



CANCER CLAIM FORM

Thank you for trusting Aflac with your Cancer needs.

- If you are interested in filing your claim online or uploading documentation on an existing claim, register using aflac.com/smartclaim.

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

*Date of Birth (mm/dd/yy) / / Telephone Number where we can reach you - -

*Home Address

*City *State *Zip Code -

Check box if this is a permanent address change.

Patient Information:

*Last Name *First Name *Date of Birth (mm/dd/yy) / /

*Sex: Male Female

*Relationship: Primary Policyholder Spouse Dependent Child

Cancer Checklist

- Is this the initial claim for this cancer diagnosis? No Yes (If yes, please submit the initial pathology report or exam that diagnosed cancer.)
- Please be sure to include the following information along with this claim form: positive Pathology Report and itemized bills from facility including diagnosis and/or procedure codes and charge amounts (Itemized bills may include but are not limited to the following: UB04 from your provider, HCFA1500 from your provider, etc.)
- Has the patient been diagnosed with cancer? No Yes (If yes, please submit the initial pathology report or exam that diagnosed cancer.)
- Type of cancer: _____
- Date of initial diagnosis: ____/____/____
- First date of treatment for this diagnosis: ____/____/____

