



GROUP VOLUNTARY ACCIDENT POLICY (GVAP1) BENEFIT ENHANCEMENT RIDER (GVAPBER) CLAIM FORM

If you have any questions on how to file your claim, please call the Benefits Call Center.

1-877-282-0808, 7:00 A.M. to 5:00 P.M. Central Standard Time or

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.

Mail or Fax Your Claim to: GoToSMBO.com / Keeler & Associates
 211 S. 23rd Street, Plattsmouth, NE 68048
 Fax: 1-402-296-3954

If you would like to have claim benefits automatically deposited into your bank account, please complete and send our ACH form (ABJ16661). This form can be found on our website at www.allstatebenefits.com or www.allstatebenefits.com/mybenefits.

CLAIMANT'S NAME: _____ Date of Birth: _____

CERTIFICATE NUMBER(S): _____ Claim Number: _____

ACCIDENT BENEFIT ENHANCEMENT RIDER ****Please submit with a Completed GVAP1 Accident Policy Claim Form****

You may have elected the **Accident Benefit Enhancement Rider** with your **Accident Certificate**. The following are benefits available under the **Accident Benefit Enhancement Rider**. If you elected this rider, please check the **Benefits** below you believe may be due **based upon the Covered Person's Accidental Injury** and attach the **Required Documentation**. The required documentation needs to include the patient's name, diagnosis and date(s) of service. The required bills from your provider include: UB04, HCFA 1500, or an itemized bill. We also need you to sign and submit the Authorization to Release Information to AHL form ABJ21476. If additional information is needed you will be notified.

Benefits may vary by product and/or state. Please refer to your certificate and rider for specific benefits available under your Coverage.

<input type="checkbox"/> Accident Follow Up Treatment	Provide the bill or medical record for follow up treatment with the physician as outlined in the certificate/rider.
<input type="checkbox"/> Anesthesia	Provide the bill for general anesthesia for a covered surgery listed in the certificate/rider.
<input type="checkbox"/> Appliance	Provide a bill or medical record showing a prescription for an appliance as outlined in the certificate/rider.
<input type="checkbox"/> Blood and Plasma	Provide the bill for blood or plasma as outlined in the certificate/rider.
<input type="checkbox"/> Brain Injury Diagnosis	Provide the CT, MRI, EEG, PET, or x-ray showing a brain injury as outlined in the certificate/rider.
<input type="checkbox"/> Burn Benefit	Provide the bill or medical records documenting a burn as outlined in the certificate/rider.
<input type="checkbox"/> Coma with Respiratory Assistance	Provide medical records documenting a coma with respiratory assistance as outlined in the certificate/rider.
<input type="checkbox"/> CT or MRI	Provide a bill for a CT (Computed Tomography) or MRI (Magnetic Resonance Imaging) or a copy of the report as outlined in the certificate/rider.
<input type="checkbox"/> Eye Surgery	Provide the operative report or medical record showing eye surgery as outlined in the certificate/rider.
<input type="checkbox"/> Family Member Lodging	Provide bills for family member lodging as outlined in the certificate/rider.
<input type="checkbox"/> Hospital Admission	Provide the bill including room and board charges for hospital admission as outlined in the certificate/rider.

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.

CLAIMANT'S NAME: _____ Date of Birth: _____
 CERTIFICATE NUMBER(S): _____ Claim Number: _____

<input type="checkbox"/> Laceration	Provide a bill or medical record showing a laceration as outlined in the certificate/rider.
<input type="checkbox"/> Medicine	Provide the receipt for prescription or over the counter medication as outlined in the certificate/rider.
<input type="checkbox"/> Medical Supplies	Provide the receipt for medical supplies as outlined in the certificate/rider.
<input type="checkbox"/> Non-Local Transportation	Provide documentation of non-local transportation as outlined in the certificate/rider.
<input type="checkbox"/> Open Abdominal or Thoracic Surgery	Provide the operative report showing open abdominal or thoracic surgery as outlined in the certificate/rider.
<input type="checkbox"/> Paralysis	Provide medical records documenting paralysis as outlined in the certificate/rider.
<input type="checkbox"/> Physical Therapy	Provide the bill or medical records showing physical therapy provided by a licensed physical therapist as outlined in the certificate/rider.
<input type="checkbox"/> Post Accident Transportation	Provide a receipt for post-accident transportation as outline in the certificate/rider.
<input type="checkbox"/> Prosthesis	Provide a bill for a covered prosthesis as outlined in the certificate/rider.
<input type="checkbox"/> Rehabilitation Unit	Provide the bill for inpatient rehabilitation as outlined in the certificate/rider.
<input type="checkbox"/> Ruptured Disc Surgery	Provide the operative report showing the surgical repair of a ruptured disc as outlined in the certificate/rider.
<input type="checkbox"/> Skin Graft	Provide the bill or an operative report documenting skin grafting as outlined in the certificate/rider.
<input type="checkbox"/> Tendon, Ligament, Rotator Cuff or Knee Cartilage Surgery	Provide the operative report showing a tendon, ligament, rotator cuff, or knee cartilage surgery as outlined in the certificate/rider.

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FRAUD WARNINGS BY STATE

NOTICE IN ALABAMA: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

NOTICE IN ALASKA, ARKANSAS, KENTUCKY, LOUISIANA, MAINE, NEW JERSEY AND NEW MEXICO: 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 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 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 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 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 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 or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or 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.



AMERICAN HERITAGE LIFE INSURANCE COMPANY

HOME OFFICE:
1776 AMERICAN HERITAGE LIFE DRIVE
JACKSONVILLE, FLORIDA 32224-6687

AUTHORIZATION TO RELEASE INFORMATION TO AHL & Keeler & Associates

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.

Claimant/Applicant's Signature

Date Signed (mm/dd/yyyy)

Claimant/Applicant's Printed Name

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)