INSTRUCTIONS FOR FILING DENTAL CLAIMS

PLEASE DO NOT SUBMIT THIS FORM FOR PRECERTIFICATION.
AFLAC DOES NOT REQUIRE PRECERTIFICATIONS AND WILL NOT COMPLETE THE FORM FOR PRECERTIFICATION.

1. All claims must be submitted on a typed ADA claim form; a copy is on the back of these instructions. Your dentist may prefer to file your claims electronically with WebMD.

2. Only dental claims may be filed with this claim form. If you need to file a claim under another AFLAC policy, please submit the appropriate claim form.

3. Please ask your dentist's office to complete the entire form. Blank fields will cause the form to be returned and the claim processing to be delayed. We must have the following information:
   - The policyholder’s dental policy number.
   - The policyholder’s complete name as it is printed on the Dental Plan ID card.
   - The patient’s full name, sex, date of birth and relationship to the insured.
   - The treatment date, tooth or surface, ADA code and charge for each procedure.
   - The patient’s Social Security number. (This will speed up claim processing.)

4. If the patient is a full-time student and over age 19, please indicate this on the form.

5. If you are filing for the initial benefit under the Orthodontic Rider, the patient must be a covered dependent child less than 17 years of age. There is a two-year waiting period before benefits are payable under the Orthodontic Rider.

6. Your dentist may submit the claim electronically to WebMD. Make sure that AFLAC’s payer number (58066) is included on each claim submitted.

Submit the typed claim form directly to AFLAC at:
AFLAC Worldwide Headquarters
Attention: Claims Department
1932 Wynnton Road
Columbus, GA 31999-7254

If you have any questions, please call our toll-free number 1-800-99-AFLAC (1-800-992-3522) or visit our Web site at www.aflac.com.

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.
AUTHORIZATION TO OBTAIN INFORMATION

I authorize the following to give information (as defined below) to American Family Life Assurance Company of Columbus (AFLAC) or any person or entity acting on its part: any medical professional, medical care institution, insurer (including AFLAC, with respect to other AFLAC coverages), reinsurer, government agency (including departments of public safety and motor vehicle departments), consumer reporting agency or employer. “Information” means facts or opinions relating to my past, present, or future physical or mental health or condition (excluding psychotherapy notes), employment, other insurance coverage, or any other non-medical facts that AFLAC deems appropriate to evaluate claims for benefits during the time this authorization is valid. I understand that any disclosure of information to AFLAC for the purpose of evaluating claims for benefits for coverage other than health plan coverage means the information may no longer be protected by federal privacy regulations. I further understand, however, that such information may be re-disclosed only in accordance with other applicable laws or regulations.

I understand that this information will be used by AFLAC to evaluate claims for benefits.

I understand that I may revoke this authorization at any time, except to the extent that (1) AFLAC has taken action in reliance on this authorization, or (2) other law provides AFLAC with the right to contest a claim under the policy or the policy itself. My revocation must be submitted in writing to AFLAC, Claims Department, Worldwide Headquarters, 1932 Wynnton Road, Columbus, GA 31999.

Unless otherwise revoked, I agree that this authorization will expire two years from the date indicated below.

I agree that a copy of this authorization is as valid as the original.

Signature __________________________ Date __________________________ Printed Name __________________________

Individual/Guardian/Personal Representative

Printed Name __________________________

If this authorization has been signed by a personal representative on behalf of an individual, his/her authority to act on behalf of the individual must be set forth here:
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Signature   Date   Printed Name
Individual/Guardian/Personal Representative

Printed Name

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RETAINT THIS COPY FOR YOUR RECORDS