



Allstate

Benefits

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 5:00 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.
You may mail your claim to: American Heritage Life Insurance Company, P.O. Box 43067, Jacksonville, Florida 32203-3067
Additional claim forms are available on our website at www.allstateatwork.com.
If you are filing a claim within the first 24 months your policy is in force, additional information may be required.

ACCIDENTAL INJURY CLAIM
NO DISABILITY

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.) Is he/she a full-time student? Yes No
If yes, please submit proof of student status.

FIRST CLAIM CONTINUED CLAIM

ACCIDENT/DISABILITY
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.
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.

ASK US FOR DETAILS -
DEPENDING UPON THE NATURE
OF YOUR ACCIDENT AND TREATMENT
REQUIRED, YOU MAY NOT
NEED ALL OF THE
DOCUMENTS LISTED.

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.

## 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:     /    /     Date discharged:     /    /      
MO/DAY/YR MO/DAY/YR
  - 14b. When do you expect patient to resume partial duties?     /    /     Full duties?     /    /      
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?     /    /      
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:     /    /     Phone: (     ) \_\_\_\_\_  
MO/DAY/YR

Street Address: \_\_\_\_\_

City/Town: \_\_\_\_\_

State/Province: \_\_\_\_\_ Zip Code: \_\_\_\_\_

**\* THIS FORM MAY BE UNNECESSARY IF YOUR PHYSICIAN HAS PROVIDED YOU WITH SIMILAR DOCUMENTATION TO SUBMIT.**

# 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 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		Amount	Source of Income
From	To		
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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, insurance company, the Medical Information Bureau or other organization, institution or person, that has records or knowledge of me or my health to give to American Heritage Life Insurance Company (AHL) its subsidiaries or its reinsurers any information relating to my claim. 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

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone No.: (\_\_\_\_) \_\_\_\_\_