

Aflac Group - Online Filing Submissions Process

- www.aflacgroupinsurance.com/customer-service/file-a-claim.aspx
- Video is available on the above website: “How to file claim online”
- Claims intake portal (for claim submission only)
 - ✓ Wellness
 - ✓ Accident
 - ✓ Critical Illness
 - ✓ Hospital Indemnity
- Claim status will continue to be available through contacting our Customer Service Center (1-800-433-3036)

Select File Online



File a Claim

Service Request

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Aflac Group Insurance Claim Forms

▼ File a Wellness Benefit Claim

▲ **File an Accident Claim**

File an Accident Claim Online

Simply select "File Online" below and follow the instructions.

 [File Online](#)



File an Accident Claim via Fax or Mail

Please provide a date and complete description of your accident. You can provide this information in the designated space on the claim form.

If the accident resulted from the use of a motor vehicle(s), a copy of the police or accident report is required. If your injury occurred on the job, a first report of injury filed with your employer must be attached to the completed claim form.

If you were first treated in an emergency room, a copy of the hospital discharge papers is required to verify the first date of treatment, diagnosis, and procedure.

Please include all dates of treatment and charges incurred due to the accident.

Please date and sign all required forms where indicated.

Select Claim type



What type of claim would you like to file? ⓘ

Wellness Claim

Accident Claim

Critical Illness Claim

Hospital Indemnity Claim

Explanation on needed documents provided per product:

Accident

ACCIDENT CLAIM

Before you begin, make sure these documents are ready to upload.

Required

- Itemized Bill from the Physician's Office (HCFA 1500)

If Applicable

- | | |
|--|--|
| <ul style="list-style-type: none">Itemized Bill from the Hospital or Medical Facility (UB04)
Required only if there was a hospital stay | <ul style="list-style-type: none">Follow Up Visit-Receipts (with dates and charges)
Required only if there were follow up visits or physical therapy |
| <ul style="list-style-type: none">Surgical Report
Required only if the accident involved surgery | <ul style="list-style-type: none">Chart Note (with admission and discharge paperwork)
Required only if there was a hospital stay |
| <ul style="list-style-type: none">Ambulance Bill
Required only if there was emergency transport | <ul style="list-style-type: none">Appliance Receipt
Required only if medical equipment was used (such as crutches, wheelchair, etc.) |
| <ul style="list-style-type: none">Major Diagnostic Exam Report of Billing
Required only if diagnostic tests were performed (such as X-ray, CT Scan, MRI, MRA, EEG, etc.) | <ul style="list-style-type: none">Accident Report (i.e. police report)
Required only if a motor vehicle accident occurred |

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Explanation on needed documents provided per product:

Critical Illness





CRITICAL ILLNESS CLAIM

Before you begin, make sure these documents are ready to upload.

Needed

-  **Attending Physician's Statement**
Before you proceed submitting your claim, please be aware in many cases a signed Attending Physician's Statement will be needed. Submitting your claim at this time without it could delay the processing of your claim. Before proceeding, we recommend downloading this form and having your Physician complete and sign it.
[Download form](#)

If Applicable

-  **Chart Note (with admission and discharge paperwork)**
Required only if there was a hospital stay
-  **Pathologist Report**
Required only if diagnosed with a malignant condition (such as Cancer, Carcinoma in situ, Skin Cancer, etc.)
-  **Surgical Report**
Required only if the critical illness treatment involved surgery (such as Coronary Artery Bypass Surgery or other Heart Event, Major Organ Transplant, Bone Marrow
-  **Heart Attack; Sudden Cardiac Arrest Medical Reports**
Please include reports such as discharge summary, cardiology consult report, cardiac catheterization report,
-  **Stroke Medical Reports**
Please include reports such as Discharge summary, Initial diagnosis MRI and/or CT test reports, Follow-up MRI and/or CT test reports as proof of permanent neurological damage, Neurologist or therapist office notes, etc.
-  **Renal Failure Medical Reports**
Please include reports such as End Stage Renal Disease Medical Evidence Report, Proof of dialysis start date, Renal transplant operative report, etc.
-  **Health Care Provider Medical Documentation**
Please submit documentation indicating diagnosis and severity of such as Loss of sight, speech or hearing, Coma, Burns or Paralysis
-  **Itemized Bill from the Hospital or Medical Facility (UB04)**
Required only if there was a hospital stay

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Explanation on needed documents provided per product:

Hospital Indemnity












HOSPITAL INDEMNITY CLAIM

Before you begin, make sure these documents are ready to upload.

Required

-  Itemized Bill from the Physician's Office (HCFA 1500)

If Applicable

- | | |
|--|--|
| <ul style="list-style-type: none"> Itemized Bill from the Hospital or Medical Facility (UB04)
Required only if there was a hospital stay | <ul style="list-style-type: none"> Chart Note (with admission and discharge paperwork)
Required only if there was a hospital stay |
| <ul style="list-style-type: none"> Surgical Report
Required only if surgery took place | <ul style="list-style-type: none"> Follow Up Visit-Receipts (with dates and charges)
Required only if there were follow up visits or physical therapy |
| <ul style="list-style-type: none"> Major Diagnostic Exam Report of Billing
Required only if diagnostic tests were performed (such as X-ray, CT Scan, MRI, MRA, EEG, etc.) | <ul style="list-style-type: none"> Accident Report (i.e. police report)
Required only if a motor vehicle accident occurred |
| <ul style="list-style-type: none"> Pathologist Report
Required only if diagnosed with a malignant condition (such as Cancer, Carcinoma in situ, Skin Cancer, etc.) | <ul style="list-style-type: none"> Pharmacy Receipts
Required only if outpatient prescription drugs were prescribed |
| <ul style="list-style-type: none"> Health Care Provider Medical Documentation
Please submit documentation indicating diagnosis and severity of such as Loss of sight, speech or hearing, Coma, Burns or Paralysis | <ul style="list-style-type: none"> Renal Failure Medical Reports
Please include reports such as End Stage Renal Disease Medical Evidence Report, Proof of dialysis start date, Renal transplant operative report, etc. |
| <ul style="list-style-type: none"> Stroke Medical Reports
Please include reports such as Discharge summary, Initial diagnosis MRI and/or CT test reports, Follow-up MRI and/or CT test reports as proof of permanent neurological damage, Neurologist or therapist office notes, etc. | |



Verify Your Identity

To keep our system safe and secure, we need to verify your identity.

★ Indicates required field

First Name★

Middle Name

Last Name★

Date of Birth★



Phone number

Address Line 1★

Address Line 2

City★

State★



Zip Code★

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Next Steps: Verify insured identity and then begin completing the online claim form and uploading the supporting documentation.



Claim Details

Policyholder & Patient Information

Begin

Health Screening

Begin

Physician Information

Begin

Direct Deposit Information (Optional)

Enroll now to receive your claim payment electronically. You can also update or stop your existing direct deposit information.

Begin

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Review Your Claim

Please make sure all information is correct. To edit your claim, select the "Edit Claim" button.

Policyholder Information

Name John B Doe Born 1/1/1985	Contact Information (555) 555-5555 johndoe@example.com	Address 100 Yellow Brick Rd Kansas City KS 12345
Permanent Address Change? Yes	Social Security Number ***.**.6789	Employer's Name Bob's Tire Shop
Policy Number B1234567	Employee ID BTS12345	

Patient Information

Name John B Doe Born 1/1/1985	Relationship to Policyholder Self
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Health Screening

Screening Test Annual Physical Exam	Date Of Screening 12/10/2018
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Physician Information

Physician's Name Dr. Who	Phone number (987) 654-3210	Address 100 Twilight Zone Rosewell NM 99999
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Direct Deposit Information

Enroll in Direct Deposit

Account Type Checking	9-Digit Routing Number 123456789	Account Number ****1111
Financial Institution Bank of Aflac Group	Address 1 Aflac Group Pkwy Columbia SC 12345	Phone number (123) 456-7890

[EDIT CLAIM](#)

Final Step: Review the claim information entered and sign and submit..

Sign & Submit

- By checking this box, the user consents to have read and agree to the [Electronic Signature Terms and Conditions](#) and understands that s/he is not providing a handwritten signature, that this checkbox is acting as the user's signature, and that by checking this box, it has the effect of a legal written signature, will be legally binding, and that all of the information provided in this submission is true and correct. The user further represents and warrants that the person submitting this is the same person who authenticated him- or herself at the identity validation page after having accepted the [Online and Mobile Terms and Conditions](#) of this website, which are incorporated herein by reference.

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