Home Office Use Only

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 CLAIMS

- Please fill out the sections which apply to your specific claim.
- Enclose the information requested and include your policy number. To obtain your policy number call **1-800-348-4489**.
- You may **fax** your claim to us at **1-904-992-2899**. Please allow 48 hours for our records to be updated with information confirming receipt of your fax or claim.
- or, You may mail your claim to: **Allstate Workplace Division**
  Attn: Claim Department
  1776 American Heritage Life Drive
  Jacksonville, Florida 32224-6687
- Additional claim forms are available on our website at www.ahlcorp.com.
- If you are filing a claim within the first 12 to 24 months your policy is in force, additional information may be required. Please notify your doctor we will be contacting him/her and provide him/her with a copy of your authorization to release information to us.
- **FOR ALL CLAIMS (First Claim or Continued Claim):**
  - ❑ Complete PART 1: Section A – POLICYHOLDER and,
  - ❑ Sign the Authorization (Page 2)

PART 1

Section A POLICYHOLDER

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

1. Name: First: _____ Middle: _____ Last: _____

   Social Security Number: ___-___-___ Date of Birth: ___/___/___ (MO/DAY/YR) ❑ Male ❑ Female

2. Home Number: (___)_____ E-mail: _____ Avg. Monthly Earnings: _____

PATIENT

3. Name: First: _____ Middle: _____ Last: _____
4. Date of Birth: ___/___/___ (MO/DAY/YR) Age: _____ ❑ 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.

Section B TYPE OF CLAIM: ❑ FIRST CLAIM ❑ CONTINUED CLAIM

_____ ACCIDENT/DISABILITY Policy No.(s): _____ _____
- ❑ Routine Pregnancy
- ❑ Ongoing Disability

_____ CANCER Policy No.(s): _____ _____
- ❑ Wellness Benefit
- ❑ Intensive Care

_____ HEART/STROKE Policy No.(s): _____ _____

_____ HOSPITAL INDEMNITY Policy No.(s): _____ _____

_____ CRITICAL ILLNESS Policy No.(s): _____ _____

_____ WAIVER OF PREMIUM Policy No.(s): _____ _____

➔ **PLEASE NOTE: Failure to complete this information will cause a delay in the processing of your claim.**

Allstate Workplace Division is the marketing name for American Heritage Life Insurance Company (home office: Jacksonville, Florida), a wholly-owned subsidiary of The Allstate Corporation (home office: Northbrook, Illinois)

Important: To avoid delay, please sign authorization below.

Note: Due to Internal Revenue Service requirements concerning social security number verification and backup withholding requirements, this form is required to be completed prior to claim payment. Check to be sure that all information is correct before signing.

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.)**

Taxpayor Identification Number Certification

2. **Federal law requires us to send to the Internal Revenue Service a percentage of any income you may be entitled to unless you certify under penalties of perjury that you have shown your correct Social Security Number and you have not been notified that you are subject to any Internal Revenue Service backup withholding order.**

   Under penalties of perjury, I certify that:

   A. The Social Security Number shown in Section A line (1) is my correct taxpayor identification number (or I am waiting for a number to be issued to me), and

   B. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) The IRS has notified me that I am no longer subject to backup withholding, and

   C. I am a U.S. person (including a U.S. resident alien).

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medically related facility, insurance company or other organization, institution or person that has any records or knowledge of me (or my dependents) to give such information to American Heritage Life Insurance Company or its designee. 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 American Heritage Life in writing of my desire to do so. A photographic copy of this authorization shall be as valid as the original, regardless of date signed. I understand that 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.

The Internal Revenue Service does not require your consent to any provisions of this document other than the certification required to avoid backup withholding.

Sign here _____ Date:_____ ❑ Check here if address is new

Claimant

Street Address:_____City:_____State:_____ Zip: _____Telephone No:. ( )_____

NOTICE IN ALASKA, ARKANSAS, KENTUCKY, LOUISIANA, MAINE, NEW JERSEY, 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, NEW HAMPSHIRE, 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 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 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 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 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 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 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 DISTRICT OF COLUMBIA: WARNING: 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 TENNESSEE: 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.

INSTRUCTIONS FOR FILING ACCIDENT CLAIMS:

- ❑ A copy of the hospital bill. 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.
- ❑ **PART 2: 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.

Section C 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: ____/____/____ (MO/DAY/YR) **Injury:** ____/____/____ (MO/DAY/YR) 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: ____/____/____ (MO/DAY/YR)

***If you are claiming <u>disability</u> due to your accident, please have your physician complete the* ATTENDING PHYSICIAN STATEMENT, PART 2 and your employer complete the EMPLOYER'S STATEMENT, PART 4.**

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

PART 2: Attending Physician's Statement should be completed and signed by your doctor.

- ❑ **PART 4: 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.

Section D DISABILITY AND WAIVER OF PREMIUM CLAIMS

INJURY OR ILLNESS YOU ARE CLAIMING: _____

Date you were first treated for your illness or injury: ____/____/____ (MO/DAY/YR) Date you were last treated for your illness or injury: ____/____/____ (MO/DAY/YR)

Date of your accident or the date you first noticed the symptoms of your illness: ____/____/____ (MO/DAY/YR)

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 Worker's Compensation) from any other source? If "yes," from whom? _____

***Please submit a copy of your payment statement with this form.* Please have your treating physician complete the ATTENDING PHYSICIAN STATEMENT, PART 2 and your employer complete the EMPLOYER'S STATEMENT, PART 4**

Section E DISABILITY CLAIM FOR ROUTINE PREGNANCY (6 weeks for vaginal delivery, or 8 weeks for C-Section)

If disabled due to complications of pregnancy, before or after delivery, please complete Section D.

Date of Delivery: ____/____/____ (MO/DAY/YR) First Date of Treatment: ____/____/____ (MO/DAY/YR) Type delivery: ❑ Vaginal ❑ C-Section

Dates of Hospital Confinement: ____/____/____ (MO/DAY/YR) Name of Hospital: _____ Phone No.: (____) _____

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

Address: _____ Fax: (____) _____

Treating Physician's Signature: _____ Date: ____/____/____ (MO/DAY/YR) Tax Identification No.: _____

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

Mailing Address: _____

If you filing a claim for disability or waiver of premium, please have your employer and physician complete PARTS 2 & 4.

PART 2 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: ____/____/____ 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
    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

If you are claiming CONTINUING DISABILITY, please have your employer and physician complete PARTS 3 & 4.

PART 3 ATTENDING PHYSICIAN'S STATEMENT FOR CONTINUING DISABILITY

FIRST CLAIM FOR DISABILITY due to Accident or to Sickness: ____/____/____ MO/DAY/YR

1. Is this claim for continuation of a previous disability? ❑ Yes ❑ No

2a. Diagnosis: _____

3. Describe any other diseases or infirmity affecting present condition. _____
4. Date of initial disability due to this diagnosis ____/____/____ MO/DAY/YR
5. Is patient unable to perform job duties? ❑ Yes ❑ No If yes, may return to work ❑ part-time ❑ full-time on : ____/____/____ MO/DAY/YR

   List any work restrictions: _____ If No, date expected to return to work: ____/____/____ MO/DAY/YR

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 notice specific to your state.

PHYSICIAN VERIFICATION

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

Street Address: _____

City/Town: _____

State/Province: _____ Zip Code: _____

PART 4 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 notice specific to your state.

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. Is the employee covered under any other disability policy through the company? _____
9. Has employee returned to work? ❑ Yes ❑ No If yes, give date: ____/____/____ MO/DAY/YR
10. The employee's job title or position is: _____
11. Current Salary or Hourly Rate: _____

    Remarks: _____

    _____

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

    Address: _____

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

NOTE: Please make a copy of the patient's signed authorization to release information for your records.

INSTRUCTIONS FOR FILING CANCER, SPECIFIED DISEASES AND INTENSIVE CARE 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 **PART 2: 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:

- ❑ A 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 **PART 2: Attending Physician's Statement.**

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, **PART 2: 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.

WELLNESS CLAIM

If you wish to file a **Wellness/Cancer Screening claim for one of the listed tests in your Wellness Rider,** please fax or mail the name and date of the test that was performed as well as your doctor's name and phone number. If this is for another covered individual, please submit the name of the person treated.

Section F HOSPITAL CONFINEMENT, INTENSIVE CARE OR OUTPATIENT SURGERY BENEFITS

Please send an itemized copy of your hospital bill, which includes the *diagnosis, admission and discharge dates*. Have your doctor complete this section if your bills do not include diagnosis information.

Diagnosis/ICD-9 Code: _____

Dates of Inpatient Hospital Confinement: From: ____/____/____ (MO/DAY/YR) To: ____/____/____ (MO/DAY/YR)

Dates of Confinement in Intensive Care, including Coronary Care Unit: From: ____/____/____ (MO/DAY/YR) To: ____/____/____ (MO/DAY/YR)

Hospital: _____ Phone Number: (____) _____

Hospital Address: _____

Date of Surgery: ____/____/____ (MO/DAY/YR) ❑ Inpatient ❑ Outpatient

Procedure/procedure code: _____

Date of office visit following confinement or outpatient surgery: ____/____/____ (MO/DAY/YR) - ____/____/____ (MO/DAY/YR)

Signature of doctor: _____ Date: ____/____/____ (MO/DAY/YR)

Name of doctor: _____ Phone: (____) _____

Fax number: (____) _____

Address: _____ Tax ID or SSN: _____

Section G ASSIGNMENT OF BENEFITS

I request that American Heritage Life Insurance Company send benefits available under my _____ policy directly to:

_____
Name

_____
Relationship

_____
Address

_____
City State Zip

_____
Signature of Policy Owner Date