



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 Department at 1-800-348-4489, 24 hours a day, 7 days a week.

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

SICKNESS DISABILITY CLAIM ON ACCIDENT PLAN

- 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.

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

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.
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.

POLICY PAYS AN ADDITIONAL \$100/DAY FOR IN-HOSPITAL CONFINEMENT

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: ____ / ____ / ____ I returned to work on a part-time full-time basis: ____ / ____ / ____
MO/DAY/YR 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? N/A

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: / / 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: _____

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: _____

- I hereby certify that _____ did not perform any part of his/her work from, _____ through, _____
- Did insured work light duty or part-time? Yes No If yes, give dates: _____
- Prior to inability to work, he/she worked _____ hours per week and is considered ~~exempt~~ or non-exempt.
- When recovered, will he/she resume work? Yes No If not why? _____
- Is this a Workers' Compensation case? Yes No Date Workers' Compensation benefits began _____ / _____ / _____
MO/DAY/YR
Name of Workers' Compensation Company N/A

- Section 125: Were the premiums for our disability income policy paid with pre-tax dollars under a Section 125 Plan? Yes No
- 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			
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

- Current Salary or Hourly Rate: _____
- Name of Employer: _____ Date: _____ / _____ / _____
MO/DAY/YR
Address: _____
By: _____ Official Position: _____ Telephone number: (____) _____

- The employee's job title or position is: _____
- Is the employee covered under any other disability policy through the company? N/A
- Has employee returned to work? Yes No If yes, give date: _____ / _____ / _____
MO/DAY/YR
- 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
Claimant

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