

# DUCK

## CANCER SCREENING BENEFIT CLAIM FORM

If you are interested in filing your claim online, register using [aflac.com/smartclaim](https://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 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 1-800-99-AFLAC (1-800-992-3522) 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](https://aflac.com) or by calling 1-800-99-AFLAC (1-800-992-3522).

# CANCER SCREENING BENEFIT CLAIM FORM

**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  
M M D D Y Y Y Y                      M M D D Y Y Y Y

M M D D Y Y Y Y

**Treatment Date:**

**Mammogram Date:**

**Pap Smear Date:**

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Genetic Testing              | <input type="checkbox"/> Serum Protein Electrophoresis         | <input type="checkbox"/> CA153 (blood test for breast cancer monitoring) |
| <input type="checkbox"/> Chest X-ray                  | <input type="checkbox"/> Hemocult Stool Specimen               | <input type="checkbox"/> Thermography                                    |
| <input type="checkbox"/> Scopes (Oscopies)            | <input type="checkbox"/> CEA (blood test for colon cancer)     | <input type="checkbox"/> PSA (blood test for prostate cancer)            |
| <input type="checkbox"/> Scans/MRI                    | <input type="checkbox"/> CA125 (blood test for ovarian cancer) | <input type="checkbox"/> Ultrasounds                                     |
| <input type="checkbox"/> Pap Smear/Pap Smear-ThinPrep | <input type="checkbox"/> Mammogram                             | <input type="checkbox"/> Biopsy  |
| <input type="checkbox"/> HPV Screening                | <input type="checkbox"/> Cervical Cancer Screening             | <input type="checkbox"/> Cancer Vaccine                                  |
| <input type="checkbox"/> Bone Marrow Screening        | <input type="checkbox"/> P32 Uptake Test                       |  |

Actual Cost of Mammogram

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 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.**

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

\_\_\_\_\_  
POLICYHOLDER/PATIENT SIGNATURE

\_\_\_\_\_  
FAMILY RELATIONSHIP, IF NOT POLICYHOLDER

\_\_\_\_\_  
DATE