ENHANCED GROUP TERM LIFE CLAIM FORM

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 or visit our website at www.allstatebenefits.com

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: **American Heritage Life Insurance Company**
1776 American Heritage Life Drive, Jacksonville, FL 32224
Fax: 1-866-427-3706

The Group Insurance Certificate and a certified copy of death certificate must accompany this form.

SECTION I - CLAIMANT STATEMENT TO BE COMPLETED IN FULL (Please print or type)

1. Employee Name: _____ (Last / First / M.I.)
2. Employee SSN: _____ Date of Birth: _____

1. Deceased Insured Name: _____ (Last / First / M.I.)
2. Insured SSN: _____ Insured Date of Birth: _____ Insured Date of Death: _____
3. Deceased Insured Address: _____ (Street / City / State / Zip)
4. Place of Death: _____ Cause of Death: _____
5. Was death accidental? ☐ Yes ☐ No If yes, date of accident: _____ Did the accident occur on the job? ☐ Yes ☐ No
6. Full name and address of Deceased Insured's personal physician: _____
7. Full name and address of any other doctors who treated the Deceased Insured during the last 5 years:
8. Full name, address and telephone number of the Deceased Insured's employer:
9. Deceased Insured's driver's license #: _____ State of Issue: _____

1. Are you the beneficiary named in the Certificate? ☐ Yes ☐ No
2. What is your relationship to the Deceased Insured? _____
3. What is your Date of Birth? _____ What is your SSN? _____
4. Please print your name in full: _____ (Last / First / M.I.)
5. What is your address? _____ (Street / City / State / Zip)

If this is a dismemberment claim:

1. Date of Accident: _____ Did the accident occur on the job? ☐ Yes ☐ No
2. Describe Accident in Detail: _____
3. What injuries were sustained? _____

Please complete the following information if you would prefer the direct deposit of claim proceeds into your personal bank account: *(Please attach copy of a voided check)*

Bank Name: _____ Bank Telephone No.: _____

Bank Address: _____ City and State: _____

Account No.: _____ Routing No.: _____

CERTIFICATION: Please read and sign below

I acknowledge the receipt of the Fraud Warnings by State provided with this claim packet. I have read the notice for my state 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.

Signature: _____ Print Name: _____ Date: _____

SECTION II – TO BE COMPLETED ONLY IF YOU HAVE ACCIDENTAL DEATH AND DISMEMBERMENT ADDITIONAL BENEFITS AND YOUR EMPLOYER ELECTED ONE OR MORE OF THE FOLLOWING BENEFITS

Following are the additional benefits that may be covered under your Group Term Life Policy. Please check the benefits in which you are requesting. We may ask for additional information from you.

Adult Dependent Care Survivor	☐	Documentation of court appointed guardianship or custodianship, or tax returns showing dependent claimed.
Air Bag Use	☐	Traffic/Accident report.
Carjacking	☐	Incident report or other written proof of carjacking certified by the investigating officer.
Child Care	☐	Proof of child care expenses incurred.
Child Education	☐	Proof of enrollment and tuition expenses (must be provided within 30 days of our request).
Children's Additional Indemnity for Dismemberment	☐	Medical record showing dismemberment.
Common Carrier	☐	Receipt or other proof of fare-paying passenger.
Consolidated Omnibus Budget Reconciliation Act Continuation	☐	Proof that the payment will be used for continuation of the surviving person's medical coverage pursuant to COBRA.
Critical Burn	☐	Medical records showing burns over at least 25% of the body.
Emergency or Disaster Response Team Member	☐	Official documentation of participation as a member of an emergency or disaster response team.
Funeral Expense	☐	Proof of funeral expenses incurred.
Hospital Confinement or Extended Care (monthly)	☐	Bill or medical record showing hospital confinement or extended care.
Hepatitis	☐	Workers' Compensation injury report within 48 hours of the accident and blood test.
Human Immunodeficiency Virus (HIV)	☐	Workers' Compensation injury report within 48 hours of the accident and blood test.
Medical Evacuation Expense	☐	Bill or medical record showing air transport to a medical facility.
Monthly Home Mortgage Payment	☐	Documentation of the eligible loan number and telephone number of the mortgage company.
Rehabilitative Physical Therapy	☐	Proof of the prescribed therapy.
Repatriation Expense	☐	Proof of the preparation and transportation of the body to a mortuary.
Residence or Vehicle Modification	☐	Bill or documentation of modification.
Seat Belt Use	☐	Traffic/Accident report.
Spouse Education	☐	Proof of education expenses for the employee's spouse.
Spouse's Loss of Life as a Result of a Common Accident	☐	Traffic/Accident report.
Therapeutic Counseling	☐	Bill or medical records showing treatment or counseling provided by a licensed therapist or counselor registered or certified to provide psychological treatment of counseling. Notes from counseling session not required.
Total Disability	☐	Attending Physician Statement / Employer Statement.
Total and Permanent Disability (monthly)	☐	Attending Physician Statement / Employer Statement.
Total and Permanent Disability (single payment)	☐	Attending Physician Statement / Employer Statement.
Travel	☐	Proof of travel expenses incurred.
Workplace Felonious Assault	☐	Employer investigative report and police report.

ATTENDING PHYSICIAN'S STATEMENT: To be completed and signed by the Attending Physician.

SECTION #1: DESCRIBE THE CONDITION:

ICD 9/10 Code: _____ Primary Diagnosis: _____

ICD 9/10 Code: _____ Secondary Diagnosis: _____

Other Condition(s): _____

When did **Symptoms** first appear? _____ If applicable, what is the **Accident Date**? _____

Has the patient ever had the **same/similar condition**? ☐ Yes ☐ No When: _____

Is the condition due to **injury or sickness** arising out of the **patient's employment**? ☐ Yes ☐ No

Pregnancy or **Complication of Pregnancy:** Due Date: _____ Delivery Date**:** _____ ☐ Normal Delivery ☐ C-Section

SECTION #2: TREATMENT REQUIRED:

First consultation: _____ Most recent consultation: _____ Next consultation: _____ Released: _____

Is/Was a **Surgical or Medical Procedure** Required? ☐ Yes ☐ No Date: _____ Procedure Code: _____

Procedure: _____

Is/was **Hospitalization** required? ☐ Yes ☐ No Admission Date: _____ Discharge: Date _____

Hospital: _____ City: _____ State: _____

What is the Current **Treatment Plan**? _____

_____

SECTION #3: RESTRICTIONS, LIMITATIONS AND ABILITY TO WORK:

The patient **IS ABLE** to work in the following capacity: ☐ No Work ☐ Sedentary ☐ Light ☐ Medium ☐ Heavy ☐ Very Heavy

The patient **IS UNABLE** to perform their job duties: ☐ Yes ☐ No If Yes: **FROM:** _____ **THROUGH:** _____

When is the patient expected to **RESUME WORK**? **Part Time/Partial Duties**: _____ **Full Time/Full Duties**: _____

Please provide the specific **RESTRICTIONS**: _____

Please provide the specific **LIMITATIONS**: _____

What **CLINICAL** or **DIAGNOSTIC FINDINGS** support these **Restrictions** and **Limitations**? _____

_____

SECTION #4: REFERRING PHYSICIAN:

Name: _____ Specialty: _____

Address: _____ Phone #: _____

SECTION #5: ATTENDING PHYSICIAN VERIFICATION:

Physician Signature: _____ Date: _____

Print Name: _____ Specialty: _____ Phone #: _____

Address: _____

City: _____ State: _____ Zip Code: _____

SECTION #6: CERTIFICATION: Please read and sign below

I acknowledge the receipt of the Fraud Warnings by State provided with this claim packet. I have read the notice for my state 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.

Signature: _____ Print Name: _____ Date: _____

EMPLOYER'S STATEMENT: To be completed and signed by your Employer.

If you are **Self Employed**, please complete and sign this form.
If you are **Unemployed**, please provide the last date you worked, your prior employer's name and sign this form.

SECTION #1: EMPLOYMENT INFORMATION / JOB DESCRIPTION:

Group Policy Number: _____ **Group Policyholder:** _____

Effective Date of Insurance:_____ Present Amount of Insurance: Life $_____ AD&D $_____

Employee Name (Last, First, MI): _____

Date of Hire: _____ **Employee's Job Title/Position**: _____

*Please attach a copy of the job description or list major job responsibilities.

Major Job Responsibilities: _____

This Job **Classification** is: ☐ Sedentary, ☐ Light Work, ☐ Medium Work, ☐ Heavy Work, ☐ Very Heavy Work.

Prior to inability to work, he/she worked _____ hours per week. Hourly Pay: $_____ Annual Salary: $_____

Was the employee on a leave of absence or layoff when the loss occurred? ☐ Yes ☐ No If yes, on what date did the leave of absence or layoff start and for what reason? _____

Was the insurance terminated? ☐ Yes ☐ No If yes, give the date of termination and the reason: _____

_____

Name of Insured Dependent (If Applicable): _____

Effective Date of Dependent Insurance: _____

Please provide any additional information which might assist in consideration of this claim: _____

_____

***If you are self-employed, we may require proof of income. We will notify you if additional documentation is required.**

SECTION #2: DATES MISSED WORK / RETURNED TO WORK:

I hereby certify that _____ **did not perform any part of his/her work from**_____**through** _____.

Has the employee **Returned To Work**? ☐ Yes ☐ No Part time/Partial duties(date): _____ Full time/Full duties(date): _____

Did the employee work part time/partial duty? ☐ Yes ☐ No Dates: _____

Is part time/partial duty work available? ☐ Yes ☐ No Reason: _____

When recovered, will he/she resume work? ☐ Yes ☐ No Reason: _____

SECTION #3: WORKERS' COMPENSATION / OTHER DISABILITY COVERAGE / CONTINUED PAY:

Is this a **Work Related** Condition/Injury? ☐ Yes ☐ No Workers' Compensation Begin Date: _____ End Date: _____

Workers' Compensation Carrier: _____ Benefit Amount: $_____(Monthly/Weekly)

Is the employee covered under any **Other Disability Policy/Coverage** through the Company?* ☐ Yes ☐ No

Other Disability Insurance Carrier: _____ Benefit Amount: $_____(Monthly/Weekly)

Does this policy **Replace** any prior Disability Policy/Coverage through the Company?* ☐ Yes ☐ No

Prior Disability Insurance Carrier: _____ Benefit Amount: $_____(Monthly/Weekly)

Effective Date: _____ Termination Date:_____ Maximum Benefit Period: _____ Elimination Period: _____

*We may require proof of other disability coverage or prior disability coverage for review.

Continued Pay: For Group STD & LTD only: Is the insured receiving Continued Pay, Salary Continuation, Sick or Vacation Pay? ☐ Yes ☐ No

Pay Period From Date	Through Date	Amount	Source of Income

SECTION #4: Section 125 / Employer Paid Premium: If yes, FICA withholding will be deducted from the disability claim payment.

Section 125: Were the **premiums** for this disability income policy/certificate paid with **Pre-Tax Dollars** under a **Section 125 Plan**? ☐ Yes ☐ No

Employer Paid: Were **premiums** for this disability income policy/certificate **Employer Paid**? ☐ Yes ☐ No

SECTION #5: EMPLOYER VERIFICATION: Check here if ☐ **Self Employed** or ☐ **Unemployed**

Signed by: _____ Print Name: _____ Date: _____

Title: _____ Company: _____

Address: _____ Phone #: _____

Other Comments: _____

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Signature: _____ Print Name: _____ Date: _____

ILLINOIS INTEREST STATEMENT: For contracts issued in and residents of Illinois, unless payment is made within thirty-one (31) days from the date of receipt by the company of due proof of loss, interest shall accrue on the proceeds payable because of the death of the insured, from date of death, at the rate of 10% on the total amount payable or the face amount if payments are to made in installments until the total payment or the first installment is paid.

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, 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 ARKANSAS: 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.

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.