PROOF OF DEATH - PHYSICIAN'S STATEMENT

Thank you for trusting Aflac with your Life Insurance needs.

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

*Home Address

*City | *State | *Zip Code

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

Information on Deceased:

*Last Name | Suffix | *First Name | MI

*Date of Birth (mm/dd/yy) | *Social Security Number

Proof of Death Checklist

- Date of death: ____/____/____
- Place of death: _____
- Immediate cause of death: _____
- Was death due any of the following: ☐ Suicide ☐ Homicide ☐ Injury
  - If death was due to an injury, please answer the following questions:
    - Date of the injury: ____/____/____
    - Details of the injury: _____
- If death was due to a sickness, please answer the following questions:
  - First date symptoms occurred: ____/____/____
  - First consult for sickness: _____
- For all claims, please answer the remaining questions:
  - What were the contributory causes of death?

Disease	Duration

  - How long was the deceased under your care? _____
  - Date of last visit: ____/____/____

American Family Life Assurance Company of Columbus (Aflac)
ATTN: Claims Department • 1932 Wynnton Road • Columbus, GA 31999
For information or to check claim status, visit aflac.com or call 1-800-99-AFLAC (1-800-992-3522)
Claims may be faxed to 1-877-44-AFLAC (1-877-442-3522)

***Policy Number:**

Policyholder Information:

*Last Name | Suffix | *First Name | MI

Information on Deceased:

*Last Name | Suffix | *First Name | MI

Give details of each condition for which you treated or advised the deceased:

Nature of Condition	Date	Duration	Result

To your knowledge, was the deceased hospitalized during the last three years of life? ☐ No ☐ Yes

- If yes, please complete the following information:

Hospital Name and Address	Reason	Dates

Please provide the name and addresses of other physicians who treated the deceased during the last three years of life:

Name	Address	Condition

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.

Physician's Signature | **Physician's Printed Name** | **Date**

Physician's Address | **City, State** | **Zip Code**

Physician's Phone Number | **Physician's Tax ID Number**

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