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 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 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 / 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:

☐ A copy of the hospital bill. Please 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.

☐ **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.

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: ____/____/____ (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 Workers' Compensation) from any other source? If "yes," from whom? _____

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: ____/____/____ (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

16. If "yes," explain. _____

17. Referring Physician: _____ Phone: (____) _____

Mailing Address: _____

PHYSICIAN VERIFICATION

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

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: _____

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. 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**
Claimant

Mailing Address: _____ City: _____ State: _____ Zip: _____ Phone 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 or confinement in prison.