VISION NOW EYE EXAM/ VISION CORRECTION MATERIALS CLAIM FORM

If you are interested in filing your claim online, register using aflac.com/smartclaim.

- **Benefits of filing your claim online include faster claim processing time and receiving claim communications by email.**

Please read all instructions.

Failure to follow these instructions could delay the processing of your claim.

Your Aflac policy provides an Eye Exam Benefit. To receive your Eye Exam Benefit, complete the form by following the instructions provided. Please check your policy for specific details on this benefit.

- Do not write on form except as instructed.
- Sign, date and fax or mail the completed form to the Aflac fax number/address shown below.
- Use black or blue ink only and print legibly when completing this form in its entirety.
- Mark only wellness exam boxes for test(s) and/or treatment(s) received.
- Failure to complete all sections may result in a delay in processing this claim.

Your Aflac policy also provides a Vision Correction Materials Benefit payable based on the option selected, and subject to waiting periods, if applicable. Please check your policy for specific details on this benefit. To receive your Vision Correction Materials Benefit please complete the appropriate boxes on the form by following the instructions provided and submit the bill for your Vision Correction Materials.

Please keep a copy of this completed form for your records. Please print a separate form for each additional family member or call 1-800-99-AFLAC (1-800-992-3522) to request additional forms. Claims for all other benefits covered under this policy must be filed separately using the claim forms available at aflac.com or by calling 1-800-99-AFLAC (1-800-992-3522).

American Family Life Assurance Company of Columbus (Aflac)
ATTN: Claims Department • 1932 Wynnton Road • Columbus, GA 31999
For information or to check claim status, visit aflac.com or call 1-800-99-AFLAC (1-800-992-3522)
Claims may be faxed to 1-877-44-AFLAC (1-877-442-3522)

VISION NOW EYE EXAM/ VISION CORRECTION MATERIALS CLAIM FORM

Policy Number:

All Fields are required.

Policyholder Information:

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 permanent address change.*

Patient Information:

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

Sex: ☐ Male ☐ Female

Relationship: ☐ Primary Policyholder ☐ Spouse ☐ Dependent Child

Bill must be attached when filing for the Vision Correction Benefit.

Treatment and Physician Information:

Eye Exam Information:

☐ Eye exam

Treatment Date: M M D D Y Y Y Y

Vision Correction Benefit Information:

☐ Prescription glasses, frames or lenses

☐ Contact lenses

Purchase Date: M M D D Y Y Y Y

***When filing for the Eye Exam Benefits, the treating physician must be an optometrist or an ophthalmologist.**

Physician's Phone Number:

Physician's Name

Physician's Street Address

Physician's City | State: | Zip:

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

The Provider listed above is authorized to validate the information I have provided.

POLICYHOLDER/PATIENT SIGNATURE | **FAMILY RELATIONSHIP, IF NOT POLICYHOLDER** | **DATE**

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