Have your employer complete the employer portion.
4. Have your treating physician complete the Attending Physician Statement.
5. Mail the completed forms to American Fidelity at the address listed above.
6. If you wish to fax your completed forms, please fax to 800-818-3453.

Whether completing this claim online or with the below packet, all portions must be completed to avoid undue delay in processing your request for benefits. If you have any questions regarding completion of your claim, please contact us.

PAYMENT INFORMATION

☐ **DIRECT DEPOSIT** - A checking account is the most efficient way to receive your benefit payments.

Note: A signature and additional information is required when choosing direct deposit option. Be sure to complete the appropriate section below.

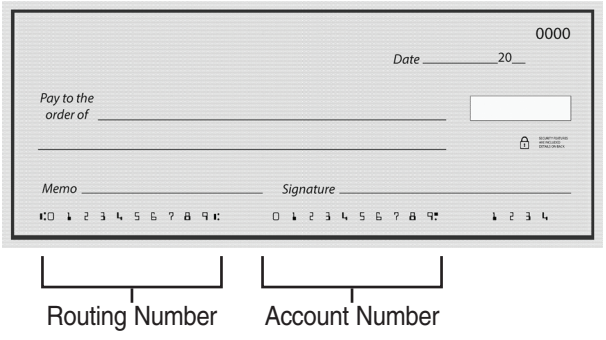
I authorize AFAC to initiate credit entries to my account at the depository named below. This authorization is to remain in force and effect until AFAC receives written notification from me of its termination in such time and in such manner as to afford AFAC and the depository opportunity to act on it. **This authorization applies to benefits payable under all insurance policies held with AFAC.**

Signature: _____ **Date:** _____

NOTE: You must provide the following information:

Routing Number: _____

Checking Account Number: _____



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Employee's Disability Benefits Application

EMPLOYEE INFORMATION

To be completed by Employee. (Please Print)

Full Name: (last, first, middle initial)	Account Number:
Residence: (street, city, state and zip code)	
Mailing Address: (P.O. Box or street, city and zip code)	Date of Birth: / /
Email Address:	
Telephone Number: (including area code)	Social Security Number: / /

DISABILITY INFORMATION

Is the disability due to: ☐ illness OR ☐ accident Date of onset / /

If accident, please describe the cause and details:

Have you ever had the same or similar condition in the past? ☐ Yes ☐ No If so, when? / /

Treating Physician's Name:

Provide ALL current treating physicians' full name(s) and contact information (attach additional list if necessary):

Physician's Name: _____ Physician's Phone Number(s):_____

Physician's Name: _____ Physician's Phone Number(s):_____

Is your disability related to your employment/occupation? ☐ Yes ☐ No

If yes, have you or do you intend to file for Worker's Compensation? ☐ Yes ☐ No

On what date did you last work? / / Dates of Total Disability: From _____ Thru _____

On what date did you return to work? / / Part Time _____ Full Time _____

If not returned to work, when do you anticipate returning to work? / /

If your request for benefits is approved, do you want us to withhold Federal Taxes from each benefit check? ☐ Yes ☐ No

If yes, amount: $ (indicate amount per month $88.00 minimum)

Identify other income sources and amount of income you are receiving or may be entitled to receive during this disability. Please check yes or no for each of the following:

	Yes	No	Amount/Month		Yes	No	Amount/Month
Your Social Security: (disability or retirement)	☑	☐	$	V.A. Benefits:	☐	☐	$
Dependent Social Security:	☐	☐	$	Worker's Compensation:	☐	☐	$
Sick Leave or Wage Continuation:	☐	☐	$	Other Disability Coverage: (identify)			
Retirement: (normal early or disability)	☐	☐	$				
State Disability Income	☐	☐	$	**Include a copy of your award or denial letter for any source in which one has been received.**			
Unemployment:	☐	☐	$				
Union	☐	☐	$				

I certify this information is true and correct.

Signature: **Date:** / /

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Attending Physician's Statement

DISABILITY CLAIM FORM
To be completed by Physician.

(Please Print)

Name of Patient:	Date of Birth: / /	Social Security Number: / /	Account Number:

DIAGNOSIS

Disabling Diagnoses: ICD Code:

Is disability the result of pregnancy? ☐ Yes ☐ No If yes, type of delivery:
Date pregnancy was diagnosed: / / Date of delivery (if delivered): / / Expected date of delivery: / /

HISTORY

When did symptoms first appear or accident happen? / / Date patient first consulted you for this condition? / /

Has the patient ever had the same or similar condition? ☐ Yes ☐ No If yes, indicate when and describe:

Was the patient referred to you? ☐ Yes ☐ No If yes, provide full name, address, and phone number of referring physician:

Is the disability work related? ☐ Yes ☐ No

TREATMENT

Frequency of treatment: ☐ Monthly ☐ Weekly ☐ Other, describe Date of next appointment : / /

Please describe current treatment:

List all dates of treatment or medical attention since the disability began:

Is patient still under your regular care for this condition? ☐ Yes ☐ No

If no, please explain and provide name and phone number of the current treating physician:

Has the patient been confined to a hospital? ☐ Yes ☐ No
Admitted: / / Discharged: / /

If yes, give admit and discharge dates along with name and address of hospital.
Admitted: / / Discharged: / /

Name: Address:

PROGNOSIS

Is patient now Disabled? For Regular occupation? ☐ Yes ☐ No For any Occupation? ☐ Yes ☐ No

Date total disability began: / / What is the expected return to work date? / /

Is the patient released to return to work with restrictions? ☐ Yes ☐ No If yes, From: / / Through: / /

Please list return to work restrictions: _____

IMPAIRMENTS

What are the disabling impairments that prevents the patient from working?

- ☐ 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%)

ANTICIPATED LENGTH OF DISABILITY:

- ☐ 1-2 Months
- ☐ 2-3 Months
- ☐ 3-6 Months
- ☐ 6-12 Months
- ☐ Greater than 12 Months
- ☐ Permanent

Please list functional limitations/restrictions that render your patient temporarily totally disabled: 256 332-1360

Do you expect any improvement or decline in functional status? ☐ Yes ☐ No If yes, please circle improvement or decline.

PHYSICIAN INFORMATION

Attending Physician's Name & Title: (print)	Specialty:	Telephone #: ( )	Fax #: ( )
P.O. Box or Street Address:	City:	State:	Zip Code:
Form Completed By: (Name & Title)			
Signature:		Date: / /	

If you require completion of your own authorization for the release of medical records please submit the form along with the physician statement.

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Employer's Report of Claim

EMPLOYMENT

(Please Print)

Name of Employer: FRANKLIN COUNTY BOARD OF EDUCATION

Mailing Address: (P.O. Box or Street, City, State and Zip Code) P. O. BOX 610 RUSSELLVILLE, AL 35653

Name of Employee: JOSLYN GARRISON Social Security Number: 423 / 25 /4755

Date of Hire: 8 / 4 / 2010 Occupation: TEACHER

Employment Status: ☑ Full-Time ☐ Part-Time ☐ Leave of Absence ☐ Terminated ☐ Retired

DISABILITY

Date employee last worked: / / Has employee returned to work? ☐ Yes ☐ No

If yes, date returned to work: / / Full Time ☐ Part Time ☐

PREMIUMS

Does the employee participate in Social Security? ☑ Yes ☐ No If no, hired after 4/1/86? ☐ Yes ☐ No

Does employer pay a portion of the disability premium? ☐ Yes ☑ No If yes, what percent? %

Are disability premiums deducted from employee's pay on a pre-tax (section 125) basis? ☐ Yes ☑ No

Have AFA Disability premiums been withheld through the last date worked? ☑ Yes ☐ No

If not, what is the last date disability premiums were deducted? / /

SALARY AT TIME OF DISABILITY FOR EDUCATION EMPLOYERS

Number of Contract Days 187 for 2018-2019 school year. In-house days: First Day: 08-02-18

Annual Salary: $ 56952.00 Effective Date: 10-1-2019 Last Day: 05-22-2019

SALARY AT TIME OF DISABILITY FOR ALL OTHER EMPLOYERS

Hourly: $ _____ Monthly: $ _____

Gross salary for previous calendar year: $ _____ Year-to-date, gross salary: $ _____

OTHER INCOME

Did Employee's disability result from employment? ☐ Yes ☐ No Has employee made a claim for Workers' Compensation? ☐ Yes ☐ No

If yes provide the name, address, and phone number of Workers' Compensation carrier: _____

Is employee entitled to Workers' Compensation for this disability? ☐ Yes ☐ No

Is the employee receiving or eligible to receive any of the following? If yes, please complete the applicable boxes.

Other Group Disability Begins: _____ Ends: _____
Amount: $_____ ☑ Daily ☐ Weekly ☐ Monthly

Differential/Sabbatical Begins: _____ Ends: _____
Amount: $_____ ☐ Daily ☐ Weekly ☐ Monthly

Salary Continuation Begins: _____ Ends: _____
Amount: $_____ ☐ Daily ☐ Weekly ☐ Monthly

Union Benefits Begins: _____ Ends: _____
Amount: $_____ ☐ Daily ☐ Weekly ☐ Monthly

Sick Leave Begins: _____ Ends: _____
Amount: _____ ☐ Daily ☐ Weekly ☐ Monthly

State Disability Begins: _____ Ends: _____
Amount: $_____ ☐ Daily ☐ Weekly ☐ Monthly

PTO/PPT Begins: _____ Ends: _____
Amount: $_____ ☐ Daily ☐ Weekly ☐ Monthly

For Union Benefits or Other Group Disability, please list provider's:
Name: _____
Phone: _____

I hereby certify that the above named employee is a member of our Group Disability Program. The information stated above is correct to the best of my knowledge and belief.

Authorized signature of employer firm or authorized official: Elonda Cox

Printed Name: ELONDA COX **Date:** 10-15-2019

Email Address: ELONDACOX@FRANKLIN.K12.AL.US Phone: (256) 332-1360

Fax: (256) 331-0069 How do you prefer to be contacted? ☑ Email ☐ Phone ☐ Fax

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AUTHORIZATION TO DISCLOSE INFORMATION INCLUDING PROTECTED HEALTH INFORMATION

I hereby authorize the entities specified below to disclose any information about me or my dependents' health including my or my dependents' entire 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. Colorado state law prohibits the redisclosure or reuse of information disclosed about a Colorado resident under this authorization.

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. For Maine residents, information authorized for release may include information on communicable or venereal diseases such as hepatitis, syphilis, gonorrhea, AIDS/ARC (Acquired Immune Deficiency Syndrome / AIDS Related Complex) 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. For Vermont residents, this authorization does not require disclosure of prior HIV-related tests. For Wisconsin residents, results of AIDS/HIV test do not need to be reported if they were done at any anonymous counseling and testing site, if the test was not an FDA-licensed blood test, or through the use of a home test kit. For Arizona residents, release of HIV/AIDS-related information can only be disclosed for a period not to exceed 180 days from the date shown below.

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 or a delay of benefits. I understand that I may revoke this authorization at any time by writing to American Fidelity Assurance Company, PO Box 25160, Oklahoma City, OK 73125-0160 or by calling, toll-free, 1-800-662-1113. 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 redisclosed and no longer protected by the federal privacy regulations.

In addition to the Protected Health Information described above, I also authorize American Fidelity to access any other type of information deemed necessary to investigate my claim. This information includes but is not limited to financial information, information submitted or related to insurance claim(s) or insurance coverage(s) and employment records. Any party holding this information is hereby authorized to release it to American Fidelity.

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.

AFA Account# _____ Printed Name of Patient _____ Patient's Date of Birth _____

Signature (Patient) or Personal Representative (if applicable) _____ Date Signed _____

Relationship of Personal Representative to Patient (if applicable) _____

If authorization is supplied by a personal representative, a description of the authority to act on behalf of the Insured must be included.

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

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Claim Form Fraud Statements

The following fraud language is attached to, and made part of, this claim form. **Please read and do not remove this page from this claim form.**

If you live in a jurisdiction not mentioned below, the following applies to you: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit is guilty of a crime and may be subject to fines and confinement in prison.

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, District of Columbia, Louisiana, 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.

California and Texas - For your protection California and Texas 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, Idaho and 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.

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.

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.

Kentucky - Any person who knowingly and with intent to defraud any insurance company or other person files a 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.

Maine, Tennessee, Virginia and 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 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.

New Hampshire - Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

New Jersey - Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

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.

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.

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 by 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 [be] 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.