If you are interested in filing your claim online, register using aflac.com/smartclaim.

Benefits of filing your claim online include faster claim processing time and receiving claim communications by email.

Please read all instructions and complete the form, failure to do so could delay the processing of your claim.

Please check your policy for specific details on this benefit.

- Do not include receipts, statements or other claim documentation with this form.
- Do not write on form except as instructed.
- Sign, date and fax or mail the completed form to the Aflac New York fax number/address shown below.
- Use black or blue ink only and print legibly when completing this form in its entirety.
- Mark only wellness exam boxes for test(s) and/or treatment(s) received.
- Failure to complete all sections may result in a delay in processing this claim.
- Some types of tests and/or treatment listed may not be covered by your policy.

Please keep a copy of this completed form for your records. Please print a separate form for each additional family member or call 1-800-366-3436 to request additional forms. Claims for all other benefits covered under this policy must be filed separately using the claim forms available at aflac.com or by calling 1-800-366-3436.
HEALTH SCREENING/WELLNESS BENEFIT CLAIM FORM

Policy Number: [_________________________]

All Fields are required.

Policyholder Information:

<table>
<thead>
<tr>
<th>Last Name</th>
<th>Suffix</th>
<th>First Name</th>
<th>MI</th>
</tr>
</thead>
</table>

Date of Birth (mm/dd/yy) Telephone Number where we can reach you

Home Address

City

State Zip Code

[ ] Check box if this is permanent address change.

Patient Information:

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Date of Birth (mm/dd/yy)</th>
</tr>
</thead>
</table>

Sex: [ ] Male  [ ] Female

Relationship:  [ ] Primary Policyholder  [ ] Spouse  [ ] Dependent Child

Treatment and Physician Information

<table>
<thead>
<tr>
<th>Treatment Date:</th>
<th>M M D D Y Y Y Y</th>
<th>Mammogram Date:</th>
<th>M M D D Y Y Y Y</th>
<th>Pap Smear Date:</th>
<th>M M D D Y Y Y Y</th>
</tr>
</thead>
</table>

[ ] Annual Physical  [ ] Blood Screening  [ ] Dental Exam

[ ] Ultrasound  [ ] Immunizations  [ ] Flexible Sigmoidoscopy

[ ] PSA (blood test for prostate cancer)  [ ] Eye Exam  [ ] Mammogram

[ ] Pap Smear

Physician's Name

Physician's Street Address

Physician's 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 material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

The Provider listed above is authorized to validate the information I have provided.

POLICYHOLDER/PATIENT SIGNATURE             FAMILY RELATIONSHIP, IF NOT POLICYHOLDER             DATE
NY-CW061999 NY                             _________________________________   _________________________________

American Family Life Assurance Company of New York
ATTN: Claims Department • 1932 Wynnton Road • Columbus, GA 31999-7255
For information or to check claim status, visit aflac.com or call 1-800-366-3436
Claims may be faxed to 1-877-44-AFLAC (1-877-442-3522)