



# 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 **1-866-424-8482**. Please be assured that your claim will receive our immediate attention. If you would like to receive your claim proceeds even faster, Allstate Benefits can automatically deposit them into your bank account by completing and returning our ACH form (ABJ16661). This form can be found on our website at [www.allstateatwork.com](http://www.allstateatwork.com) or electronically at [www.allstateatwork.com/mybenefits](http://www.allstateatwork.com/mybenefits). Additional claim forms are available on our website.
- You may mail your claim to: **American Heritage Life Insurance Company  
P.O. Box 43067  
Jacksonville, Florida 32203-3067**
- 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): \_\_\_\_\_ 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 (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 \_\_\_\_\_



**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.