AMERICAN HERITAGE LIFE INSURANCE COMPANY

CRITICAL ILLNESS COVERAGE WITH OPTIONAL RIDERS CLAIM FORM

Submit Claims to:
American Heritage Life Insurance Company
1776 American Heritage Life Drive, Jacksonville, FL 32224

Phone 1-800-521-3535 Fax 1-866-424-8482 or visit our website at www.allstatebenefits.com/mybenefits

For questions regarding the policy benefits, the supporting documentation, or for assistance with a claim, please contact our **Customer Care Center at 1-800-348-4489 or visit our website at www.allstatebenefits.com.**

To have claim benefits automatically deposited into the Policy/Certificate Holder's bank account, please complete and send our Direct Deposit form (ACH form). This form can be found on our website at **www.allstatebenefits.com** or **www.allstatebenefits.com/mybenefits**.

This form is designed as a communication tool to assist the examiner in reviewing the claim for available benefit. Please complete this form in its totality and complete one form per claimant.

Incomplete or blank responses may result in a delay in processing the claim request.

POLICY/CERTIFICATE HOLDER AND CLAIMANT INFORMATION: This information helps us to identify the policy, covered members, mailing address and employer to ensure benefits are being considered under the correct Coverage.

COVERAGE NUMBER(S): _____

POLICY/CERTIFICATE HOLDER INFORMATION:

First Name: _____ MI: _____ Last Name: _____

Last 4 of Social Security #: XXX-XX-_____ Birth Date: _____ Age: _____ Gender: _____

Mailing Address: _____ Apt#: _____ ☐ **Check here if address is new**

City: _____ State: _____ Zip: _____

Phone #: _____ E-mail: _____

CLAIMANT INFORMATION: (If different**)**

First Name: _____ MI: _____ Last Name: _____

Date of Birth: _____ Age: _____ Gender: _____ Relation to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Domestic Partner ☐ Other_____

CLAIM DETAILS: Please provide the following claim details. This information is very important as it tells the examiner the specific details of the claim and helps the examiner determine whether benefits are available. The Diagnosis/Condition is the condition that was diagnosed by the physician.

What are the Diagnoses/Condition(s) for this claim (list all): _____

When did the claimant first notice symptoms of the condition? _____

What was the date of the initial pathology report? (please provide a copy of the report) _____
**For Clinical Diagnosis, submit lab results and medical imaging*

Was any diagnostic testing performed? (List) _____

Have the claimant ever had the same or similar condition? ☐ Yes ☐ No If yes, when? _____

Other Conditions affecting the claimant's health: _____

When was the first physician visit for this condition? _____ Most Recent Visit: _____ Next Visit: _____

Was the claimant hospitalized due to this condition? ☐ Yes ☐ No Admission Date: _____ Discharge Date:_____

What is the claimant's current treatment? _____

Frequency of Treatment: _____ Duration of Treatment: _____

ASSIGNMENT OF BENEFITS (Not applicable in New Hampshire)

I request that American Heritage Life Insurance Company send benefits to someone other than me. Please send available benefits to the name and address shown below.*

Name: _____ Address: _____

Provider Tax ID #: _____ _____

Relationship: _____ Signature: _____ Date: _____

***Please be advised that if the claimant is covered by MEDICAID, we may be required to Assign Benefits (except disability) to Medicaid or the provider of service in accordance with State and Federal Regulations.**

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CLAIMANT'S NAME: _____ **DATE OF BIRTH:** _____

COVERAGE NUMBER(S): _____ **CLAIM NUMBER:** _____

INSTRUCTIONS FOR REQUESTING AVAILABLE BENEFITS:

- Benefits may vary by product and/or state. In addition, all the available Riders may not have been purchased and/or all the benefits listed may not be available. Please refer to the Coverage Document and Riders for specific benefits available. An outline of benefits is available on page 3 of the Coverage Document.
- Available benefits are considered in accordance with your specific Coverage, including all terms, conditions, provisions and applicable limitations and exclusions.
- Please select the benefits that may be due based upon the condition, services provided, and Coverages available.
- Please submit the supporting documentation. This documentation should include the claimant's name, diagnosis, and date(s) of service.
- If asked to provide a bill as supporting documentation, please request an itemized bill, UB04 or HCFA 1500 from the provider.
- Medical records may include but are not limited to: physician's office visit notes, hospital records, emergency room records, diagnostic test results, radiology reports, therapy visit notes, or physician consultation notes.
- We reserve the right to request additional information for review of the claim.

☐ **NEW CLAIM or** ☐ **CONTINUED CLAIM**

CRITICAL ILLNESS COVERAGE & RIDER BENEFITS: All benefits listed may not be available. Please refer to the Coverage Document and Riders for specific benefits available.

BENEFIT (IF APPLICABLE)	SUPPORTING DOCUMENTATION
☐ **Heart Attack**	Lab reports showing Elevated Cardiac Enzymes and Abnormal EKG and Hospital Admission and Discharge Summary
☐ **Stroke**	CT or MRI showing Infarction and Medical Records showing Permanent Neurologic Deficit following a Stroke
☐ **End Stage Renal Failure**	End Stage Renal Disease (ESRD) Medical Evidence Report and Medical Records showing initiation (date of 1st) Dialysis due to Irreversible Failure of Both Kidneys
☐ **Major Organ Failure** ☐ **Heart Failure**	Medical Records including Lab Results and Test Results Confirming Diagnosis
☐ **Coronary Artery Disease**	Heart Catherization/Angiogram Report showing blockage of 80% or greater
☐ **Cancer – Carcinoma In Situ** ☐ **Cancer – Invasive Cancer** ☐ **Skin Cancer** ☐ **Benign Brain Tumor**	Pathology Report *If diagnosis was made based on clinical evidence, please submit imaging and lab/test results confirming diagnosis*
☐ **Advanced Alzheimer's Disease** ☐ **Advanced Parkinson's Disease**	Medical Records documenting Test Results for Clinical Diagnosis and Records Documenting Inability to Perform 3 or more Activities of Daily Living: ☐ Bathing, ☐ Dressing, ☐ Toileting, ☐ Eating, ☐ Taking Medication
☐ **Coma**	Medical Records documenting Coma *Records must include Cause and Length of Coma and Glasgow Coma Score*
☐ **Complete Loss of Hearing**	Medical Records showing Total and Irreversible Loss of Hearing in Both Ears *Records must contain Test Results for Measurement of Auditory Thresh Hold.*
☐ **Complete Loss of Sight or Complete Blindness**	Medical Records showing Total and Irreversible Loss of Sight in Both Eyes *Records must include Visual Acuity and Visual Field Test Results*
☐ **Complete Loss of Speech**	Medical Records showing Irreversible Loss of Speech *Records must show use of Medical Device for Communication*
☐ **Occupational HIV**	Incident Report from Employer, and Result of Preliminary Tests (other than Urine or Saliva) Performed within 14 days of Exposure and Subsequent Test Results performed within 26 weeks of Initial Exposure that has a Positive Diagnosis
☐ **Paralysis**	Medical records showing Total and Permanent Loss of Muscle Function of 2 or more Limbs Resulting from a Disease or Injury
☐ **Coronary Artery Bypass Graft (CABG)** ☐ **Angioplasty, Atherectomy, Stent Placement** ☐ **Heart Transplant** ☐ **Major Organ Transplant** ☐ **Bone Marrow Transplant**	Operative Report
☐ **Lifestyle Enhancement Rider**	Receipt for Filling a Qualified Prescription and Documentation Issued by the Sponsor of the Program or Event (A Course or Assessment Certificate of Completion, a Statement of Completion, or an Official Race Time)

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COVERAGE NUMBER(S): _____ **CLAIM NUMBER:** _____

CRITICAL ILLNESS COVERAGE & RIDER BENEFITS: (Continued) All benefits listed may not be available. Please refer to the Coverage Document and Riders for specific benefits available.

☐ **Cardiopulmonary Enhancement Rider**	Medical Records Demonstrating Diagnosis supported by Pathology Results, Lab Results and Medical History: ☐ Sudden Cardiac Arrest, ☐ Pulmonary Embolism, ☐ Pulmonary Fibrosis
☐ **Specified Diseases**	Medical Records Demonstrating Diagnosis supported by Pathology Results, Lab Results, and Medical History of a Listed Disease. (Some may require proof of inability to perform Activities of Daily Living) ☐ Adrenal Hypofunction (Addison's Disease), ☐ Lou Gehrig's Disease (ALS), ☐ Bacterial Meningitis, ☐ Cerebral Palsy, ☐ Cystic Fibrosis, ☐ Diphtheria, ☐ Encephalitis, ☐ Huntington's Chorea, ☐ Legionnaire's Disease, ☐ Malaria, ☐ Multiple Sclerosis, ☐ Muscular Dystrophy, ☐ Myasthenia Gravis, ☐ Necrotizing Fasciitis, ☐ Osteomyelitis, ☐ Poliomyelitis, ☐ Rabies, ☐ Scleroderma, ☐ Sickle Cell Anemia, ☐ Systemic Lupus, ☐ Tetanus, ☐ Tuberculosis
☐ **Chronic Illnesses**	Medical Records Demonstrating Diagnosis supported by Pathology Report, Lab Results, and Medical History AND Proof of Inability to perform Activities of Daily Living due to a Listed Disease: ☐ Adrenal Hypofunction (Addison's Disease), ☐ Lou Gehrig's Disease (ALS), ☐ Arthritis, ☐ Huntington's Chorea, ☐ Multiple Sclerosis, ☐ Muscular Dystrophy, ☐ Osteomyelitis, ☐ Osteoporosis
☐ **Critical Injury**	Medical Records documenting Accident and Injury and Proof of Inability to perform Activities of Daily Living
☐ **Transportation** ☐ **Lodging**	Bill or Medical Record showing Treatment on or during Travel Dates or Lodging and Bill for Airfare or Map for Vehicle Mileage or Bill/Receipt for Lodging
☐ **Hospital Confinement Benefit**	Hospital Bill or Medical Records documenting Inpatient Hospital Confinement due to Sickness or Injury.
☐ **Second Evaluation**	Medical Record with Office Notes for Date of Consultation for Second Opinion
☐ **Waiver of Premium**	Completed Attending Physician's Statement and Employer's Statement
☐ **Wellness** ☐ **Wellness and Preventative Care**	Itemized Bill, Receipt, Results with Test Name and Date of Service. ☐ Biopsy for Skin Cancer ☐ Blood Test for Triglycerides ☐ Bone Marrow Testing ☐ CA125 (Cancer Antigen 125 – blood test for Ovarian Cancer) ☐ CA15-3 (Cancer Antigen 15-3 blood test for Breast Cancer) ☐ CEA (Carcinoembryonic Antigen - blood test for Colon Cancer) ☐ Chest X-Ray ☐ Colonoscopy ☐ Doppler Screen of Carotid Arteries ☐ Doppler Screening for Peripheral Vascular Disease ☐ Echocardiogram ☐ EKG - Electrocardiogram ☐ Flexible Sigmoidoscopy ☐ Hemocult Stool Analysis ☐ HPV (Human Papillomavirus Vaccination) ☐ Lipid Panel (total cholesterol count) ☐ Mammography, including Breast Ultrasound ☐ Pap Smear, including ThinPrep Pap Test ☐ PSA (Prostate Specific Antigen – blood test for prostate cancer) ☐ Serum Protein Electrophoresis (test for Myeloma) ☐ Stress Test on Bike or Treadmill ☐ Thermography ☐ Ultrasound screening of the Abdominal Aorta for Abdominal Aortic Aneurysms

PROVIDERS: Please list all Providers the claimant has seen in the past 2 years including the providers treating this Condition**.**

1.

Attending Physician's Name:	Address:	Phone #:
Specialty	Dates Consulted:	Reason for Visit / Condition

2.

Primary Care Physician's Name:	Address:	Phone #:
Specialty	Dates Consulted	Reason for Visit / Condition

3.

Other Physician/ Specialist Name:	Address:	Phone #:
Specialty	Dates Consulted	Reason for Visit / Condition

4.

Hospital Name:	Address	Phone #:
Dates Hospitalized:	Reason for Hospitalization / Condition:	

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CLAIMANT'S NAME: _____ **DATE OF BIRTH:** _____

COVERAGE NUMBER(S): _____ **CLAIM NUMBER:** _____

ATTENDING PHYSICIAN'S STATEMENT: To be completed and signed by the Attending Physician

SECTION #1: DESCRIBE THE CONDITION:

ICD 9/10 Code: _____ Primary Diagnosis: _____

ICD 9/10 Code: _____ Secondary Diagnosis: _____

Other Condition(s): _____

When did symptoms first appear? _____ If applicable, what was the Accident Date? _____

Has the patient ever had the same/similar condition? ☐ Yes ☐ No If yes, when? _____

Is the condition due to injury or sickness arising out of the patient's employment? ☐ Yes ☐ No

Pregnancy or Complication of Pregnancy: Due Date: _____ Delivery Date: _____ ☐ Normal Delivery ☐ C-Section

SECTION #2: TREATMENT REQUIRED:

First consultation: _____ Most recent consultation: _____ Next consultation: _____ Released: _____

Is/Was a Surgical or Medical Procedure Required? ☐ Yes ☐ No Date: _____ Procedure Code: _____

Procedure: _____

Is/was Hospitalization required? ☐ Yes ☐ No Admission Date: _____ Discharge: Date _____

Hospital: _____ City: _____ State: _____

What is the Current Treatment Plan? _____

_____

SECTION #3: RESTRICTIONS, LIMITATIONS AND ABILITY TO WORK: Please provide specific details/dates and understand responses such as "no work", "totally disabled", "undetermined" or "unknown" will not enable us to evaluate your patient's claim for benefits and may result in us having to contact you for clarification

The patient **IS ABLE** to work in the following capacity: ☐ No Work, ☐ Sedentary, ☐ Light, ☐ Medium, ☐ Heavy, ☐ Very Heavy

The patient **IS UNABLE** to perform their job duties: ☐ Yes ☐ No If Yes, (Dates): FROM: _____ THROUGH: _____

When is the patient expected to **RESUME WORK**? (Dates) Part Time/Partial Duties: _____ Full Time/Full Duties: _____

The patient **IS UNABLE** to: ☐ Stand ___Hours; ☐ Sit ___Hours; ☐ Walk ___Hours; ☐ Lift ___Pounds; ☐ Carry ___Pounds; ☐ Drive ___Hours;

☐ Type; ☐ Reach ☐ Kneel ☐ Squat ☐ Climb ☐ Crawl

Please provide the specific **RESTRICTIONS**: _____

Please provide the specific **LIMITATIONS**: _____

The Restrictions and Limitations are: ☐ Temporary: (How long? _____) or ☐ Permanent

What **CLINICAL** or **DIAGNOSTIC FINDINGS** support these Restrictions and Limitations? _____

_____

SECTION #4: REFERRING PHYSICIAN:

Name: _____ Specialty: _____

Address: _____ Phone #: _____

SECTION #5: ATTENDING PHYSICIAN VERIFICATION:

I am aware that it is a crime to fill out this form with facts I know are false or to leave out facts I know are relevant and important. I certify that the answers given on this form are true, complete and correctly recorded.

Physician Signature: _____ Date: _____

Print Name: _____ Specialty: _____ Phone #: _____

Address: _____ City: _____ State: _____ Zip Code: _____

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CLAIMANT'S NAME: _____ **DATE OF BIRTH:** _____

COVERAGE NUMBER(S): _____ **CLAIM NUMBER:** _____

EMPLOYER'S STATEMENT: To be completed and signed by the Employer

☐ Check here if you are Self Employed, then complete and sign this form.

☐ Check here if you are Unemployed. Please provide the last date you worked _____and prior employer's name then sign this form

SECTION #1: EMPLOYMENT INFORMATION / JOB DESCRIPTION:

Name of Employer/Company: _____

Date of Hire: _____ Employee's Job Title/Position: _____

*Please attach a copy of the job description or list major job responsibilities.

Major Job Responsibilities: _____

This Job Classification is: ☐ Sedentary, ☐ Light Work, ☐ Medium Work, ☐ Heavy Work, ☐ Very Heavy Work.

Prior to inability to work, they worked _____ hours per week. Hourly Pay: $_____ Annual Salary: $_____

If you are self-employed, we may require proof of income. We will notify you if additional documentation is required.

SECTION #2: DATES MISSED WORK / RETURNED TO WORK:

I hereby certify that _____ did not perform any part of his/her work from _____ through _____

Has the employee Returned To Work? ☐ Yes ☐ No Part time/Partial duties(date): _____ Full time/Full duties(date):_____

Did the employee work part time/partial duty? ☐ Yes ☐ No Dates: _____

Is part time/partial duty work available? ☐ Yes ☐ No Reason: _____

When recovered, will he/she resume work? ☐ Yes ☐ No Reason: _____

SECTION #3: WORKERS' COMPENSATION / OTHER DISABILITY COVERAGE / CONTINUED PAY:

Is this a Work Related Condition/Injury? ☐ Yes ☐ No Workers' Compensation Begin Date: _____ End Date: _____

Workers' Compensation Carrier: _____ Benefit Amount: $_____(Monthly/Weekly)

Is the employee covered under any Other Disability Policy/Coverage through the Company?* ☐ Yes ☐ No

Other Disability Insurance Carrier: _____ Benefit Amount: $_____(Monthly/Weekly)

Does this policy Replace any prior Disability Policy/Coverage through the Company?* ☐ Yes ☐ No

Prior Disability Insurance Carrier: _____ Benefit Amount: $_____(Monthly/Weekly)

Effective Date: _____ Termination Date:_____ Maximum Benefit Period: _____ Elimination Period: _____

***We may require proof of other disability coverage or prior disability coverage for review.**

Continued Pay: Group Short Term Disability and Long Term Disability only:

Is the insured receiving Continued Pay, Salary Continuation, Sick or Vacation Pay? ☐ Yes ☐ No

Pay Period From Date	Through Date	Amount	Source of Income
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

SECTION #4: Section 125 / Employer Paid Premium : If yes, FICA withholding will be deducted from the disability claim payment.

Section 125: Were the premiums for this disability income policy/certificate paid with Pre-Tax Dollars under a Section 125 Plan? ☐ Yes ☐ No

Employer Paid: Were premiums for this disability income policy/certificate Employer Paid? ☐ Yes ☐ No

SECTION #5: EMPLOYER VERIFICATION: Check here if ☐ **Self Employed** or ☐ **Unemployed**

I am aware that it is a crime to fill out this form with facts I know are false or to leave out facts I know are relevant and important. I certify that the answers given on this form are true, complete and correctly recorded.

Signed by: _____ Print Name: _____ Date: _____

Title: _____ Company: _____

Address: _____ Phone #: _____

Other Comments: _____

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CLAIMANT'S NAME: _____ **DATE OF BIRTH:** _____

COVERAGE NUMBER(S): _____ **CLAIM NUMBER:** _____

CERTIFICATION: The Certificate/Policy Holder or Claimant who completed the claim form please read and sign below.

I acknowledge the receipt of the Department of Insurance Claim Fraud Statements provided with this claim packet. I have read the notices and I am aware that it is a crime to fill out this form with facts I know are false or to leave out facts I know are relevant and important. I certify that the answers given on this claim form are true, complete, and correctly recorded. **Please also remember to sign and date the attached authorization required to process your claim.**

Signature:_____ Print Name: _____ Date: _____

FRAUD WARNINGS BY STATE

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, 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: FRAUD NOTICE: 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 MARYLAND: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NOTICE IN NEW HAMPSHIRE: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638.20.

NOTICE IN NEW YORK: 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 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.

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 OREGON: Any person who makes intentional misstatement that is material to the risk may be found guilty of insurance fraud by a court of law.

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 PUERTO RICO: Any person who knowingly and with the intention to defraud includes false information in an application for insurance or file, assist or abet in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars ($5,000), not to exceed ten thousand dollars ($10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.

NOTICE IN TENNESSEE AND WASHINGTON: 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.

NOTICE IN WEST VIRGINIA AND RHODE ISLAND: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

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CLAIMANT'S NAME: _____ **DATE OF BIRTH:** _____

COVERAGE NUMBER(S): _____ **CLAIM NUMBER:** _____

AUTHORIZATION TO RELEASE INFORMATION TO AMERICAN HERITAGE LIFE INSURANCE COMPANY

I hereby authorize any physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, health care provider, Pharmacy Benefit Manager, insurance company, the Medical Information Bureau (MIB) or other organization, institution or person that has any health related records or knowledge of me or minor dependents to disclose the entire medical record (excluding psychotherapy notes and in MAINE and VERMONT HIV related test results) to American Heritage Life Insurance Company (AHL), its duly authorized representatives, its subsidiaries or its reinsurers. This authorization extends to any minor dependent on whom insurance is requested or claim for benefits is being made.

The information to be obtained shall include insurance claim history from any Prescription Drug Database, pharmacy benefit manager, ambulance, insurance company, medical transport service, or the MIB. Also, I authorize any entity, person, or organization that has these records about me, including but not limited to my employer, employer representative and compensation sources, insurance company, financial institution or governmental entities, including departments of public safety and motor vehicle departments, to give any information or record it has about me, my employment, employment history or income to AHL.

I understand that this information will be used to evaluate and administer my claim for benefits or to evaluate my eligibility for insurance. I understand that there is a possibility of redisclosure of any information disclosed pursuant to this authorization and that information, once disclosed, may no longer be protected by certain federal regulations governing privacy and confidentiality, though it may still be protected by state privacy laws or other applicable privacy laws. I also authorize AHL or its reinsurers to make a brief report of my health information to MIB.

This authorization shall remain in force for 24 months following the date of my signature below or termination of my coverage, whichever occurs first. A copy of this authorization is as valid as the original. I or my legal representative may request a copy of this authorization. I understand that I may revoke this authorization at any time by sending a written notification to: **Attn: Privacy Officer, American Heritage Life Insurance Company, 1776 American Heritage Life Drive, Jacksonville, FL 32224.**

I understand that a revocation of this authorization is not effective if AHL has relied on the protected health information or has a legal right to contest a claim under an insurance policy or to contest the policy itself. The revocation will not apply to any information AHL requests or discloses prior to AHL receiving my revocation request. If I choose not to sign this authorization or if I later revoke it, I understand that AHL may not be able to process my application for coverage, or if coverage has been issued, AHL may not be able to administer my claim for benefits and this may result in a denial of my claim for benefits or request for services.

Claims submitted on dependents 18 and older require an authorization signed by the dependent.

_____ _____

Claimant/Applicant's Signature Date Signed (mm/dd/yyyy)

_____ _____XXX-XX-_____

Claimant/Applicant's Printed Name Last Four Digits of Social Security Number

If signed by the legal representative, please describe the authority under which the representative is authorized to act and enclose any related documentation granting authority.

_____ _____

Signature of Legal Representative Relationship

_____ _____

Print Name of Legal Representative Date Signed (mm/dd/yyyy)

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