VISION NOW℠ EYE EXAM/VISION CORRECTION MATERIALS CLAIM FORM

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

Your Aflac policy provides one Eye Exam Benefit per covered person per policy year, and this letter is designed specifically for this benefit. To receive your Eye Exam Benefit, complete the form by following the instructions provided.

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 appropriate boxes on the form by following the instructions provided.

Please keep a copy of this completed form for your records. 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 this policy must be filed separately using form S-00221 available at aflac.com or by calling 1-800-99-AFLAC (1-800-992-3522).

- **Do not write on 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.**

American Family Life Assurance Company of Columbus (Aflac)
Attn: Claims Department • 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 espanõl

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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.

Policyholder Information

Policyholder First Name: | Middle Initial: | Policyholder Last Name:

Policyholder Birth Date: M M D D Y Y Y Y | ZIP of mailing address:

Policy Number

Patient Information

First Name: | Middle Initial: | Last Name:

Relationship: ☐ Primary Policyholder ☐ Spouse ☐ Dependent Child

Sex: ☐ Male ☐ Female

Patient Birth Date: M M D D Y Y Y Y

Eye Exam

☐ Eye exam

Treatment Date: M M D D Y Y Y Y

Vision Correction Benefit

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

☐ Prescription glasses, frames or lenses

☐ Contact lenses

Purchase Date: M M D D Y Y Y Y

Provider Information

Must be an optometrist or an ophthalmologist. Applies only when filing for the Eye exam benefit.

Phone Number: - -

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 | **DATE**

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