



Allstate.

Workplace Division

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 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 CANCER / SPECIFIED DISEASE / ICU / HEART / STROKE CLAIMS

- To avoid processing delays, please fill out the sections which apply to your specific claim.
- Include your policy number(s). To obtain your policy number(s) call 1-800-348-4489.
- You may fax your claim to us at 1-972-510-1773. Please be assured that your claim will receive our immediate attention. You will usually receive a response from us in the mail within 10 business days following the receipt of your claim. The length of time in the mail will depend on your location.
- 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.

POLICYHOLDER

Employer Name (Company): _____ Occupation: _____

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

E-mail: _____ Policy Number: _____

Social Security Number: _____ Date of Birth: ____/____/____ Male Female
MO/DAY/YR

2. Home Number: (____) _____

PATIENT'S INFORMATION

3. Name: First: _____ Middle: _____ Last: _____

4. Date of Birth: ____/____/____ Age: _____ Social Security Number: _____ Male Female
MO/DAY/YR

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.

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

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.
- Include a copy of your itemized hospital billing if you were hospitalized.
- Have the doctor complete **Attending Physician's Statement** and attach an itemized billing showing the diagnosis, services provided and the actual charges made to you.
- Any other bills pertaining to this claim, such as anesthesia, chemotherapy or radiation treatments, ambulance, lodging, or travel, may be forwarded to this office.
- 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:

- 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. Include a copy of your itemized hospital billing and **Attending Physician's Statement**.

HOSPITAL INCOME AND INTENSIVE CARE CLAIMS:

- Please send a copy of your hospital bill showing charges and number of days in the intensive care unit.
- If the hospital bill fails to give the diagnosis, **Attending Physician's Statement** must be completed by the doctor.
- A copy of the police report is required 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.

INSTRUCTIONS FOR FILING TRANSPORTATION AND LODGING CLAIMS:

Please attach receipts for lodging and transportation (common carrier).

TRANSPORTATION AND LODGING

Name of Patient: _____ Condition Treated: _____
Dates of Travel: _____ Dates of Lodging: _____
Home Address: _____ Location of Treatment: _____

ATTENDING PHYSICIAN'S STATEMENT

Patient's Name: _____ Age: _____

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

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

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 3 for notice specific to your state.

PHYSICIAN VERIFICATION

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

Street Address: _____

City/Town: _____

State/Province: _____ Zip Code: _____

ASSIGNMENT OF BENEFITS

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 _____

