


**Allstate**

Workplace Division

## CLAIM FORM AND INSTRUCTIONS

If you have any questions regarding our determination of your claim, or if you would like to appeal any determination, please contact our Customer Care Center at 1-800-348-4489  
8:00 A.M. to 8:00 P.M. Eastern Standard Time

The furnishing of this form, or its acceptance by the Company as proof, must not be construed as an admission of any liability on the part of the Company, nor a waiver of any of the conditions of the insurance contract.

### INSTRUCTIONS FOR FILING CLAIMS

- Please fill out the sections which apply to your specific claim.
- Enclose the information requested and include your policy number. To obtain your policy number call **1-800-348-4489**.
- You may **fax** your claim to us at **1-904-992-2899**. Please allow 3 business days for our records to be updated with information confirming receipt of your fax or claim; or
- You may mail your claim to:
 

**Allstate Workplace Division**  
**Attn: Claim Department**  
**1776 American Heritage Life Drive**  
**Jacksonville, Florida 32224-6687**
- Additional claim forms are available on our website at [www.ahcorp.com](http://www.ahcorp.com).
- If you are filing a claim within the first 12 to 24 months your policy is in force, additional information may be required. Please notify your doctor we will be contacting him/her and provide him/her with a copy of your authorization to release information to us.
- **FOR ALL CLAIMS (First Claim or Continued Claim):**
  - Complete PART 1: Section A – POLICYHOLDER and,
  - Sign the Authorization (Page 2)

## PART 1

### Section A POLICYHOLDER/ CERTIFICATEHOLDER

Employer Name (Company/Address): \_\_\_\_\_ Occupation: \_\_\_\_\_

1. Name: First: \_\_\_\_\_ Middle: \_\_\_\_\_ Last: \_\_\_\_\_

 Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  Male  Female  
MO/DAY/YR

2. Home Number: (\_\_\_\_) \_\_\_\_\_ E-mail: \_\_\_\_\_ Avg. Monthly Earnings: \_\_\_\_\_

### PATIENT

3. Name: First: \_\_\_\_\_ Middle: \_\_\_\_\_ Last: \_\_\_\_\_

 4. Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Age: \_\_\_\_\_  Male  Female  
MO/DAY/YR

 5. This person is your: \_\_\_\_\_ (ex: self, wife, son, etc.) Is he/she a full-time student?  Yes  No If yes, please submit proof of student status.

### Section B TYPE OF CLAIM: FIRST CLAIM CONTINUED CLAIM

\_\_\_\_\_ ACCIDENT/DISABILITY Policy No.(s): \_\_\_\_\_

- 
- Routine Pregnancy
- 
- 
- Ongoing Disability

- 
- Outpatient Physicians Benefit
- 
- 
- Hospital Income Benefit

\_\_\_\_\_ CANCER Policy No.(s): \_\_\_\_\_

- 
- Wellness Benefit
- 
- 
- Intensive Care

\_\_\_\_\_ HEART/STROKE Policy No.(s): \_\_\_\_\_

\_\_\_\_\_ HOSPITAL INDEMNITY Policy No.(s): \_\_\_\_\_

\_\_\_\_\_ CRITICAL ILLNESS Policy No.(s): \_\_\_\_\_

\_\_\_\_\_ WAIVER OF PREMIUM Policy No.(s): \_\_\_\_\_

**➔ PLEASE NOTE: Failure to complete this information will cause a delay in the processing of your claim.**

*Allstate Workplace Division is the marketing name for American Heritage Life Insurance Company (home office: Jacksonville, Florida), a wholly-owned subsidiary of The Allstate Corporation (home office: Northbrook, Illinois)*

**Important: To avoid delay, please sign authorization below.**

**Note: Due to Internal Revenue Service requirements concerning social security number verification and backup withholding requirements, this form is required to be completed prior to claim payment. Check to be sure that all information is correct before signing.**

1. **Section 125:** Were the premiums for your **disability income policy** paid with pre-tax dollars under a Section 125 Plan?  Yes  No (if in doubt, please ask your employer.)

**Taxpayer Identification Number Certification**

2. **Federal law requires us to send to the Internal Revenue Service a percentage of any income you may be entitled to unless you certify under penalties of perjury that you have shown your correct Social Security Number and you have not been notified that you are subject to any Internal Revenue Service backup withholding order.**

**Under penalties of perjury, I certify that:**

- A. The Social Security Number shown in Section A line (1) is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and**
- B. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) The IRS has notified me that I am no longer subject to backup withholding, and**
- C. I am a U.S. person (including a U.S. resident alien).**

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medically related facility, insurance company or other organization, institution or person that has any records or knowledge of me (or my dependents) to give such information to American Heritage Life Insurance Company or its designee. This authorization is valid for a period of 24 months from the date signed. I understand that I may revoke this authorization at any time by notifying American Heritage Life in writing of my desire to do so. A photographic copy of this authorization shall be as valid as the original, regardless of date signed. I understand that I or my representative may receive a copy of this authorization by supplying policy number(s) and Insured's name in a written request to the company.

**The Internal Revenue Service does not require your consent to any provisions of this document other than the certification required to avoid backup withholding.**

Sign here \_\_\_\_\_ Date: \_\_\_\_\_  Check here if address is new  
Claimant  
Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Telephone No.: ( ) \_\_\_\_\_

**NOTICE IN ALASKA, ARKANSAS, KENTUCKY, LOUISIANA, MAINE, NEW JERSEY, NEW MEXICO, AND VIRGINIA:**

Any person who knowingly and with intent to injure, defraud or deceive an insurance company files a claim containing false, incomplete or misleading information may be prosecuted under state law.

**NOTICE IN DELAWARE, IDAHO, INDIANA, MINNESOTA, NEW HAMPSHIRE, AND OKLAHOMA:** Any person who knowingly and with intent to injure, defraud or deceive an insurance company files a claim containing false, incomplete or misleading information is guilty of a felony.

**NOTICE IN ARIZONA:** For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

**NOTICE IN CALIFORNIA:** For your protection, California law requires the following to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

**NOTICE IN COLORADO:** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

**NOTICE IN DISTRICT OF COLUMBIA: WARNING:** It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

**NOTICE IN FLORIDA:** Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

**NOTICE IN OHIO:** Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

**NOTICE IN PENNSYLVANIA:** 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.

**NOTICE IN TENNESSEE:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

**NOTICE IN TEXAS:** Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.



**If you are filing a claim for disability or waiver of premium, please have your employer and physician complete PARTS 2 & 4.**

**PART 2 ATTENDING PHYSICIAN'S STATEMENT**

Patient's Name: \_\_\_\_\_ Age: \_\_\_\_\_

1. Diagnosis: \_\_\_\_\_
  2. If condition is due to pregnancy, what is expected delivery date? Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
MO/DAY/YR
  3. When did symptoms first appear or accident happen? Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
MO/DAY/YR
  4. When did patient first consult you for this condition? Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
MO/DAY/YR
  5. Has patient ever had same or similar condition? (If "yes," state when and describe.)  Yes  No \_\_\_\_\_
  6. Describe any other diseases or infirmity affecting present condition. \_\_\_\_\_
  7. Nature of surgical or obstetrical procedure, if any (describe fully). \_\_\_\_\_
  8. Is patient unable to perform job duties?  Yes  No If yes, from \_\_\_\_\_ through \_\_\_\_\_
  - 9a. What specific job duties is patient unable to perform? \_\_\_\_\_
  - 9b. Specific RESTRICTIONS (What the patient should not do and why). Please quantify in hours, weight, etc. \_\_\_\_\_
  - 9c. Specific LIMITATIONS (What the patient cannot do and why). \_\_\_\_\_
  10. If retired or unemployed which activities of daily living (ADLs) is patient unable to perform? \_\_\_\_\_
  11. Date patient last examined by you: \_\_\_\_\_ Frequency of visits:  weekly  monthly  other \_\_\_\_\_
  12. Is patient:  ambulatory  bed confined  house confined  other \_\_\_\_\_
  13. If patient is hospitalized, give name and address of hospital.  
Hospital: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_
  - 14a. Date admitted: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Date discharged: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
MO/DAY/YR MO/DAY/YR
  - 14b. When do you expect patient to resume partial duties? \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Full duties? \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
MO/DAY/YR MO/DAY/YR
  - 14c. If patient is unemployed or retired, on what date would you expect a person of like age, gender and good health to resume his/her normal and necessary activities? \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
MO/DAY/YR
  15. Is condition due to injury or sickness arising out of patient's employment?  Yes  No  
If "yes," explain. \_\_\_\_\_
- Name and address of referring physician if any.  
Name: \_\_\_\_\_ Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip \_\_\_\_\_
16. Have you completed paperwork for any other insurance company?  Yes  No Social Security Disability?  Yes  No

**If you are claiming CONTINUING DISABILITY, please have your employer and physician complete PARTS 3 & 4.**

**PART 3 ATTENDING PHYSICIAN'S STATEMENT FOR CONTINUING DISABILITY**

FIRST CLAIM FOR DISABILITY due to Accident or to Sickness: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
MO/DAY/YR

1. Is this claim for continuation of a previous disability?  Yes  No
  - 2a. Diagnosis: \_\_\_\_\_
  3. Describe any other diseases or infirmity affecting present condition. \_\_\_\_\_
  4. Date of initial disability due to this diagnosis \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
MO/DAY/YR
  5. Is patient unable to perform job duties?  Yes  No If yes, may return to work  part-time  full-time on : \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
MO/DAY/YR
- List any work restrictions: \_\_\_\_\_ If No, date expected to return to work: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
MO/DAY/YR

**Remember, it is a crime to fill out this form with facts you know are false or to leave out facts you know are relevant and important. Check to be sure that all information is correct before signing. Please refer to page 2 for notice specific to your state.**

**PHYSICIAN VERIFICATION**

Signed: \_\_\_\_\_, MD Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_  
MO/DAY/YR

Street Address: \_\_\_\_\_

City/Town: \_\_\_\_\_

State/Province: \_\_\_\_\_ Zip Code: \_\_\_\_\_

**PART 4**

**EMPLOYER'S STATEMENT**

**Remember, it is a crime to fill out this form with facts you know are false or to leave out facts you know are relevant and important. Check to be sure that all information is correct before signing. Please refer to page 2 for notice specific to your state.**

1. I hereby certify that \_\_\_\_\_ did not perform any part of his/her work from, \_\_\_\_\_ through, \_\_\_\_\_.

2. Did insured work light duty or part-time?  Yes  No If yes, give dates \_\_\_\_\_

3. Prior to inability to work, he/she worked \_\_\_\_\_ hours per week and is considered  exempt or  non-exempt.

4. When recovered, will he/she resume work?  Yes  No If not why? \_\_\_\_\_

5. Is this a Workers' Compensation case?  Yes  No Date Workers' Compensation benefits began \_\_\_\_/\_\_\_\_/\_\_\_\_  
MO/DAY/YR  
Name of Workers' Compensation Company \_\_\_\_\_

6. Section 125: Were the premiums for our disability income policy paid with pre-tax dollars under a Section 125 Plan?  
 Yes  No

7. Is the employee receiving or has he/she received continued pay?  Yes  No If yes, please complete the following:

Pay Period		Amount	Source of Income
From	To		
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

8. Is the employee covered under any other disability policy through the company? \_\_\_\_\_

9. Has employee returned to work?  Yes  No If yes, give date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
MO/DAY/YR

10. The employee's job title or position is: \_\_\_\_\_

11. Current Salary or Hourly Rate: \_\_\_\_\_

Remarks: \_\_\_\_\_  
\_\_\_\_\_

Name of Employer: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
MO/DAY/YR

Address: \_\_\_\_\_

By: \_\_\_\_\_ Official Position: \_\_\_\_\_ Telephone number: (\_\_\_\_) \_\_\_\_\_

**NOTE: Please make a copy of the patient's signed authorization to release information for your records.**

