Do not include receipts, statements or other documentation with this form.

Your Aflac policy provides one Wellness Benefit per policy year. Please note that these benefits are not payable for treatment within the first 12 months of the policy’s effective date. To receive your Wellness Benefit, complete the form by following the instructions provided. Please keep a copy of this completed form for your records. Claims for all other benefits covered under your policy must be filed separately using the appropriate claim form.

If your Aflac policy also provides a Mammogram Benefit, please mark the appropriate box and indicate the date the mammogram was performed. Please check your policy for specific benefits covered under your policy.

If your Aflac policy also provides a Pap Smear Benefit, please mark the appropriate box and indicate the date the pap smear was performed. Please check your policy for specific benefits covered under your policy.

- Do not write on form except as instructed.
- Incomplete forms cannot be processed and will be returned.
- Please do not fax this completed form to Aflac.
- Mark only wellness exam box(es) for test(s) that you had performed.
ACCIDENT WELLNESS BENEFIT CLAIM FORM

Some of the tests listed may not be covered under the Wellness Benefit of your policy. Please check your policy for a list of covered wellness procedures or call 1-800-99-AFLAC (1-800-992-3522) for a Wellness Form specifically tailored for your policy.

Please use black or blue ink only and print legibly when completing this form in its entirety. Keep a copy of the supporting documentation and this completed form for your records. Sign, date, and mail the completed form to the Aflac address shown below.

Policyholder Information
Policyholder First Name: ___________________________ Middle Initial: ___________________________ Policyholder Last Name: ___________________________
Policyholder Birth Date: ____________ ____________ ____________ ____________ ____________ ____________
ZIP of mailing address: ___________________________

Patient Information
First Name: ___________________________ Middle Initial: ___________________________ Last Name: ___________________________
Relationship: 
- Primary Policyholder
- Spouse
- Dependent Child
Sex: Male □ Female □
Patient Birth Date: ____________ ____________ ____________ ____________ ____________ ____________

Wellness Exam
Treatment Date: ____________ ____________ ____________ ____________ ____________ ____________
- Annual physical
- Ultrasound
- PSA (blood test for prostate cancer)
- Pap smear

Pap Smear Date: ____________ ____________ ____________ ____________ ____________ ____________

Mammogram
Mammogram Date: ____________ ____________ ____________ ____________ ____________ ____________

Treatment date must be provided.
- Blood screening
- Immunizations
- Eye exam
- Mammogram

Physician Information
Name: ___________________________
Street Address: ___________________________
City: ___________________________
State: ___________________________
ZIP: ___________________________
Phone Number: ____________ ____________ ____________ ____________ ____________ ____________

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

I certify that the information provided is true and correct:

_____________________________________________________________________________ ____________
POLICYHOLDER SIGNATURE DATE