



WELLNESS CLAIM FORM

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.
 Claim forms and other valuable information may be found on www.AllstateBenefits.com

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.

POLICYHOLDER / CERTIFICATEHOLDER

Insured's Name: _____ Patient: _____ Male Female

Policy Number(s): 1) _____ 2) _____

Insured's Social Security Number: _____ Patient's Date of Birth: _____ / _____ / _____
MO/DAY/YR

Home Number: (_____) _____ E-mail: _____

Filing a claim for your calendar year Wellness Benefit is easy! If you have had one of the listed preventative tests or HPV Vaccination shown below, please check the appropriate boxes and attach any documentation you may have showing the provider, patient's name, the date of the test, and exam performed. If your policy was issued in Pennsylvania or California, please send us the actual bill and the Explanation of Benefits from your Major Medical Carrier.

Thank you for selecting Allstate Benefits and for having your annual wellness exam!

WELLNESS SCREENINGS	
<input type="checkbox"/> Biopsy for skin cancer	<input type="checkbox"/> Flexible sigmoidoscopy
<input type="checkbox"/> Blood test for triglycerides	<input type="checkbox"/> Hemocult stool analysis
<input type="checkbox"/> Bone Marrow Testing	<input type="checkbox"/> HPV (Human Papillomavirus) Vaccination
<input type="checkbox"/> CA125 (cancer antigen 125 - blood test for ovarian cancer)	<input type="checkbox"/> Lipid Panel (total cholesterol count)
<input type="checkbox"/> CA15-3 (cancer antigen 15-3 - blood test for breast cancer)	<input type="checkbox"/> Mammography, including Breast Ultrasound
<input type="checkbox"/> CEA (carcinoembryonic antigen – blood test for colon cancer)	<input type="checkbox"/> Pap Smear, including ThinPrep Pap Test
<input type="checkbox"/> Chest X-ray	<input type="checkbox"/> PSA (prostate specific antigen – blood test for prostate cancer)
<input type="checkbox"/> Colonoscopy	<input type="checkbox"/> Serum Protein Electrophoresis (test for myeloma)
<input type="checkbox"/> Doppler screening for carotids	<input type="checkbox"/> Stress test on bike or treadmill
<input type="checkbox"/> Doppler screening for peripheral vascular disease	<input type="checkbox"/> Thermography
<input type="checkbox"/> Echocardiogram	<input type="checkbox"/> Ultrasound screening of the abdominal aorta for abdominal aortic aneurysms
<input type="checkbox"/> EKG (Electrocardiogram)	

ASSIGNMENT OF BENEFITS FOR WELLNESS COVERAGE (n/a in New Hampshire)

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

Name	Address
Provider's Tax Identification Number	City State Zip
Relationship	

Signature of Policy Owner _____

Date _____

You may mail or fax your claim to:
American Heritage Life Insurance Company
 1776 American Heritage Life Drive, Jacksonville, FL 32224

Phone 1-800-348-4489 Fax 1-800-430-4188

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 thousands dollars (\$5,000), not to exceed ten thousands 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.