Allstate
Workplace Division

CLAIM FORM AND INSTRUCTIONS

If you have any questions while completing your claim or need assistance, please call Keeler & Associates (GoToSMBO.com) at 877-282-0808.
7:00 A.M. to 4:00 P.M. Central 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 GROUP VOLUNTARY STD / LTD / 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 **1-877-282-0808**.
- You may **fax** your claim to us at **1-402-296-3954**. Please be assured that your claim will receive our immediate 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 40795
  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.

CERTIFICATEHOLDER

Employer Name (Company/Address): _____ Occupation: _____

1. Certificateholder's Name: First: _____ Middle: _____ Last: _____

   E-mail: _____ **Certificate Number:** _____

   Social Security Number: _____ Date of Birth: ___/___/___ (MO/DAY/YR) ☐ Male ☐ Female

2. Home Number: (___) _____ Avg. Monthly Earnings: _____

PATIENT'S INFORMATION

3. Name: First: _____ Middle: _____ Last: _____

4. Date of Birth: ___/___/___ (MO/DAY/YR) Age: ___ Social Security Number: _____ ☐ Male ☐ Female

This person is your: _____ (ex: self, wife, son, etc.)

☐ FIRST CLAIM ☐ CONTINUED CLAIM

GROUP VOLUNTARY STD/LTD Policy No.(s): _____

☐ Waiver of Premium

INSTRUCTIONS FOR FILING FIRST CLAIM FOR DISABILITY 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.**

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: _____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, 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 and confinement in prison.

DISABILITY AND WAIVER OF PREMIUM CLAIMS (CERTIFICATEHOLDER)

INJURY OR ILLNESS YOU ARE CLAIMING: _____

Date you were first treated for your illness or injury: ____/____/____ (MO/DAY/YR) Date you were last treated for your illness or injury: ____/____/____ (MO/DAY/YR)

Date of your accident or the date you first noticed the symptoms of your illness: ____/____/____ (MO/DAY/YR)

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: ____/____/____ (MO/DAY/YR) First Date of Treatment: ____/____/____ (MO/DAY/YR) Type of delivery: ☐ Vaginal ☐ C-Section

Date of Hospital Confinement: ____/____/____ (MO/DAY/YR) Name of Hospital: _____ Phone No.: (____) _____

Physician's Name: _____ Phone: (____) _____

Address: _____ Fax: (____) _____

Treating Physician's Signature: _____ Date: ____/____/____ (MO/DAY/YR) Tax Identification No.: _____

Referring Physician: _____ Phone No.: (____) _____

Mailing Address: _____

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.

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

Remarks: _____

ATTENDING PHYSICIAN'S STATEMENT (PHYSICIAN)

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: ____/____/____ 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

If "yes," explain. _____

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

Mailing Address: _____

PHYSICIAN VERIFICATION

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

Street Address: _____

City/Town: _____

State/Province: _____ Zip Code: _____

AMERICAN HERITAGE LIFE INSURANCE COMPANY ("AHL")
Attn: Policyholder Services
1776 American Heritage Life Drive
Jacksonville, FL 32224

Telephone: (800) 521-3535

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Individual's Name _____
Last First Middle

Home Address

_____
Street City State/Zip Code

Home Telephone _____ **Date of Birth** _____

Policy Number(s) _____

MY HEALTH INFORMATION: The health information that is subject to this Authorization consists of:

☒ All Health information about me created or received by AHL, except for the following:

_____

☐ Other:

_____

AUTHORIZED DISCLOSURE: I authorize AHL to disclose my health information described above to

Name ("Recipient") Keeler and Associates

Address 2209 1st Ave., Plattsmouth, NE 68048 877-282-0808

TERM: This Authorization will remain in effect until:

☒ I revoke it in writing.

☐ the _____day of_____, 20_____.

I authorize disclosure in the manner described above, and understand that:

- AHL will not condition my enrollment or eligibility for insurance benefits on my provision of this Authorization.
- AHL does not guarantee that Recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.
- I may revoke this Authorization in writing at any time.
- This Authorization will remain in effect until the Term of the Authorization expires or I provide a written notice of revocation to AHL at the address listed above. The revocation will be effective upon AHL's receipt of my written notice.

_____ _____ _____
Signature of Individual Date Signature of Witness

American Heritage Life Insurance Company
1776 American Heritage Life Drive
Jacksonville, Florida 32224

Allstate Workplace Division

CLAIMS ADMINISTRATION

DIRECT DEPOSIT AUTHORIZATION FORM

Authority is hereby given to American Heritage Life Insurance Company (AHL) to credit the account number shown below for claims payment for all of your AHL policies (unless benefits are assigned). AHL will make any adjustments, including the initiation of any credit or debit entries on the account, for the limited purpose of claims payment due to the accountholder or due to AHL. Once the deposit transaction occurs, AHL has five days to withdraw only the amount deposited if an error has occurred.

TRANSACTION TYPE: ☐ New Setup ☐ Cancellation ☐ Change Financial Institution ☐ Change Account Number

POLICY/CERTIFICATEHOLDER INFORMATION:

Policy/Certificateholder Name: _____ Home Phone: _____

Policy/Certificate Number(s): _____/_____

(Signing this authorization will allow AHL to deposit claims payments for all eligible policies)

Social Security Number: _____

FINANCIAL INSTITUTION:

Financial Institution Name: _____

Address: _____

Routing Transit Number _____ Account Number_____

Tape a Voided Check for Checking Account Here

This authority is to remain in full force and effect until AHL has received written notification revoking the authority. Your policy/certificateholder information and your financial institution information above must be complete and accurate and must be that of the policy/certificateholder on file. To ensure accuracy, a voided check must be attached. Please notify AHL immediately if your financial institution or account information has changed by sending written notification to the address indicated below. Should you have any questions, please contact us at 1-800-348-4489.

Authorization Signature: _____ Date: _____

Print Name: _____

Deliver the completed and signed authorization form with voided check to:

Fax to: 1-402-296-3954 OR **Mail to:** Allstate Workplace Division
Attention: Claims ACH Department
1776 American Heritage Life Drive,
Jacksonville, FL 32224-6687