

AFLAC CLAIM COVER SHEET

(Claims may be sent in by mail or by fax.)

TO: Kathryn Csemez
AFLAC
3516 Plank Road, Suite 102
Fredericksburg, VA 22407

DATE: _____

FAX NUMBER: 540-548-2324

PHONE NUMBER: 540-548-3484

Employee's Name: _____

Social Security Number: _____

Daytime Phone Number: _____

Number of Pages Attached: _____

Patient's Name: _____

Relationship to Employee: Self Spouse Dependent Child

Receipts are attached for services rendered which may qualify for payment under the following plan(s):

_____ Accident Plan
Date of Accident: _____
Briefly describe how accident happened: _____

_____ Cancer Plan

_____ Intensive Care Plan

Thank you.

