Please read all instructions.
Failure to follow these instructions will delay the processing of your claim.

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

Your Aflac policy provides one Wellness Benefit per covered person, per calendar year, and this form is designed specifically for this benefit. To receive your Wellness Benefit, complete the form by following the instructions provided. Please print a separate form for each additional covered family member or call 1-800-99-AFLAC (1-800-992-3522) to request additional forms. Claims for all other benefits covered under your Cancer policy must be filed separately, using the Cancer Claim Form.

If any of your wellness tests resulted in a diagnosis of cancer, please submit your claim for cancer treatment separately, using the Cancer Claim Form.

If your Aflac policy also provides one Mammogram Benefit per calendar year, 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 one Pap Smear Benefit per calendar year, 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.

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.

- Do not write on the 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.
Cancer Screening 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.

Policyholder First Name: ___________________________ Policy Number: ___________________________

Policyholder Last Name: ___________________________ Policyholder Birth Date: M M D D Y Y Y Y

Policyholder Birth Date: M M D D Y Y Y Y

Patient First Name: ___________________________ Middle Initial: ___________________________

Patient Last Name: ___________________________ Patient Birth Date: M M D D Y Y Y Y

Relationship to Policyholder:  
- Primary Policyholder
- Spouse
- Dependent Child

Wellness Exam Treatment Date: M M D D Y Y Y Y

- Colonoscopy
- Virtual colonoscopy
- Flexible sigmoidoscopy
- Pap smear - ThinPrep
- Pap smear

Pap Smear Date: M M D D Y Y Y Y

Mammogram Date: M M D D Y Y Y Y

Provide actual cost for Mammogram: ___________________________

Doctor or Medical Facility Name and Address. Must be completed in its entirety.

Name: ___________________________

Street Address: ___________________________

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.

I certify that the information provided is true and correct:

Policyholder Signature: ___________________________ Printed Name: ___________________________ Date: ___________________________

American Family Life Assurance Company of Columbus (Aflac) Worldwide Headquarters • 1932 Wynnton Road • Columbus, GA 31999-7251 1-800-99-AFLAC (1-800-992-3522) • aflac.com • 1-800-SI-AFLAC (1-800-742-3522) en español Z06197CA □ CANREV