AMERICAN HERITAGE LIFE INSURANCE COMPANY (AHL)

LIFE 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.

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: _____ SS #:_____

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

Mailing Address: _____

City: _____ State: _____ Zip: _____

Employer: _____ Occupation: _____

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

First Name: _____ MI:_____ Last Name: _____ SS #:_____

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

Resident State: _____ Marital status at time of death: □ Single □ Married □ Widowed □ Divorced (If divorced, provide dissolution paperwork)

Section 2 – PERSON MAKING THE CLAIM:

First Name: _____ MI:_____ Last Name: _____ SS #:_____

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

Mailing Address: _____ City: _____ State:_____ Zip: _____

Physical Address: _____ City: _____ State: _____ Zip: _____

Your relationship to the deceased: □ Self □ Spouse □ Domestic Partner □ Child □ Other: _____

Are you the beneficiary named in the Coverage? □ Yes □ No □ Unknown (Please provide documentation showing beneficiary designation)

Section 3 – CLAIM DETAILS:

1. Is this a death claim? □ Yes □ No Date of Death: _____ Cause of Death: _____
2. What was the cause(s) of death? (List all): _____
   When did symptoms of this condition first occur? _____
3. Was the cause of death accidental? If so, Accident date: _____ Time: _____ AM/PM
   Describe how the accident happened: _____
   _____
   Was the accident work-related? □ Yes □ No
   Was a police or traffic report filed? □ Yes □ No (If yes, please provide a copy of the report)
   Was this an auto accident? □ Yes □ No (If yes, the claimant was the: □ Driver □ Passenger)
4. When did the deceased last work? _____ Where did the deceased last work? _____
5. Attending Physician and Hospital:

Physician Name: _____	Facility Name: _____
Address: _____	Address: _____
_____	_____
Phone#: _____	Phone#: _____
First Visit: _____ Next Visit: _____	Dates of Service: _____
Follow Up Visits: _____	Admission Date: _____ Discharge Date: _____

Section 4 – SUPPORTING DOCUMENTATION:

Please provide a certified copy of the death certificate

Additional supporting documentation required may include:

- Medical Documentation for the date of service that supports your claim such as: Hospital and/or Physician Office Records, Admission and Discharge Summaries, Diagnostic Test Results, Operative or Procedure Reports, Physician Consultation Notes
- **Additional Information (if applicable) including but not limited to:** Accident report, Autopsy report, Toxicology report, Policy or Certificate of Coverage

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

Section 5 – ASSIGNMENT OF BENEFITS – Provide a fully executed assignment:

I would like to assign benefits to □ Funeral Home □ Funding Company □ Other: _____

Name: _____ Telephone #: _____

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

Section 6 – DIRECT DEPOSIT OF BENEFITS– You must attach a copy of a voided, pre-printed check, including:

Account Holder's Name: _____

Bank Name: _____ Bank Phone Number:_____

Bank Address: _____ City, State, Zip:_____

Account Number: _____ Routing Number**:**_____

The financial institution information provided above is complete and accurate. By signing this authorization, I consent for AHL to deposit this claim payment into my bank account.

Signature: _____ Date: _____ Print Name:_____

Section 7 –INTERNAL REVENUE SERVICE REQUIREMENTS: Social security number verification and back up withholding requirements

Tax Payor Identification Number Certification

Federal law requires us to send to the Internal Revenue Service a percentage of any income you may be entitled to unless you certify under penalties of perjury that you have shown your correct Social Security Number and you have not been notified that you are subject to any Internal Revenue Service backup withholding order.

Under penalties of perjury, I certify that:

A. The Social Security Number shown on page 1 is my correct tax payor identification number (or I am waiting for a number to be issued to me), and

B. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) The IRS has notified me that I am no longer subject to backup withholding, and

C. I am a U.S. person (including a U.S. resident alien), and

D. The Foreign Account Tax Compliance Act (FATCA) code entered on this form (if any) indicating that the payee is exempt from FATCA reporting is correct.

The Internal Revenue Service does not require your consent to any provisions of this document other than the certification required to avoid backup withholding.

Claimant Signature: _____ Print Name: _____ Date: _____

Complete Social Security Number/Tax Payor Identification Number: _____

□ Check here if address is new

Address: _____

City: _____ State: _____ Zip: _____ Telephone #: _____

Section 8 –EMPLOYER'S STATEMENT – To be completed and signed by the employer when a claim is filed within the first 2 years of coverage. It is also required for all group coverage and waiver of premium claims.

EMPLOYMENT INFORMATION: Check here if □ Self Employed or □ Unemployed If unemployed, provide last date worked:

Name of employer/company:_____ Date of hire: _____ Weekly earnings: $_____

Employee's job title/position: _____Major job responsibilities: _____

Amount of insurance: Life: $_____ Accidental death and dismemberment: $_____

I hereby certify that _____ last worked on _____.

Was this a work-related condition/injury? □ Yes □ No

Was the employee on leave of absence or lay off when the event occurred □ Yes □ No If yes, why? _____

Was the insurance terminated? □ Yes □ No If yes, when? _____

List Beneficiary(ies) on file (include a copy of beneficiary designation): _____

WAIVER OF PREMIUM CLAIMS: (If applicable): I hereby certify that _____ did not work from _____ through _____. Has the employee returned to work? □ Yes □ No Part time/Partial duties(date): _____ Full time/Full duties(date): _____

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.

Signed by: _____ Print Name: _____ Date: _____

Title: _____ Company: _____

Address: _____ Phone #: _____

Other Comments: _____

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INSURED'S NAME: _____ **CLAIMANT'S NAME:** _____

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

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

Section 9 - CERTIFICATION: The Certificate/Policy 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 false or fraudulent information to obtain or amend insurance coverage or to make a 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 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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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)

_____ _____XXX-XX-_____

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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