NUMBER OF PAGES INCLUDING COVER: _____

DATE: _____

TO:

AFLAC CLAIMS DEPT.

INBOUND FAX IMAGING

1-877-44-AFLAC

(1-877-442-3522)

FROM: _____

PHONE: _____

FAX : _____

Policyholder: _____

Policy Number(s):

_____

_____

_____

Associate Writing Number:

_____

Send check to associate for delivery:

YES ❑ NO ❑

Check will be mailed to policyholder if this section is not completed entirely.

❑ **Accident (w/o disability)** ❑ **Intensive Care** ❑ **Cancer** ❑ **Cancer Wellness**

❑ **Accident (w/ disability)** ❑ **Specified Health Event** ❑ **Long Term Care**

❑ **Short Term Disability** ❑ **Hospital Indemnity** ❑ **Home Health Care**

Associate Message: _____

_____

_____

- ***EACH POLICYHOLDER REQUIRES A SEPARATE FAX COVER PAGE AND A SEPARATE FAX TRANSMISSION.***
- ***THE SYSTEM CANNOT ACCEPT THE ACCIDENT BARCODED WELLNESS FORM. PLEASE MAIL THESE FORMS TO AFLAC CLAIMS DEPARTMENT.***
- ***YOUR "TRANSMISSION SUCCESSFUL" CONFIRMATION LETS YOU KNOW THAT THE FAX HAS BEEN RECEIVED. IT IS NOT NECESSARY TO CALL TO VERIFY.***

PLEASE COPY THIS FORM FOR FUTURE USE.

****** This form is available on the AFLAC website at www.aflac.com ******