



# PHYSICIAN'S VISIT BENEFIT CLAIM FORM

Your Aflac Personal Sickness Indemnity policy pays a Physician's Visit Benefit for services rendered under the supervision of a physician, after the effective date of your policy (see policy schedule).

- Please complete all sections of the form, sign, date, and mail form to the address shown below.
- Submit only one treatment date per claim form.
- Each additional treatment date should be on a separate claim form.
- Claims for all other benefits covered under this policy should be filed separately.
- Do not fax or photocopy this document.
- Incomplete forms will be returned for completion.
- Do not attach receipts, statements or other documentation to this form.
- Use blue or black ink only

## Policyholder Information:

Policy Number:

First Name:

Last Name:

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Policyholder Birth Date:

## Patient Information:

Patient First Name:

Middle Initial:

Patient Last Name:

Sex:

Male

Female

Patient Birth Date:

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Date of Physician's Visit:

Relationship:

Primary Policyholder

Spouse

Dependent Child

Check if dependent is full-time student

Physician's Phone Number:

Physician's Name:

Physician's Street Address:

Physician's City:

State:

ZIP:

**Any person who, knowingly and with intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine no less than five thousand (\$5,000) dollars or more than ten thousand (\$10,000) dollars, or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a minimum of two (2) years.**

Policyholder Signature

Printed Name

Date