Routine Pregnancy Claim Filing Instructions

Use this form only for child birth with no complications.

Save Time and Paper - File Your Claim Online!

We offer two ways to file your routine pregnancy claim: online or by mail/fax.

Before you get started, don't forget to have your employer and attending physician complete the Employer's Report of Claim and Attending Physician's Statements. These forms can be found in this packet or when filing your claim online.

How To File Online:

1. Login to your secured Online Service Center (OSC) account at www.americanfidelity.com/MyAccount.
2. From the "My Claims" tab, click "File A Claim" to get started.
3. On the "Type of Claim" screen, select "Disability" and then "Routine Pregnancy".
4. Conveniently upload your completed Attending Physician's Statement, Employer's Report of Claim and the Authorization to Disclose Protected Health Information during your claim filing process.
5. Follow the step-by-step instructions to complete your online claim filing process.
6. Check the status of your claim by selecting the "My Claims" tab at the top of the screen!

How To File By Mail or Fax:

1. Complete the Authorization to Disclose Protected Health Information and the Employee's Disability Benefit Application.
2. Have your employer and attending physician complete the Employer's Report of Claim and Attending Physician's Statement.
3. Mail the completed forms to American Fidelity:
   A. Authorization to Disclose Protected Health Information
   B. Employee's Disability Benefits Application
   C. Employer's Report of Claim
   D. Attending Physician's Statement
4. 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 call:

Toll Free: 800-662-1113

Local: 405-523-5025

Our Family, Dedicated To Yours.®

Educational Services Division
Benefits Department
P.O. Box 25160
Oklahoma City, Oklahoma 73125-0160
www.americanfidelity.com

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize the entities specified below to disclose any information about my entire medical record, benefits payable, or benefit eligibility for this disability 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) Verteran'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.

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. 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.

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 AFES Benefits Department, 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. 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.

______________________________ ______________________________

Signature (Patient) or Personal Representative (if applicable) Printed Name (Patient)

______________________________ ______________________________

Relationship of Personal Representative to Patient Date

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.

Warning: Any person who knowingly and with intent to injure, defraud, or deceive an insurer files a statement of claim containing any false, incomplete, or misleading information may be guilty of insurance fraud and subject to criminal and civil penalties.
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.
AR, DC, LA, MD, NJ, NM, TX, and WV - 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.
DE, ID, IN, MN, OH, and OK - **WARNING:** 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.
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.
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.
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.
Oregon - Any person who knowingly and with intent to defraud or solicit another to defraud an insurer: (1) by submitting an application, or (2) by filing a claim containing a false statement as to any material fact, 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.
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.
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.
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.
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.

REQUEST FOR ROUTINE PREGNANCY BENEFITS

ATTN: AFES BENEFITS DEPT.
P.O. Box 25160
Oklahoma City, Oklahoma 73125
Toll Free: 1-800-662-1113
Fax: 1-800-818-3453
www.americanfidelity.com

Routine Pregnancy - Use this form only for child birth with no complications.

SECTION 1: EMPLOYEE'S DISABILITY BENEFITS APPLICATION

See page 2 for fraud statements.

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

1. Full names and addresses of all treating physicians: (attach additional list if necessary)
____
____
____

2. If hospitalized, give full name(s) and addresses of hospitals: (attach additional list if necessary)
Admit Date / / Discharge Date / /
Name(s) ____________________
Addresses ____________________

3. On what date did you last work?__________
Dates of total disability:
From __________ Thru __________
On what date did you return to work?
If not returned to work, when do you anticipate returning to work?__________

4. Please complete if you desire benefits deposited directly into your bank account.
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.**
Bank/Credit Union Name: __________
Signature: __________
NOTE: You must attach a voided check to begin direct deposit.

5. 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)

6. Are you receiving or eligible to receive other income during this period of disability? ❐ Yes ❐ No $ __________ Month
Sick Leave or Wage Continuation: ❐ Yes ❐ No $ __________ Month Other Disability Coverage: ❐ Yes ❐ No $ __________
Signature: __________ Date:__________

I certify this is true and correct information.

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize the entities specified below to disclose any information about my entire medical record or benefits payable for this disability 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.

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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.

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.

__________ Signature (Patient) or Personal Representative (if applicable)

__________ Printed Name (Patient)

__________ Relationship of Personal Representative to Patient

__________ Date

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

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Fax: 1-800-818-3453
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SECTION 2: EMPLOYER'S REPORT OF CLAIM

Name of Employer: Phone No.: ( ) Fax No.: ( )

Mailing Address: (include street, city, state and zip code)

Name of Employee: Social Security Number: - - Occupation: Date of Hire: / /

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

Please furnish the percentage of the employee's AFA disability premium you pay: __________%

Are the AFA disability premiums withheld before or after taxes? ☐ Before ☐ After

Have you withheld the employee's disability premium for the current month?

☐ Yes ☐ No

If not, what is the last month you deducted disability premiums? _____________

CONTRACTED SALARY AT TIME OF DISABILITY

☐ 9 ☐ 10 ☐ 12 Month Work Schedule

Annual: $ ________________________________ Effective Date: ________/__________/________

Number of hours worked per week at time of disability ___________________.

Number of Contract days: _____________ for ______________ school year.

Date employee last worked:__________/__________/__________ Has employee returned to work? ☐ Yes ☐ No If Yes, date returned to work: Full Time: ____________________

Provide: The final date the employee is entitled to fully paid sick leave____

The **first** date the employee is entitled to differential____

The **last** date the employee is entitled to differential____

The daily rate differential/sabbatical pay $____

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: ____

Title: ____ Date: ______________________________

REQUEST FOR ROUTINE
PREGNANCY BENEFITS

ATTN: AFES BENEFITS DEPT.
P.O. Box 25160
Oklahoma City, Oklahoma 73125
Toll Free: 1-800-662-1113
Fax: 1-800-818-3453
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SECTION 3: ATTENDING PHYSICIAN'S STATEMENT

Name of Patient: Date of Birth: Social Security Number: - -

DIAGNOSIS

Diagnosis: ICDA Code:

Type of delivery: ____________________

Date pregnancy was diagnosed? ____/____/____

Date of delivery: (if delivered) ___/___/_____ Expected Date of Delivery? ___/___/_____

HISTORY

When did symptoms first appear? ____/____/____

Date patient first consulted you for this condition? ____/____/____

Was the patient referred to you? ❐ Yes ❐ No If yes, full name and address of referring physician: ____________________

____

____

TREATMENT

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.

Name: ____________________

Address: ____________________

PROGNOSIS

Dates of total disability: (unable to work) From: ____________________ Through: ____________________

Attending Physician's Name: (print) Degree: Telephone #: ( ) - Fax #: ( ) -

Street Address: City: State: Zip Code:

Signature: Federal Tax ID #: Date: