Home Office Use Only



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

Workplace Division

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.ahlcorp.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	<u> </u>
Employer Name (Company/Address): _		Occupation:
1. Name: First:	Middle:	Last:
Social Security Number:	Date of Birth:	/ / Male
		Avg. Monthly Earnings:
PATIENT 3. Name: First:	Middle:	Last:
4. Date of Birth: / / MO/DAY/YR	Age:	☐ Male ☐ Female
	_ (ex: self, wife, son, etc.) Is	s he/she a full-time student? Yes No If yes,
Section B TYPE OF CLAIM:	☐ FIRST CLAI	M CONTINUED CLAIM
ACCIDENT/DISABILITY Routine Pregnancy Ongoing Disability		Dutpatient Physicians Benefit Hospital Income Benefit
CANCER Wellness Benefit Intensive Care	Policy No.(s):	
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)

		. =		41 1 1		
	Importa Due to Internal Revenue Service req rm is required to be completed prior		curity number ver	ification and b	ackup withholding requirements,	
	ection 125: Were the premiums for youbt, please ask your employer.)	our disability income policy paid	l with pre-tax dolla	ars under a Se	ction 125 Plan? Yes No (if i	in
Taxpa	vor Identification Number Certification	on				
2. F						
U	nder penalties of perjury, I certify that	it:				
	A. The Social Security Number shown in Section A line (1) is my correct taxpayor identification number (or I am waiting for a number to be issued to me), and					to
	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).					
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						
	ization at any time by notifying America					
as the	original, regardless of date signed. I ur	derstand that I or my representativ	e may receive a c	opy of this auth	orization by supplying policy number(s)
and In:	sured'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 h		Date:		 cr	neck 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.

INSTRUCTIONS FOR FILING ACCIDENT CLAIMS	
We need: A copy of the hospital bill. Make sure the bill includes your diagnosis a	and the number of days you were in the hospital. If you were treated in
the emergency room or a doctor's office, please include a copy of thes	se bills also.
☐ PART 2: Attending Physician's Statement should be completed an	d signed by your doctor
We may also need: A copy of the accident report if the accident was investigated by the	police or sheriff
☐ A copy of the blood alcohol report or drug screening if the patient v	
☐ A certified copy of the death certificate if the patient is deceased.	•
Section C ACCIDENT POLICY CLAIMS	
Please attach itemized bill(s), including date(s) of service, diagnosis code	
Date of accident: / / Injury: / / MO/DAY/YR MO/DAY/YR	Time of accident: □ a.m. □ p.m.
Where did it happen? Tell us exactly how y	your accident/injury happened:
Did your injuries occur while you were working for pay or profit? Yes N	
Have you ever had a similar injury?	If so, please tell us when: // // MO/DAY/YR
If you are claiming disability due to your accident, please have your phys	
and your employer complete the EMPLOYER'S STATEMENT, PART 4.	
INSTRUCTIONS FOR FILING FIRST CLAIM FOR DISABILITY (due to Accid	ent or Sickness) AND WAIVER OF PREMILIM:
PART 2: Attending Physician's Statement should be completed and signed	
	monthly salary and pre-tax information, and signed by your employer. If
you are self-employed, also send us a copy of your current business li may be required.	cense and your most recent quarterly tax records. Additional information
Section D DISABILITY AND WAIVER OF PREM	IIIM CLAIMS
INJURY OR ILLNESS YOU ARE CLAIMING:	
Date you were first treated for your illness or injury:/ Date you were first treated for your illness or injury:/	MO/DAY/YR
Date of your accident or the date you first noticed the symptoms of your illness	:
If you are claiming an injury, did your injury occur at work? ☐ Yes ☐ No	MO/DAY/YR
List all physicians seen in the past five (5) years:	
Name Address Phone	Specialty Dates Consulted Reason for Consult
Name Address Findle	Specialty Dates Consulted Reason for Consult
List all hospital confinements in the past five (5) years:	
Name Address From/To	Reason Confined
List all pharmacies used in the past five (5) years: (include address and phone	number)
I have been unable to work since: / / I returned	d to work on a □ part-time □ full-time basis: /
Describe why you are unable to work:	
Are you receiving Disability Benefits (Salary Continuation, Sick Pay, Social source? If "yes," from whom?	
Please submit a copy of your payment statement with this form. Please	have your treating physician complete the ATTENDING PHYSICIAN
STATEMENT, PART 2 and your employer complete the EMPLOYER'S STA	
Section E DISABILITY CLAIM FOR ROUTINE PR	EGNANCY (6 weeks for vaginal delivery, or 8 weeks for C-Section)
If disabled due to complications of pregnancy, befo	re or after delivery, please complete Section D.
Date of Delivery: / / First Date of Treatment:	/ / Type of delivery: □ Vaginal □ C-Section
Date of Delivery:/ First Date of Treatment:	MO/DAY/YR
Date of Hospital Confinement: / / Name of Hospital Mo/DAY/YR	Phone No.: ()
Physician's Name:	
Address:	
Treating Physician's Signature:	
Referring Physician	MO/DAY/YR Phone No : (

Mailing Address: _

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:					
If condition is due to pregnancy, what is expected delivery date? Date/	_				
MO/DAY/YR					
When did symptoms first appear or accident happen? Date/					
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?	_				
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.	_				
- Specific NEW Trans (What the patient cheat not do and mily). Thouse quantity in heart, noight, 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	_				
Hospital: State: State:					
14a. Date admitted:/ Date discharged:/					
MO/DAY/YR 14b. When do you expect patient to resume partial duties?/ / Full duties?/ / MO/DAY/YR 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?/					
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:	_				
16. Have you completed paperwork for any other insurance company? ☐ Yes ☐ No Social Security Disability? ☐ Yes ☐ No					
If you are claiming <u>CONTINUING DISABILITY</u> , 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: /					
Is this claim for continuation of a previous disability? □ Yes □ No					
2a. Diagnosis:	_				
Describe any other diseases or infirmity affecting present condition.	_				
Date of initial disability due to this diagnosis//					
5. Is patient unable to perform job duties? \(\text{Yes} \) Yes \(\text{No If yes, may return to work } \text{\text{\text{\text{part-time}}}} \) full-time on : \(\text{\tintete}\ta}\text{\tex{\tex					
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 be sure that all information is correct before signing. Please refer to page 2 for notice specific to your state.	to				
PHYSICIAN VERIFICATION					
Signed:, MD Date:/ Phone: ()					
Street Address:	_				
City/Town:					

____ Zip Code: ____

State/Province:

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/						
	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 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:/						
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.

CANCER CLA	AIMS:	SPECIFIED DISEASES	AND INTENSI	VE CARE	CLAINS				
	A pathology report diagnosi this report to you at your re- submit the clinical evidence	quest.) If the diagnosis of that established a posit	of cancer was r ive diagnosis o	nade by cl f cancer.					
	Include a copy of your itemized hospital billing if you were hospitalized.							rvices	
	Any other bills pertaining to forwarded to this office.		sthesia, chemot	therapy or	radiation treatme	ents, ambula	nce, lodgin	g, or travel,	, may be
	Transportation and Lodging transportation and lodging emedical verification of treating transportation and lodging emedical verification of treating transportation and Lodging emedical verification and Lodging transportation and Lodging emission and Lodging emi	expenses. This informat							
SPECIFIED D			r diagnostic stud	dies. whicl	h initially diagnos	ed the speci	fied diseas	e. must acc	company
	your first claim. Include a c							o, maor aoc	ompany
	If the hospital bill fails to giv	e the diagnosis, PART 2	2: Attending P	hysician's	s Statement mus	st be comple	ted by the o	doctor.	
WELLNESS (·				•			
	o file a Wellness/Cancer Scr cedure performed and the mo								
Section I		NFINEMENT, INT							
	nd an itemized copy of y r complete this section i					ssion and	aiscriarge	e dates.	наче
Diagnosis/I	ICD-9 Code:								
Dates of In	patient Hospital Confine	ement: From:	/ / MO/DAY/YR	To:		/ //YR	_		
Dates of Co	onfinement in Intensive	Care, including Co	ronary Care	Unit: F	rom: /	/ / / / / / / / / / / / / / / / / / /	To:	/ MO/DAY/YE	<u>/</u>
Hospital: _									
Hospital Ad	ddress:								
Date of Sur	rgery: /	/ D/DAY/YR	☐ Inpati	ent	□ Outpatient				
Procedure/	/procedure code:								
Date of offi	ice visit following confine	ement or outpatient	t surgery:		/ / MO/DAY/YR		/ MO/DAY/Y	/ R	
Signature	of doctor:					Date:		/ MO/DAY/YR	<u> </u>
	octor:				Phone: ()			
	er: <u>(</u>)								
Address: _					Tax	ID or SSN	1 :		
Section (G ASSIGNMENT	OF BENEFITS							
I request the directly to:	nat American Heritage L	ife Insurance Comp	pany send b	enefits a	available unde	er my			policy
Name									
Provider's Tax	x Identification Number								
Relationship									
Address									
City		State	;	Zip					
Signature of F	Policy Owner					Date			