

REQUEST FOR MEDICAL REIMBURSEMENT



Medical/Supplement Dept
ATTN: AWD DEPARTMENT
P.O. Box 268898
Oklahoma City, Oklahoma 73126-8898
1-800-267-2322 Local 416-7750
Fax No: 1-888-243-3453

Any person who knowingly, and with intent to injure, defraud, or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete, or misleading information may be guilty of fraud.
Instructions: Complete all questions and attach itemized bills.

STATEMENT OF INSURED					
A. ABOUT YOU	INSURED'S LAST NAME	First Name	Initial	Date of Birth	ACCOUNT NUMBER
	Insured's Address (City, State, Zip)			Insured's Social Security Number	
	Employer - Name			Home Telephone #	
	Present Employment Status with above Employer <input type="checkbox"/> Full Time <input type="checkbox"/> On Leave <input type="checkbox"/> No Longer Employed Date You Last Worked <input type="checkbox"/> Part Time <small>Scheduled Working hours per week</small> <input type="checkbox"/> Retired Mo. Day Yr.				
B. ABOUT THE PATIENT	PATIENT INFORMATION (CHECK ONE)		Patient's Name	Patient's Birth Date	Patient's Social Security No.
	For whom do you make this request? <input type="checkbox"/> Self <input type="checkbox"/> Wife <input type="checkbox"/> Husband <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Other <small>identify</small>	If Claim is for a Dependant Child Under 21, is Such Child Living in Your Household? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Dependant Child is between age 21 and 25 years old is (s)he a full-time student? <input type="checkbox"/> Yes <input type="checkbox"/> No		
C. ABOUT THE CLAIM	Did the accident result from employment? _____ Yes _____ No				
	If yes, are you filing or will you be filing for Workers' Compensation? _____ Yes _____ No				
	If claim is due to an injury, explain how, where and when it happened.				
	Was treatment provided within 72 hours of injury?				
	If claim is due to an illness, give date of onset and diagnosis. (for Cancer Benefits, give date of Diagnosis)				
D. ABOUT OTHER INSURANCE	OTHER INSURANCE INFORMATION				
	Is patient covered by any other insurance? If yes, Individual Group Medicare	Person carrying coverage:	Group (Employer, Assoc, etc.):	Date of Birth:	
		Policy number:	Phone number of other insurance	Insurance company	
E. ABOUT THE INFORMATION RELEASE	INSURED CERTIFICATION CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION				
	I hereby authorize any physician, hospital, pharmacy, insurance company, Workers' Compensation Carrier, Social Security office or organization to release any information regarding the medical history, treatment, disability, or benefits payable for this disability to the American Fidelity Assurance Company or its representative. A photocopy of this authorization shall be as valid as the original. This authorization shall be considered valid for the duration of the claim, but not to exceed one year from the date signed. By signing below I certify the above information is true and correct to the best of my knowledge. By state law, you must be advised that: THE INFORMATION YOU AUTHORIZE FOR RELEASE MAY INCLUDE INFORMATION WHICH MAY BE CONSIDERED A COMMUNICABLE OR VENEREAL DISEASE WHICH MAY INCLUDE, BUT ARE NOT LIMITED TO DISEASES SUCH AS HEPATITIS, SYPHILIS, GONORRHEA, THE HUMAN IMMUNODEFICIENCY VIRUS ALSO KNOWN AS ACQUIRED IMMUNE DEFICIENCY SYNDROME ("AIDS"). The information you authorize for release may include your history of treatment for physical and/or emotional illness to include psychological testing and treatment records of alcohol and drug abuse.				
	Date	Signature of Patient - If Spouse	Date	Signature of Insured	