

MAIL TO: American Heritage Life Insurance Company
1776 American Heritage Life Drive • Jacksonville, Florida 32224-6688

CLAIM FORM

If you have any questions regarding our determination of your claim, or if you would like to appeal any determination, please contact our customer service department at 1-800-348-4489. 8:15 A.M. to 4:30 P.M. Eastern Standard Time
Toll Free Claims Number

Has a claim been filed before?
Yes No

This claim is for:
Group Voluntary Disability

Short Term Long Term



Allstate

Workplace Division

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.

This form is to be returned to our office at the end of each 30 days of disability or immediately if you have returned to work.

PLEASE PRINT CLEARLY AND COMPLETE FORM ENTIRELY IN ORDER TO AVOID A DELAY IN THE PROCESSING OF YOUR CLAIM.

A

Policy Number: _____ Present Occupation: _____

Employer Name (Company/Address) _____

1. Name: First _____ Middle _____ Last _____

Social Security Number ____ / ____ / ____ Date of Birth ____ / ____ / ____ Male Female

2. Work Number: () _____ Average Monthly Earnings: \$ _____

B

3. What sickness or injury are you claiming? _____

4. List all doctors who have treated you for this condition: Name/Address _____

_____ Phone Number: _____

5. Have you received treatment, medication or advice from a doctor in the past for this or a similar condition? _____

If, yes Date: _____ Doctor's Name: _____

Address: _____ Phone Number: () _____

IF ACCIDENTAL INJURY

6. (A) Date injured: _____ (B) Where did it happen? _____ (C) Time of accident _____ a.m. p.m.

7. Tell us exactly how your accident happened: _____

8. Did your injuries occur while you were working for pay or profit? On the job Off the job.

If yes, please include a copy of your workers' compensation earnings.

C

9. Dates unable to work: _____ a.m. p.m. to _____ a.m. p.m.

10. Dates confined to your house: _____ a.m. p.m. to _____ a.m. p.m.

11. Have you returned to your main (or principal) duties? Date returned part-time _____ Date returned full-time: _____

12. Are you receiving Disability Benefits (Salary Continuation or Sick Pay) from any other source? If "yes," from whom?

Please submit a copy of your payment statement with this form.

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.

Allstate Workplace Division is the marketing name for American Heritage Life Insurance Company (home office: Jacksonville, Florida – ahlcorp.com). All products are underwritten by American Heritage Life Insurance Company, a wholly-owned subsidiary of The Allstate Corporation (home office: Northbrook, Illinois – allstate.com).

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. 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 below for notice specific to your state.

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.)

Taxpayer 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 line (1) is my correct taxpayer 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 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 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.

ATTENDING PHYSICIAN'S STATEMENT

Patient's Name _____

Age _____

1. Diagnosis: (Describe complications if any) Is condition due to pregnancy? Yes No _____

If "yes," what was approximate date of commencement of pregnancy? Date – MO/DAY/YR _____

2. When did symptoms first appear or accident happen? Date – MO/DAY/YR _____

3. When did patient first consult you for this condition? Date – MO/DAY/YR _____

4. Has patient ever had same or similar condition? (If "yes," state when and describe) Yes No _____

5. Describe any other diseases or infirmity affecting present condition. _____

6. Nature of surgical or obstetrical procedure, if any (describe fully). _____

6a. Charge for this procedure \$ _____ Date – MO/DAY/YR _____

Where performed: _____ If in hospital, in patient outpatient

7. Is patient still under your care for this condition? Yes No

If discharged give date _____ Date – MO/DAY/YR _____

8. If patient hospitalized, give name and address of hospital.

Hospital _____ City _____ State _____

Date admitted – MO/DAY/YR _____ Date discharged – MO/DAY/YR _____

9. How long was or will patient be continuously totally disabled (unable to work)? From Date – MO/DAY/YR _____ through _____

10. If still disabled, when do you expect patient to resume full duties? _____

11. Is condition due to injury or sickness arising out of patient's employment? Yes No

If "yes," explain. _____

8. Name and address of referring physician if any

Name _____ Address _____

City _____ State _____ Zip _____

PHYSICIAN VERIFICATION

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

Street Address _____ City/Town _____

State/Province _____ Zip Code _____

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EMPLOYER'S STATEMENT

1. I hereby certify that _____ did not perform any part of his/her work from _____
to_____.

2. Prior to disability, he/she worked _____ hours per week and is considered _____ exempt or _____ non-exempt.

3. When recovered, will he/she resume work? _____ If not why? _____

4. Is this a Workers' Compensation case? _____ Date Workers' Compensation benefits began _____

Name of Company _____

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

6. Did Insured receive salary continuance or sick pay? Yes No If yes, please complete coordination of benefits form.

Name of Employer _____ Date _____ Address _____

By _____ Official Position _____ Telephone number (____) _____

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