# CANCER POLICY WELLNESS CLAIM FORM

AFLAC Worldwide Headquarters
ATTN: Claims Department
1932 Wynnton Road
Columbus, Georgia 31999
Toll-Free Fax: 1-877-442-3522

Cancer Policy Number: _____

**IMPORTANT: A copy of the charges must be attached. This benefit is limited to one payment per calendar year per covered person.**

Patient's Name: _____

Relationship to Policyholder: Self ☐ Spouse ☐ Child ☐

Patient's Date of Birth: _____ Male ☐ Female ☐

Policyholder's Name: _____

Street Address: _____

☐ Check here if this is a new address

City, State, Zip: _____

Telephone No: _____

Treatment Date: _____