



# WALMART GROUP CRITICAL ILLNESS 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 the AWD Walmart Claim Department at **1-800-514-9525**, 8:00 A.M. to 8:00 P.M. Eastern Standard Time or at [www.allstateatwork.com/mybenefits](http://www.allstateatwork.com/mybenefits)

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.

- To avoid delays in processing please fill out the sections which apply to your specific claim.
- Include your certificate number. To obtain your certificate number, you may call **1-800-514-9525** or visit our website at [www.allstateatwork.com/mybenefits](http://www.allstateatwork.com/mybenefits).
- You may **fax** your claim to us at **1-877-423-8804** or scan and **electronically submit** your claim through: [www.allstateatwork.com/mybenefits](http://www.allstateatwork.com/mybenefits).
- You may also **mail** your claim to: **American Heritage Life Insurance Company  
P.O. Box 41488  
Jacksonville, Florida 32203-1488**

Please be assured that your claim will receive our prompt attention. You will usually receive a response from us, including mail time, within 10 business days following the receipt of your claim. The length of time in the mail will depend on your location.

- Additional claim forms are available on our website at [www.allstateatwork.com/mybenefits](http://www.allstateatwork.com/mybenefits).

## INSURED AND PATIENT INFORMATION

1. Insured's Name: First: \_\_\_\_\_ Middle: \_\_\_\_\_ Last: \_\_\_\_\_

E-mail: \_\_\_\_\_ Certificate Number: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  Male  Female  
MO/DAY/YR

2. Daytime Phone Number: (\_\_\_\_) \_\_\_\_\_ Evening/Cell Phone Number: (\_\_\_\_) \_\_\_\_\_

3. Occupation: \_\_\_\_\_

## PATIENT'S INFORMATION

4. Name: First: \_\_\_\_\_ Middle: \_\_\_\_\_ Last: \_\_\_\_\_

5. Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_  Male  Female  
MO/DAY/YR

6. This person is your: \_\_\_\_\_ (self, wife, child, etc.) If your child is over 18 years of age, is he/she a full-time student?  Yes  No If yes, please send proof of student status.

## INSTRUCTIONS FOR FILING CRITICAL ILLNESS CLAIMS:

- The results of a tissue specimen, culture(s) and/or titer(s) or other diagnostic studies, which initially diagnosed the specified disease, must accompany your claim. Include a copy of your itemized hospital billing and **Attending Physician's Statement**. Thank You.



**PLEASE CHECK THE BOX(S) THAT BEST DESCRIBE YOUR CLAIM**

Following are the benefits available under your Wal-Mart Group Critical Illness Policy. Please check the benefit(s) you believe may be due based upon your condition. You will need to attach medical record documentation of your condition.

<b>WELLNESS BENEFIT</b>	<input type="checkbox"/>	*Physician, clinic, or facility receipt showing the specific wellness exam performed and the date it was provided
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**CRITICAL ILLNESS BENEFIT** (Please check the illness which you are requesting benefits)

Heart Attack	<input type="checkbox"/>	*Electrocardiograph proof and lab reports showing elevated cardiac enzymes or biochemical markers
Stroke	<input type="checkbox"/>	*Medical record documentation of permanent neurological deficit
Transient Ischemic Attack (TIA)	<input type="checkbox"/>	*Medical record documentation of a TIA
Coronary Artery By-Pass Surgery	<input type="checkbox"/>	*Medical record or billing proof of procedure
Invasive Cancer	<input type="checkbox"/>	*Pathology report
Carcinoma in situ	<input type="checkbox"/>	*Pathology report
End Stage Renal Failure	<input type="checkbox"/>	*Medical record documentation showing proof of failure to both kidneys and proof of dialysis or transplant
Alzheimer's Disease	<input type="checkbox"/>	*Medical record documentation by psychiatrist or neurologist to include proof of inability to perform 3 or more activities of daily living

**SPECIFIED DISEASES:** (Please check the illness for which you are requesting benefits)

Addison's Disease	<input type="checkbox"/>	
Amyotrophic Lateral Sclerosis (Lou Gehrig's Disease)	<input type="checkbox"/>	
Cerebrospinal Meningitis (bacterial)	<input type="checkbox"/>	
Cerebral Palsy	<input type="checkbox"/>	
Cystic Fibrosis	<input type="checkbox"/>	
Diphtheria	<input type="checkbox"/>	
Encephalitis	<input type="checkbox"/>	
Huntington's Chorea	<input type="checkbox"/>	
Legionnaire's Disease	<input type="checkbox"/>	*Confirmation by culture or sputum
Malaria	<input type="checkbox"/>	
Multiple Sclerosis	<input type="checkbox"/>	
Muscular Dystrophy	<input type="checkbox"/>	
Myasthenia Gravis	<input type="checkbox"/>	
Necrotizing fasciitis	<input type="checkbox"/>	
Osteomyelitis	<input type="checkbox"/>	
Poliomyelitis	<input type="checkbox"/>	
Rabies	<input type="checkbox"/>	*Also eligible for Recurrence Benefit
Sickle Cell	<input type="checkbox"/>	
Systemic Lupus	<input type="checkbox"/>	
Systemic Sclerosis	<input type="checkbox"/>	
Tetanus	<input type="checkbox"/>	
Tuberculosis	<input type="checkbox"/>	

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|--|---|
| <input type="checkbox"/> <b>RECURRENCE BENEFIT</b>                         | <input type="checkbox"/> <b>TRANSPORTATION BENEFIT</b>                        |
| <input type="checkbox"/> <b>WAIVER OF PREMIUM</b>                          | <input type="checkbox"/> <b>LODGING BENEFIT</b>                               |
| <input type="checkbox"/> <b>NATIONAL CANCER INSTITUTE (NCI) EVALUATION</b> | <input type="checkbox"/> <b>MAJOR ORGAN TRANSPLANT OPTIONAL BENEFIT RIDER</b> |

**SIGN THIS PART ONLY IF YOU WISH TO ASSIGN YOUR BENEFITS TO A PROVIDER OR A FACILITY**

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

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Provider or Facility Tax Identification Number

\_\_\_\_\_  
Address

\_\_\_\_\_  
City State Zip

\_\_\_\_\_  
Signature of Insured

\_\_\_\_\_  
Date

## 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. 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: \_\_\_\_\_

### Important: To avoid delay, please sign authorization below.

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: \_\_\_\_\_ 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, 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 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 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 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 DISTRICT OF COLUMBIA: FRAUD NOTICE:** 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 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 MARYLAND:** Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**NOTICE IN NEW HAMPSHIRE:** Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638.20.

**NOTICE IN NEW YORK:** 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

**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 OREGON:** Any person who makes intentional misstatement that is material to the risk may be found guilty of insurance fraud by a court of law.

**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 PUERTO RICO:** Any person who knowingly and with the intention to defraud includes false information in an application for insurance or file, assist or abet in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousands dollars (\$5,000), not to exceed ten thousands dollars (\$10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.

**NOTICE IN TENNESSEE AND WASHINGTON:** 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.

**NOTICE IN WEST VIRGINIA AND RHODE ISLAND:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.