



Cancer Screening Wellness Benefit Claim Form

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.**



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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:

Policyholder Last Name:

Patient First Name:

Relationship to Policyholder:

☐ Primary Policyholder ☐ Spouse ☐ Dependent Child

Middle Initial:

Policy Number

Policyholder Birth Date:

M M D D Y Y Y Y

ZIP of mailing address:

Patient Last Name:

Patient Sex:

☐ Male ☐ Female

M M D D Y Y Y Y

Patient Birth Date:

Wellness Exam Treatment Date:

M M D D Y Y Y Y

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

- ☐ Breast MRI
☐ Testicular Ultrasound
☐ Hemocult stool specimen
☐ CEA (blood test for colon cancer)
☐ CA 125 (blood test for ovarian cancer)
☐ Mammogram

- ☐ Chest X-Ray
☐ CA153
☐ Thermography
☐ PSA (blood test for prostate cancer)
☐ Breast ultrasound/Breast sonogram
☐ Biopsy

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.

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

Printed Name

Date