



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 A HOSPITAL INDEMNITY (SHOP) CLAIM

- 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(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.AllstateBenefits.com or electronically at www.AllstateBenefits.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.)

INSTRUCTIONS FOR FILING HOSPITAL INDEMNITY (SHOP) CLAIMS:

- Please include a copy of your itemized hospital bill with the admitting diagnosis.
- Have your doctor complete the Attending Physician's Statement including the diagnosis treated. Attach an itemized bill showing the services provided, procedure codes and the actual charges made to you.
- Any other bills pertaining to this claim, such as anesthesia, ambulance, and receipts for your prescription drugs.

INSTRUCTIONS FOR FILING TRANSPORTATION CLAIMS:

- Please attach receipts for transportation (common carrier) and complete below for mileage.

Dates of Travel: _____ Location of Treatment: _____

Home Address: _____

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
Relationship	State
Signature of Policy Owner	Zip

Signature of Policy Owner

Date

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.