CANCER, SPECIFIED DISEASE, INTENSIVE CARE, AND HEART / STROKE CLAIM FORM

Allstate BENEFITS

If you have any questions regarding benefits available, how to file 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 or visit our website at 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.

Mail or Fax Your Claim to: **American Heritage Life Insurance Company**
P.O. Box 43067, Jacksonville, FL 32203
Fax: 1-866-424-8482

If you would like to have claim benefits automatically deposited into your bank account, please complete and send our ACH form (ABJ16661). This form can be found on our website at www.allstatebenefits.com or www.allstatebenefits.com/mybenefits.

INSTRUCTIONS FOR FILING CANCER, SPECIFIED DISEASE, INTENSIVE CARE, AND HEART / STROKE CLAIMS

ALL CLAIMS:

- To avoid processing delays, please complete all required form sections.
- You **must** sign and submit the **Authorization to Release Information to AHL** (form ABJ21476).
- If you are filing a claim within the first 24 months your policy is in force, additional information may be required.

CANCER CLAIMS:

- ☐ A pathology report diagnosing cancer **must** accompany your first claim for that diagnosis of cancer. (The hospital or doctor will furnish this report to you at your request.) If the diagnosis of cancer was made by clinical information instead of pathological means, please submit the clinical evidence that established a positive diagnosis of cancer.
- ☐ Submit a completed **Attending Physician's Statement** and attach itemized billing showing the diagnosis, services provided and the actual charges made to you.
- ☐ Submit a copy of your itemized hospital billing if you were hospitalized.
- ☐ Submit any other bills pertaining to this claim, such as anesthesia, or ambulance.
- ☐ *Chemotherapy/Radiation Therapy Claims* – Please include a copy of the itemized bill with procedure codes. ***(Cancer and Specified Disease Additional Benefit Rider and CP12 only)*** – To avoid delay, please send a copy of your Explanation of Benefits from your Major Medical Carrier to assist with the actual cost of the treatment.
- ☐ *Transportation and Lodging* - Please review your policy to determine what expenses are covered. Send us a statement detailing your transportation and lodging expenses. This information should include mileage, where you traveled from and to, lodging receipts and medical verification of treatment for this time.

SPECIFIED DISEASE CLAIMS:

- ☐ The results of tissue specimen, culture(s) and/or titer(s) or other diagnostic studies, which initially diagnosed the specified disease, **must** accompany your first claim.
- ☐ Submit a copy of your itemized hospital billing and a completed **Attending Physician's Statement.**

HOSPITAL INCOME AND INTENSIVE CARE CLAIMS:

- ☐ Submit hospital bill showing charges and number of days in the intensive care unit. If the hospital bill fails to give the diagnosis, submit a completed **Attending Physician's Statement**.
- ☐ Submit a police report for all accidents investigated by any law enforcement agency.

HEART STROKE CLAIMS:

- ☐ Submit diagnostic test result showing a diagnosis of disease of the heart, heart attack, or stroke.

POLICYHOLDER / CERTIFICATE HOLDER INFORMATION

Policy / Certificate Number: _____

Employer Name (Company): _____ Occupation: _____

Policyholder's Name: First: _____ Middle: _____ Last: _____

Social Security Number: _____ Date of Birth: ___/___/___ Age: _____ ☐ Male ☐ Female

Mailing Address: _____ Apt #: _____

City: _____ State: _____ Zip: _____ ☐ Check here if address is new

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

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. Please check to be sure all information is correct before signing. Please refer to the fraud notice specific to your state.

CLAIMANT INFORMATION

Claimant's Name: First: _____ Middle: _____ Last: _____

Date of Birth: ____/____/____ Age: _____ Social Security Number: _____ ☐ Male ☐ Female

Relation to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

CERTIFICATION

I acknowledge receipt of the Fraud Warnings by State 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.

Signature: _____ Date: _____

Print Name: _____

ASSIGNMENT OF BENEFITS (OPTIONAL)

Not available 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

* Please be advised that if you are covered by MEDICAID, we may be required to assign benefits to the provider of service in accordance with State and Federal Regulations.

PLEASE REMEMBER TO SIGN AND DATE THE ATTACHED AUTHORIZATION

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. Please check to be sure all information is correct before signing. Please refer to the fraud notice specific to your state.

ATTENDING PHYSICIAN'S STATEMENT

To be completed and signed by the Attending Physician

Patient's Name:_____ Age: _____

1. Diagnosis: _____
2. If condition is due to pregnancy, what is expected delivery date? Date ____/____/____
3. When did symptoms first appear or accident happen? Date ____/____/____
4. When did patient first consult you for this condition? Date ____/____/____
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: ____/____/____

14b. When do you expect patient to resume partial duties? ____/____/____ Full duties? ____/____/____

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: _____ State: _____ Zip _____
16. Have you completed paperwork for any other insurance company? ☐ Yes ☐ No Social Security Disability? ☐ Yes ☐ No

PHYSICIAN VERIFICATION

Signed: _____, MD Date: ____/____/____ Phone: (____) _____

Street Address: _____

City/Town: _____

State/Province: _____ Zip Code: _____

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AMERICAN HERITAGE LIFE INSURANCE COMPANY
HOME OFFICE:
1776 AMERICAN HERITAGE LIFE DRIVE
JACKSONVILLE, FLORIDA 32224-6687

AUTHORIZATION TO RELEASE INFORMATION TO AHL

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.

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

_____ _____
Claimant/Applicant's Printed Name 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)

ABJ21476