



CLAIM FORM AND INSTRUCTIONS

If you have any questions regarding benefits available, or how to file 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 GROUP VOLUNTARY DISABILITY / WAIVER OF PREMIUM CLAIMS

Please check the box or boxes that best describes your current claim:

- Disability
- Waiver of Premium
- Benefit for Organ Donor
- Routine Pregnancy
- FMLA
- Survivor & Accident Death
- On-the-Job Accident
- Return of Premium Due to Layoff

- 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 **1-800-348-4489**.
- You may **fax** your claim to us at **1-866-427-3693**. 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.allstatebenefits.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 NAME

E-mail: _____ Certificate Number: _____

Social Security Number: _____ Date of Birth: ____/____/____ Male Female
MO/DAY/YR

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

PATIENT'S INFORMATION

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

4. Date of Birth: ____/____/____ Age: ____ Social Security Number: _____ Male Female
MO/DAY/YR

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

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.

DISABILITY AND WAIVER OF PREMIUM CLAIMS (CERTIFICATEHOLDER)

INJURY OR ILLNESS YOU ARE CLAIMING: _____

Date you were first treated for your illness or injury: _____ / _____ / _____ Date you were last treated for your illness or injury: _____ / _____ / _____
MO/DAY/YR 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: _____ / _____ / _____ I returned to work on a part-time full-time basis: _____ / _____ / _____
MO/DAY/YR 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: _____ / _____ / _____ First Date of Treatment: _____ / _____ / _____ Type of delivery: Vaginal C-Section
MO/DAY/YR MO/DAY/YR

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

Physician's Name: _____ Phone: (_____)

Address: _____ Fax: (_____)

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

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 5 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:

| 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: _____ 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. _____

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

Mailing Address: _____

PHYSICIAN VERIFICATION

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

Street Address: _____

City/Town: _____

State/Province: _____ Zip Code: _____

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.