AMERICAN HERITAGE LIFE INSURANCE COMPANY

DISABILITY COVERAGE CLAIM FORM

Submit Claims: Online at: **www.allstatebenefits.com** by Fax to: 1-866-424-8482 or by
Mail to: American Heritage Life Insurance Company 1776 American Heritage Life Drive, Jacksonville, FL 32224

For questions regarding the policy benefits, supporting documentation, or for claim assistance, instructions can be found on our website or contact our Customer Care Center at 1-800-521-3535. Please refer to the Coverage Documents for benefits available as well as applicable terms, conditions, exclusions, and limitations.

Direct Deposit: Please complete and submit our Direct Deposit (ACH) form located on our website.

Assignment of Benefits: To assign benefit to another individual or provider, please complete and submit our Assignment of Benefits form located on our website.

Incomplete or blank responses may result in a delay in processing the claim request.

Section 1 – POLICY/CERTIFICATE HOLDER & CLAIMANT INFORMATION.

COVERAGE NUMBER(S): _____

POLICY/CERTIFICATE HOLDER INFORMATION:

First Name: _____ MI:_____ Last Name: _____ Last 4 of SS #: XXX-XX-_____

Birth Date:_____ Age: _____ Gender: _____ Phone #: _____ Email: _____

Mailing Address – We will update our system with this address and use this address to send future correspondence and checks.

Number & Street:_____

City: _____ State: _____ Zip: _____

CLAIMANT INFORMATION: (If different than Policy/Certificate Holder)

First Name: _____MI:_____ Last Name: _____

Date of Birth: _____ Age: _____ Gender: _____ Relation to Insured: □ Self □ Spouse □ Domestic Partner □ Child □ Other: _____

Section 2 – CLAIM DETAILS: Tell us about the Claim. This is a □ New Claim or □ Ongoing Claim.

1. What are the Diagnoses/Condition(s) for this claim? (List all): _____
   When did symptoms of this condition first occur? _____
   Is the condition related to pregnancy? □ Yes □ No Due Date: _____ Delivery Date: _____ □ Normal Delivery or □ C-Section
2. Is the condition an Injury resulting from an accident? Accident date: _____ Time: _____ AM/PM
   Was the accident work-related? □ Yes □ No (If yes, please provide workers' compensation or other state disability benefits approval or denial)
   Was a police or traffic report filed? □ Yes □ No (If yes, please provide a copy of the report)
   For auto accidents, the claimant was the: □ Driver □ Passenger
3. Where was treatment provided/received?

   Physician Name: _____
   Address: _____
   _____
   Phone#: _____
   First Visit: _____ Next Visit: _____
   Follow Up Visits: _____

   Facility Name: _____
   Address: _____
   _____
   Phone#: _____
   Dates of Service: _____
   Admission Date: _____ Discharge Date: _____
4. Was the claimant actively employed when the disability began? □ Yes □ No (If no, please provide the employment separation papers)
   What is the first date the claimant was unable to work? _____
   Has the claimant returned to work? □ Yes □ No Part time/Partial duties: _____Full time/Full duties: _____
5. Did this policy replace prior disability coverage? □ Yes □ No

   Prior Disability Carrier: _____
   Effective Date:_____ Elimination Period: _____
   Monthly Benefit $: _____ Maximum Benefit Period: _____
   If Applicable, Termination date: _____

   Does the claimant have other active disability coverage? □ Yes □ No

   Other Active Disability Carrier: _____
   Effective Date: _____ Elimination Period: _____
   Monthly Benefit $: _____ Maximum Benefit Period: _____
   If Applicable, Termination date: _____

   If applicable, please provide the other disability coverage approval, denial or statement for review.

Section 3 – Supporting Claim Documentation. Send us any documentation showing the condition, treatment and restrictions/limitations precluding the claimant from working. This documentation must include the claimant's name, provider name, and date(s) of service.

Please provide a completed and signed: Attending Physician's Statement and Employer's Statement

Additional supporting documentation may include:

- **Medical Records you receive or can obtain such as:** Hospital and/or Physician Office Records, Admission and Discharge Summaries, Diagnostic Test Results, Therapy Notes, Operative or Procedure Reports, and/or Physician Consultation Notes.
- **Additional Information (if applicable) such as:** Physician Letter or Certification, Job Description, Attendance Records, Itemized Bills, Explanation of Benefits, and/or any additional Information you would like us to review.

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. Please check to be sure all information is correct before signing. Please refer to the fraud notice specific to your state.

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CLAIMANT'S NAME: _____ **DATE OF BIRTH:** _____

COVERAGE NUMBER(S): _____ **CLAIM NUMBER:** _____

Section 4 – ATTENDING PHYSICIAN'S STATEMENT. To be completed by the attending physician

SECTION #1: DESCRIBE THE CONDITION:

ICD 9/10 Code: _____ Primary Diagnosis: _____

ICD 9/10 Code: _____ Secondary Diagnosis: _____

Other Condition(s): _____

When did symptoms first appear? _____ If applicable, what was the accident date? _____

Has the patient ever had the same/similar condition? □ Yes □ No If yes, when? _____

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

Pregnancy or Complication of Pregnancy: Due Date: _____ Delivery Date: _____ □ Normal Delivery □ C-Section

SECTION #2: TREATMENT REQUIRED:

First consultation: _____ Most recent consultation: _____ Next consultation: _____ Released: _____

Is/was diagnostic testing performed? □ Yes □ No Test(s):_____ Dates: _____

Results: _____

Is/Was a surgical or medical procedure required? □ Yes □ No Date: _____ Procedure Code: _____

Procedure: _____

Is/was hospitalization required? □ Yes □ No Admission Date: _____ Discharge: Date _____

Hospital: _____ City: _____ State: _____

What is the current treatment plan? _____

_____

SECTION #3: RESTRICTIONS, LIMITATIONS AND ABILITY TO WORK:

Please provide specific details and dates. Responses such as "no work", "totally disabled", "undetermined" or "unknown" will not enable us to evaluate your patient's claim for benefits and may result in us having to contact you for clarification

The patient is able to work in the following capacity: □ No Work □ Sedentary □ Light □ Medium □ Heavy □ Very Heavy

The patient is unable to perform their job duties: □ Yes □ No If yes, please provide the dates from: _____ through: _____

When is the patient expected to resume part time/partial duties: _____ full time/full duties: _____

The patient is unable to: □ Stand ___Hours; □ Sit ___Hours; □ Walk ___Hours; □ Lift ___Pounds; □ Carry ___Pounds; □ Drive ___Hours;
□ Perform Data Entry □ Reach □ Kneel □ Squat □ Climb □ Crawl

Please provide the specific restrictions: _____

Please provide the specific limitations: _____

The restrictions and limitations are: □ Temporary (If so, how long? _____) □ Permanent

What clinical or diagnostic findings support these restrictions and limitations? _____

_____

SECTION #4: REFERRING PHYSICIAN:

Name: _____ Specialty: _____

Address: _____ Phone #: _____

SECTION #5: ATTENDING PHYSICIAN VERIFICATION:

I am aware that it is a crime to fill out this form with facts I know are false or to leave out facts I know are relevant and important. I certify that the answers given on this form are true, complete and correctly recorded.

Physician Signature: _____ Date: _____

Print Name: _____ Specialty: _____ Phone #: _____

Address: _____ City: _____ State: _____ Zip Code: _____

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COVERAGE NUMBER(S): _____ **CLAIM NUMBER:** _____

Section 5 – EMPLOYER'S STATEMENT. To be completed by the employer.

□ Check here if you are self-employed, then complete and sign this form.

□ Check here if you are unemployed. Please provide the last date you worked _____and prior employer's name then sign this form.

SECTION #1: EMPLOYMENT INFORMATION / JOB DESCRIPTION:

Name of employer/company: _____

Date of hire: _____ Employee's job title/position: _____

*Please attach a copy of the job description or list major job responsibilities.

Major job responsibilities: _____

This job classification is: □ Sedentary □ Light Work □ Medium Work □ Heavy Work □ Very Heavy Work.

Prior to inability to work, they worked _____ hours per week. Hourly Pay: $_____ Annual Salary: $_____

If you are self-employed, we may require proof of income. We will notify you if additional documentation is required.

SECTION #2: DATES MISSED WORK / RETURNED TO WORK:

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

What is the expected or estimated return to work date? _____

Has the employee returned to work? □ Yes □ No If yes, Part time/Partial duties(date): _____ Full time/Full duties(date):_____

Did the employee work part time/partial duty? □ Yes □ No If yes, dates: _____

Is part time/partial duty work available? □ Yes □ No If no, reason: _____

When recovered, will he/she resume work? □ Yes □ No If no, reason: _____

SECTION #3: WORKERS' COMPENSATION / OTHER DISABILITY COVERAGE / CONTINUED PAY:

Is this a work-related **c**ondition/injury? □ Yes □ No If yes, Workers' Compensation Begin Date: _____ End Date: _____

Workers' compensation carrier: _____ Benefit Amount: $_____(Monthly/Weekly)

Is the employee covered under any other disability policy/coverage through the company?* □ Yes □ No

Other disability insurance carrier: _____ Benefit Amount: $_____(Monthly/Weekly)

Effective Date: _____ Termination Date:_____ Maximum Benefit Period: _____ Elimination Period: _____

Does this policy replace any prior disability policy/coverage through the company?* □ Yes □ No

Prior disability insurance carrier: _____ Benefit Amount: $_____(Monthly/Weekly)

Effective Date: _____ Termination Date:_____ Maximum Benefit Period: _____ Elimination Period: _____

*We may require proof of other disability coverage or prior disability coverage.

Continued Pay: This is for Group Short-Term Disability and Long-Term Disability only.

Is the insured receiving continued pay, salary continuation, sick or vacation pay? □ Yes □ No

Pay Period From Date	Through Date	Amount	Source of Income
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

SECTION #4: Section 125 / Employer Paid Premium: If yes, FICA withholding will be deducted from the disability claim payment.

Section 125: Were the premiums for this disability income policy/certificate paid with pre-tax dollars under a Section 125 Plan? □ Yes □ No

Employer Paid: Were premiums for this disability income policy/certificate employer paid? □ Yes □ No

SECTION #5: EMPLOYER VERIFICATION: Check here if □ Self Employed or □ Unemployed

I am aware that it is a crime to fill out this form with facts I know are false or to leave out facts I know are relevant and important. I certify that the answers given on this form are true, complete and correctly recorded.

Signed by: _____ Print Name: _____ Date: _____

Title: _____ Company: _____

Address: _____ Phone #: _____

Other Comments: _____

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CLAIMANT'S NAME: _____ **DATE OF BIRTH:** _____

COVERAGE NUMBER(S): _____ **CLAIM NUMBER:** _____

Note: Don't forget to provide the supporting claim documentation.

Section 6 – CERTIFICATION. The Policy/Certificate Holder or Claimant who completed the claim form please read and sign below.

I acknowledge the receipt of the Department of Insurance Claim Fraud Statements provided with this claim packet. I have read the notices and I am aware that it is a crime to fill out this form with facts I know are false or to leave out facts I know are relevant and important. I certify that the answers given on this claim form are true, complete, and correctly recorded. **Please also remember to sign and date the attached authorization required to process your claim.**

Signature:_____ Print Name: _____ Date: _____

FRAUD WARNINGS BY STATE

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 thousand dollars ($5,000), not to exceed ten thousand 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 imprisonment.

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CLAIMANT'S NAME: _____ **DATE OF BIRTH:** _____

COVERAGE NUMBER(S): _____ **CLAIM NUMBER:** _____

AUTHORIZATION TO RELEASE INFORMATION TO AMERICAN HERITAGE LIFE INSURANCE COMPANY

I hereby authorize any physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, health care provider, Pharmacy Benefit Manager, insurance company, the Medical Information Bureau (MIB) or other organization, institution or person that has any health related records or knowledge of me or minor dependents to disclose the entire medical record (excluding psychotherapy notes and in MAINE and VERMONT HIV related test results) to American Heritage Life Insurance Company (AHL), its duly authorized representatives, its subsidiaries or its reinsurers. This authorization extends to any minor dependent on whom insurance is requested or claim for benefits is being made.

The information to be obtained shall include insurance claim history from any Prescription Drug Database, pharmacy benefit manager, ambulance, insurance company, medical transport service, or the MIB. Also, I authorize any entity, person, or organization that has these records about me, including but not limited to my employer, employer representative and compensation sources, insurance company, financial institution or governmental entities, including departments of public safety and motor vehicle departments, to give any information or record it has about me, my employment, employment history or income to AHL.

I understand that this information will be used to evaluate and administer my claim for benefits or to evaluate my eligibility for insurance. I understand that there is a possibility of redisclosure of any information disclosed pursuant to this authorization and that information, once disclosed, may no longer be protected by certain federal regulations governing privacy and confidentiality, though it may still be protected by state privacy laws or other applicable privacy laws. I also authorize AHL or its reinsurers to make a brief report of my health information to MIB.

This authorization shall remain in force for 24 months following the date of my signature below or termination of my coverage, whichever occurs first. A copy of this authorization is as valid as the original. I or my legal representative may request a copy of this authorization. I understand that I may revoke this authorization at any time by sending a written notification to: **Attn: Privacy Officer, American Heritage Life Insurance Company, 1776 American Heritage Life Drive, Jacksonville, FL 32224.**

I understand that a revocation of this authorization is not effective if AHL has relied on the protected health information or has a legal right to contest a claim under an insurance policy or to contest the policy itself. The revocation will not apply to any information AHL requests or discloses prior to AHL receiving my revocation request. If I choose not to sign this authorization or if I later revoke it, I understand that AHL may not be able to process my application for coverage, or if coverage has been issued, AHL may not be able to administer my claim for benefits and this may result in a denial of my claim for benefits or request for services.

Your provider may require you to complete an additional authorization form. If asked to complete this authorization, your prompt response will help expedite the process.

Claims submitted on dependents 18 and older require an authorization signed by the dependent.

_____ _____

Claimant/Applicant's Signature Date Signed (mm/dd/yyyy)

_____ _____

Claimant/Applicant's Printed Name Last Four Digits of Social Security Number

If signed by the legal representative, please describe the authority under which the representative is authorized to act and enclose any related documentation granting authority.

_____ _____

Signature of Legal Representative Relationship

_____ _____

Print Name of Legal Representative Date Signed (mm/dd/yyyy)

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