Instructions for filing Weliness claim thru Allstate.

Go to www.allstateatwork.com
Click on top tab Benefits Manager and in Benefits Manager blue box click on MY Benefits online then click on click here
Click on not registered and then click on registration box.
Type in your social security #, zip code and date of birth.
The next step should ask for a user I.D. and password.
You should be prompted back to put in your user ID and password.
Once your user I.d. and password has been successfully saved then on the right hand corner of the screen click on
submit a claim and at the top of the page you will see File an express Wellness claim.
Click in box yes I would like to file an express wellness claim and click continue at the bottom of the page.
The next step will be to fill out information regarding your claim. Please ask for itemized statement from your Doctor
The next step will ask if you want a paper check or money directed into your checking account for direct deposit. click continue
The last step will verify it was successfully submitted to the home office claims department for payment.
Also ask for an itemized statement that shows the test that were performed for your wellness visit.

Thank you and if you have any questions please call 251-650-4998.

AMERICAN HERITAGE LIFE INSURANCE COMPANY

WELLNESS BENEFIT CLAIM FORM

Submit Claims to:
American Heritage Life Insurance Company
1776 American Heritage Life Drive, Jacksonville, FL 32224
Phone 1-800-521-3535 Fax 1-800-430-4188 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_____

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 Claimant's Wellness Screening provided
- Please submit the supporting documentation. This documentation should include the claimant's name, diagnosis, and date(s) of service.
- If providing a bill as supporting documentation, please request an itemized bill, UB04 or HCFA 1500 from the provider.
- We reserve the right to request additional information for review of the claim.

SUPPORTING DOCUMENTATION	Bill or medical record documenting the listed Treatment / Testing. Date of Service: _____ *If your policy was issued in Pennsylvania or California, please send the actual bill and the Explanation of Benefits from your Major Medical Carrier.*

BENEFIT (IF APPLICABLE)	**BENEFIT (IF APPLICABLE)**
☐ 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	

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. 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.

Name: _____ Address: _____

Provider Tax ID #: _____ _____

Relationship: _____ Signature: _____ Date: _____

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

AMERICAN HERITAGE LIFE INSURANCE COMPANY

WELLNESS BENEFIT CLAIM FORM

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 ERSEY, 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.

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

AMERICAN HERITAGE LIFE INSURANCE COMPANY

WELLNESS BENEFIT CLAIM FORM

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 or older require an authorization signed by the dependent.

_____ _____

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

_____ _____

Claimant/Applicant's Printed Name | xxx-xx- 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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