Allstate Benefits

CLAIM FORM AND INSTRUCTIONS

If you have any questions regarding benefits available, or 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

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 ACCIDENT INCLUDING POLICY RIDERS/ DISABILITY/ WAIVER OF PREMIUM CLAIMS

- To avoid delays in processing please fill out the sections which apply to your specific claim.
- Include your policy number(s). To obtain your policy number call **1-800-348-4489**.
- You may **fax** your claim to us at **1-866-424-8482**. Please be assured that your claim will receive our prompt attention. If you would like to receive your claim proceeds even faster, Allstate Benefits can automatically deposit them into your bank account by completing and returning our ACH form (ABJ16661). This form can be found on our website at www.AllstateBenefits.com or electronically at www.AllstateBenefits.com/mybenefits. Additional claim forms are available on our website.
- You may mail your claim to: **American Heritage Life Insurance Company**
  P.O. Box 43067
  Jacksonville, Florida 32203-3067
- If you are filing a claim within the first 24 months your policy is in force, additional information may be required.

POLICYHOLDER / CERTIFICATEHOLDER

Employer Name (Company/Address): _____ Occupation: _____

1. Policyholder's Name: First: _____ Middle: _____ Last: _____
   Policy Number(s): 1)_____ 2)_____
   Social Security Number: _____ Date of Birth: ___/___/___ ☐ Male ☐ Female
2. Home Number: (___) _____ Avg. Monthly Earnings: _____ **E-mail:** _____

PATIENT'S INFORMATION

3. Name: First: _____ Middle: _____ Last: _____
4. Date of Birth: ___/___/___ Age: _____ Social Security Number: _____ ☐ Male ☐ Female
5. This person is your: _____ (ex: self, wife, son, etc.)

☐ FIRST CLAIM ☐ CONTINUED CLAIM

☐ **ACCIDENT/DISABILITY** Policy No.(s): _____ / _____

☐ Accident ☐ Outpatient Physicians Rider ☐ Waiver of Premium ☐ Benefit Enhancement Rider

☐ Disability ☐ Hospital Rider ☐ Routine Pregnancy

INSTRUCTIONS FOR FILING ACCIDENT CLAIMS

We need:

- ☐ (For Puerto Rico residents only) A copy of the Explanation of Benefits (EOB) from your health insurance carrier, if applicable, if this claim is for an emergency room visit.
- ☐ A copy of the hospital bill. Please make sure the bill includes your diagnosis 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 these bills also.
- ☐ **Attending Physician's Statement** should be completed and 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 was tested for alcohol or drugs.
- ☐ A certified copy of the death certificate if the patient is deceased.

ACCIDENT POLICY CLAIMS

Please attach itemized bill(s), including date(s) of service, diagnosis code(s), procedure codes(s) and charge(s).

DATE OF ACCIDENT: ___/___/___ **Time of accident:** _____ ☐ **a.m.** ☐ **p.m.**

Where did it happen? _____ Tell us exactly how your accident/injury happened: _____

Did your injuries occur while you were working for pay or profit? ☐ Yes ☐ No ☐ On the job ☐ Off the job

Have you ever had a similar injury? _____ If so, please tell us when: ___/___/___

***If you are claiming disability due to your accident, please have your physician complete the* ATTENDING PHYSICIAN STATEMENT and your employer complete the EMPLOYER'S STATEMENT.**

ASSIGNMENT OF BENEFITS FOR ACCIDENT 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 _____

INSTRUCTIONS FOR FILING FIRST CLAIM FOR DISABILITY (due to Accident or Sickness) AND WAIVER OF PREMIUM: We need:

- ☐ **Attending Physician's Statement** should be completed and signed by your doctor.
- ☐ **Employer's Statement** should be completed, including your 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 license and your most recent quarterly tax records. Additional information may be required.

Please submit a copy of your payment statement with this form. **Please have your treating physician complete the ATTENDING PHYSICIAN STATEMENT and your employer complete the EMPLOYER'S STATEMENT.**

DISABILITY AND WAIVER OF PREMIUM CLAIMS (POLICYHOLDER / CERTIFICATEHOLDER)

INJURY OR ILLNESS YOU ARE CLAIMING: _____

Date you were first treated for your illness or injury: ___/___/___ Date you were last treated for your illness or injury: ___/___/___

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

List all physicians seen in the past five (5) years:

Name	Address	Phone	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: ___/___/___ (MO/DAY/YR) I returned to work on a ☐ part-time ☐ full-time basis: ___/___/___ (MO/DAY/YR)

Describe why you are unable to work: _____

Are you receiving Disability Benefits (Salary Continuation, Sick Pay, Social Security Disability Income, or Workers' Compensation) from any other source? If "yes," from whom? _____

DISABILITY CLAIM FOR ROUTINE PREGNANCY

Expected Recovery Period is 6 weeks for vaginal delivery, or 8 weeks for C-Section.

If disabled due to complications of pregnancy, before or after delivery, please complete Policyholder, Attending Physician's Statement, and Employer's Statement sections.

Date of Delivery: ___/___/___ First Date of Treatment: ___/___/___ Type of delivery: ☐ Vaginal ☐ C-Section

Date of Hospital Confinement: ___/___/___ Name of Hospital: _____ Phone No.: (___) _____

Physician's Name: _____ Phone: (___) _____

Address: _____ Fax: (___) _____

Treating Physician's Signature: _____ Date: ___/___/___ Tax Identification No.: _____

Referring Physician: _____ Phone No.: (___) _____

Mailing Address: _____

ATTENDING PHYSICIAN'S STATEMENT (PHYSICIAN)

Patient's Name: _____ Policy Number: _____

1. Diagnosis: _____

2. If condition is due to pregnancy, what is expected delivery date? Date ____/____/____ MO/DAY/YR

3. When did symptoms first appear or accident happen? Date ____/____/____ MO/DAY/YR

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? ☐ 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: ____/____/____ MO/DAY/YR Date discharged: ____/____/____ MO/DAY/YR

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

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

16. If "yes," explain. _____

17. Referring Physician: _____ Phone: (____) _____

Mailing Address: _____

PHYSICIAN VERIFICATION

Signed: _____, MD Date: ____/____/____ MO/DAY/YR Phone: (____) _____

Street Address: _____

City/Town: _____

State/Province: _____ Zip Code: _____

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 5 for notices specific to your state.

Policy Number: _____

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 ____/____/____ MO/DAY/YR

   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:

Pay Period From	Pay Period To	Amount	Source of Income

8. Current Salary or Hourly Rate: _____

9. Name of Employer: _____ Date: ____/____/____ MO/DAY/YR

   Address: _____

   By: _____ Official Position: _____ Telephone number: (____) _____

10. The employee's job title or position is: _____

11. Is the employee covered under any other disability policy through the company? _____

12. Has employee returned to work? ☐ Yes ☐ No If yes, give date: ____/____/____ MO/DAY/YR

13. Remarks: _____

Important: To avoid delay, please sign authorization below.

1. **Section 125:** Were the premiums for your **disability income policy** paid with pre-tax dollars under a Section 125 Plan? ☐ Yes ☒ No (**if in doubt, please ask your employer.**)

I authorize any physician, medical practitioner, hospital, clinic or other medical facility, Pharmacy Benefit Managers, insurance company, the Medical Information Bureau or other organization, institution or person, that has records or knowledge of me or my health including my prescription medication history to give to American Heritage Life Insurance Company (AHL) its subsidiaries or its reinsurers any information relating to my claim. I also authorize AHL, or its reinsurers, to make a brief report of my health information to MIB, Inc. 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 federal rules governing privacy and confidentiality, but may still be protected by state laws. A copy of this authorization is as valid as the original. This authorization applies to any dependent on whom a claim is filed. This authorization is valid for a period of 24 months from the date signed. I understand that I may revoke this authorization at any time by notifying AHL in writing of my desire to do so. I or my representative may receive a copy of this authorization by supplying policy number(s) and Insured's name in a written request to the company. (In **MAINE** – I understand that revocation of this authorization may be a basis for denying insurance benefits. Failure to sign an authorization statement may impair the ability of a regulated insurance agency to evaluate claims and may be a basis for denying a claim for benefits.)

Sign here: _____ Date: _____ ☐ **Check here if address is new**
Claimant

Mailing Address: _____ City: _____ State: _____ Zip: _____ Phone No:. (____) _____

ATTENDING PHYSICIAN'S STATEMENT (PHYSICIAN)

Patient's Name: _____ Policy Number: _____

1. Diagnosis: _____

2. If condition is due to pregnancy, what is expected delivery date? Date ____/____/____ MO/DAY/YR

3. When did symptoms first appear or accident happen? Date ____/____/____ MO/DAY/YR

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? ☐ 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: ____/____/____ MO/DAY/YR Date discharged: ____/____/____ MO/DAY/YR

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

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

16. If "yes," explain. _____

17. Referring Physician: _____ Phone: (____) _____

Mailing Address: _____

PHYSICIAN VERIFICATION

Signed: _____, MD Date: ____/____/____ MO/DAY/YR Phone: (____) _____

Street Address: _____

City/Town: _____

State/Province: _____ Zip Code: _____

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 5 for notices specific to your state.

Policy Number: _____

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 ____/____/____ MO/DAY/YR

   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:

Pay Period From	Pay Period To	Amount	Source of Income

8. Current Salary or Hourly Rate: _____

9. Name of Employer: _____ Date: ____/____/____ MO/DAY/YR

   Address: _____

   By: _____ Official Position: _____ Telephone number: (____) _____

10. The employee's job title or position is: _____

11. Is the employee covered under any other disability policy through the company? _____

12. Has employee returned to work? ☐ Yes ☐ No If yes, give date: ____/____/____ MO/DAY/YR

13. Remarks: _____

Important: To avoid delay, please sign authorization below.

1. **Section 125:** Were the premiums for your **disability income policy** paid with pre-tax dollars under a Section 125 Plan? ☐ Yes ☒ No (**if in doubt, please ask your employer.**)

I authorize any physician, medical practitioner, hospital, clinic or other medical facility, Pharmacy Benefit Managers, insurance company, the Medical Information Bureau or other organization, institution or person, that has records or knowledge of me or my health including my prescription medication history to give to American Heritage Life Insurance Company (AHL) its subsidiaries or its reinsurers any information relating to my claim. I also authorize AHL, or its reinsurers, to make a brief report of my health information to MIB, Inc. 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 federal rules governing privacy and confidentiality, but may still be protected by state laws. A copy of this authorization is as valid as the original. This authorization applies to any dependent on whom a claim is filed. This authorization is valid for a period of 24 months from the date signed. I understand that I may revoke this authorization at any time by notifying AHL in writing of my desire to do so. I or my representative may receive a copy of this authorization by supplying policy number(s) and Insured's name in a written request to the company. (In **MAINE** – I understand that revocation of this authorization may be a basis for denying insurance benefits. Failure to sign an authorization statement may impair the ability of a regulated insurance agency to evaluate claims and may be a basis for denying a claim for benefits.)

Sign here: _____ Claimant Date: _____ ☐ **Check here if address is new**

Mailing Address: _____ City: _____ State: _____ Zip: _____ Phone No:. (____) _____