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)

Aflac Group Online Claims Filing



Select File Online



File a Claim Service Request

Support FAQ

Search

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 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

Critical Illness Claim

Accident 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.

before you begin, make sure these documen	its are ready to aprodu.
Required	
Itemized Bill from the Physician's Office (HCFA 1500)	
f Applicable	
Itemized Bill from the Hospital or Medical Facility (UB04) Required only if there was a hospital stay	Follow Up Visit-Receipts (with dates and charges) Required only if there were follow up visits or physical therapy
Surgical Report Required only if the accident involved surgery	Chart Note (with admission and discharge paperwork) Required only if there was a hospital stay
Ambulance Bill Required only if there was emergency transport	Appliance Receipt Required only if medical equipment was used (such as crutches, wheelchair, etc.)
Major Diagnostic Exam Report of Billing Required only if diagnostic tests were performed (such as X-ray, CT Scan, MRI, MRA, EEG, etc.)	Accident Report (i.e. police report) Required only if a motor vehicle accident occurred

BACK NEXT

CRITICAL ILLNESS CLAIM

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

N	e	e	d	e	d
	_	_			

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

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

Stroke Medical Reports

BACK

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.

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

Pathologist Report

Required only if diagnosed with a malignant condition (such as Cancer, Carcinoma in situ. Skin Cancer, etc.)

Heart Attack; Sudden Cardiac Arrest Medical Reports

Please include reports such as discharge summary, cardiology consult report, cardiac catheterization report,

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.

Itemized Bill from the Hospital or Medical Facility (UB04)

Required only if there was a hospital stay

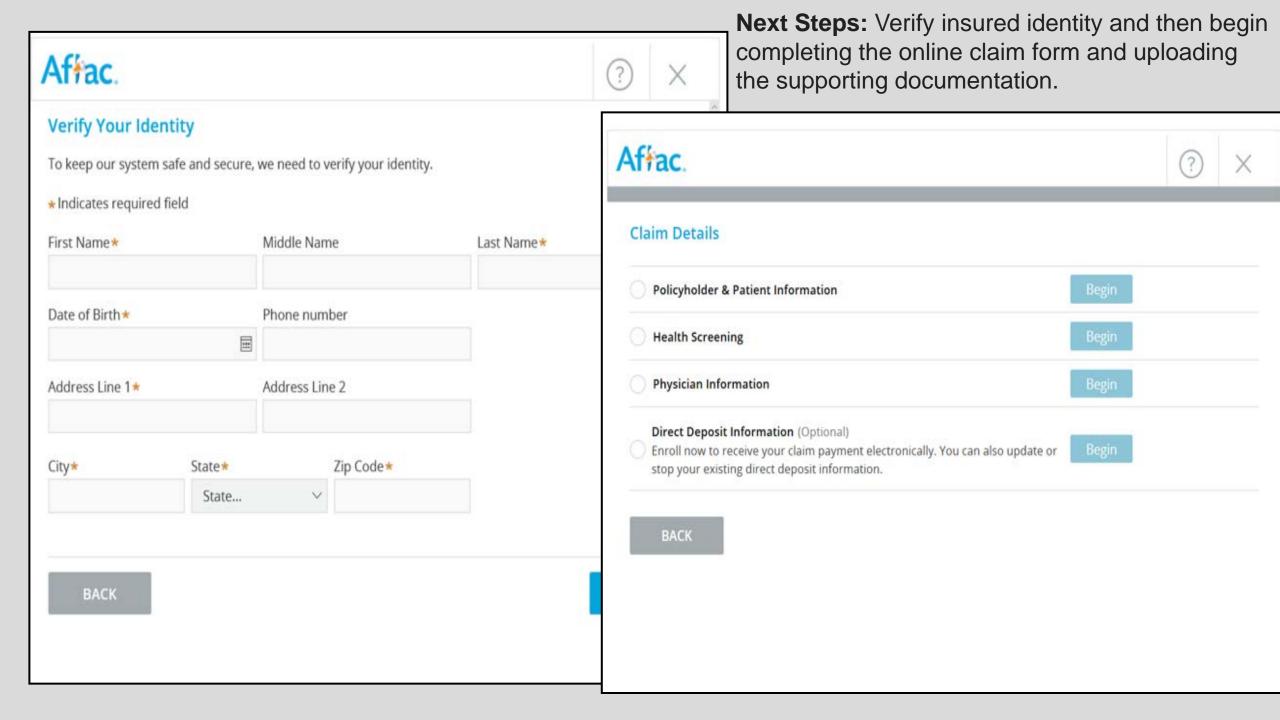
Explanation on needed documents provided per product:

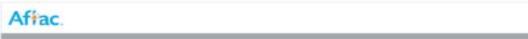
Hospital Indemnity

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 Temized Bill from the Hospital or Medical Facility Chart Note (with admission and discharge (UB04) paperwork) Required only if there was a hospital stay Required only if there was a hospital stay Surgical Report Follow Up Visit-Receipts (with dates and charges) Required only if surgery took place Required only if there were follow up visits or physical therapy Accident Report (i.e. police report) Major Diagnostic Exam Report of Billing Required only if a motor vehicle accident occurred Required only if diagnostic tests were performed (such as Xray, CT Scan, MRI, MRA, EEG, etc.) Pathologist Report Pharmacy Receipts Required only if outpatient prescription drugs were Required only if diagnosed with a malignant condition (such prescribed as Cancer, Carcinoma in situ, Skin Cancer, etc.) Health Care Provider Medical Documentation Renal Failure Medical Reports Please submit documentation indicating diagnosis and Please include reports such as End Stage Renal Disease severity of such as Loss of sight, speech or hearing, Coma, Medical Evidence Report, Proof of dialysis start date, Renal Burns or Paralysis transplant operative report, etc. 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.





Review Your Claim

Policyholder Information

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

Contact Information Address Name John B Doe (555) 555-5555 100 Yellow Brick Rd Born 1/1/1985 johndoe@example.com

Kansas City KS 12345 Employer's Name Bob's Tire Shop

Policy Number B1234567

Permanent Address Change?

Employee ID

***,**,6789

Social Security Number

BTS12345

Patient Information

Name John B Doe Relationship to Policyholder

Self

Health Screening

Born 1/1/1985

Screening Test.

Date Of Screening

Annual Physical Exam. 12/10/2018

Physician Information

Physician's Name Dr. Who

Phone number

Address 100 Twilight Zone (987) 654-3210 Rosewell NM 99999

Direct Deposit Information

Enroll in Direct Deposit

Account Type Checking

9-Digit Routing Number 123456789

Financial Institution Bank of Affac Group

Address 1 Aflac Group Pkwy Columbia SC 12345 ****1111

Account Number

Phone number (123) 456-7890 Final Step: Review the claim information entered and sign and submit..

Affac. 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.