



Allstate BENEFITS

American Heritage Life Insurance Company

1776 American Heritage Life Drive
Jacksonville, Florida 32224-6687

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 service department at 1-800-348-4489.

You may fax your claim to us at 1-866-427-3706.

STATEMENT OF CLAIM FOR GROUP LIFE INSURANCE and/or GROUP ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE

RETURN COMPLETED FORM TO
EMPLOYER

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's Name <i>Last First M.I.</i>			2. Employee's Social Security Number		3. Birth Date	4. Date of Death
5. Deceased Dependent's Name <i>Last First M.I.</i>			6. Dependent's Social Security Number		7. Dependent's Birth Date	8. Dependent's Date of Death
9. Deceased's Address: <i>Number/Street City State Zip Code</i>					10. Place of Death	
11. Cause of Death		12. Was death Accidental? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, please answer questions 13 & 14</i>		13. Date of Accident		14. Was Accident a result of employment? <input type="checkbox"/> Yes <input type="checkbox"/> No
15. Are you the beneficiary named in the Certificate? <input type="checkbox"/> Yes <input type="checkbox"/> No		16. What is your relationship to the deceased insured?		17. What is your Date of Birth?		18. What is your Social Security Number?
19. Please print your name in full: <i>Last First M.I.</i>			20. What is your address? <i>Number/Street City State Zip Code</i>			

Complete Questions 21, 22, 23, and 24 if this is a Dismemberment Claim:

21. Date of Accident		22. Was Accident a result of employment? <input type="checkbox"/> Yes <input type="checkbox"/> No	
23. Describe Accident in Detail:			
24. What injuries were sustained?			

SEE FRAUD WARNINGS APPLICABLE TO YOUR STATE ON REVERSE SIDE

I hereby authorize any hospital, practitioner, clinic, or other medically related facility, pharmacy, insurance company or government agency or other person who has attended the deceased to disclose or furnish American Heritage Life Insurance Company, or its designee, any and all medical information with respect to any illness or injury the Insured may have suffered including but not limited to medical history, drug/alcohol abuse, AIDS or AIDS related conditions; or other consultations, prescriptions, diagnosis and treatment; or any information regarding benefits provided, together with copies of all other medical records that may be requested. The information provided to American Heritage Life Insurance Company, or its designee is to be used solely for purposes of evaluating a claim. This Authorization is valid for a period of 24 months from the date signed. I understand that I may revoke this Authorization by notifying American Heritage Life in writing of my desire to do so. A photographic copy of the Authorization shall be as valid as the original, regardless of the date signed. I understand that 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 or its designee.

Signature of Claimant

Date Signed

Signature of Witness in whose presence signed or acknowledged

Date Witnessed

SECTION II – TO BE COMPLETED BY THE EMPLOYER (Continued on reverse side)

1. Group Policy Number		2. Group Policyholder				
3. Employee Name <i>Last First M.I.</i>			4. Date Employed	5. Place Employed (State)	6. Insurance Class	7. Effective Date of Insurance

Allstate Benefits is the marketing name for American Heritage Life Insurance Company (home office: Jacksonville, Florida – www.allstatebenefits.com).

All products are underwritten by American Heritage Life Insurance Company, a wholly-owned subsidiary of The Allstate Corporation (home office: Northbrook, Illinois - allstate.com).

SECTION II – TO BE COMPLETED BY THE EMPLOYER (CONTINUED)

8. Occupation	9. Present Weekly Earnings \$ _____	10. Present Amount of Insurance Life \$ _____ AD&D \$ _____	11. Date Last Worked
12. Was the employee on a leave of absence or lay-off when the loss occurred? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, on what date did the leave of absence or layoff start and for what reason?			
13. Was the insurance terminated? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, give the date of termination and the reason:			
14. Name of Insured Dependent (If Applicable) Last First M.I.			15. Effective Date of Dependent Insurance
16. Please provide any additional information which might assist in consideration of this claim:			
17. List Beneficiary on File (include a copy):			
SEE BELOW FOR FRAUD WARNINGS APPLICABLE TO YOUR STATE			
We hereby certify that the above named employee (or his dependent, if applicable) was insured continuously in accordance with the provisions of the Group Policy from the effective date of the insurance on his life to the date the loss was incurred.			
Date Signed _____ Signed By _____ Title _____ Tel. No. (____) _____ Employer's Authorized Representative			

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.

Beneficiary Information and Instructions for Group Life and Accidental Death Policies

We have prepared these instructions to assist you in filing a claim for death benefits. It is important that we receive all of the information requested.

What documentation do I need to submit?

- **A Certified Death Certificate** – must include a raised seal and cause or manner of death. You obtain a copy from the Vital Records Division of the state in which the Insured passed.
- **A Claimant's Statement** – Section I must be fully completed by each beneficiary and Section II Must be fully completed by the employer. Original signatures are required.
- **A Copy of the Enrollment Form**
- **A HIPAA Authorization**
- Any additional requirements listed below, or required by us.

Special Instructions

- **Accident Policy:** In addition to the documentation listed above, please provide copies of the Fire/Accident Report, final Autopsy Report/Coroner's Report including Toxicology Report (if performed), and any other documentation regarding the accident or incident if available.
- **Minor Beneficiary:** The Claimant's Statement must be completed by the court appointed Legal Conservator/ Guardian of the minor's Estate. A certified copy of Letters of Conservatorship/ Guardianship of the Estate of the minor must accompany this form. If Legal Conservatorship/ Guardianship is not established, the Company will hold the proceeds, at interest, until the minor reaches the age of majority. If the Insured named a Custodian for the minor, under the Uniform Transfers or the Uniform Gifts to Minors Act (UTMA or UGMA), the Custodian may complete the Claimant's Statement.
- **Estate Beneficiary:** The Claimant's Statement must be completed by the court appointed Executor or Administrator of the Estate. The Tax I.D. number for the Estate must be provided on the Claimant Statement and a certified copy of the Letters Testamentary or Letters of Administration must be submitted. Some estates may be administered with the use of a Small Estate Affidavit (or similar procedure). If you are making a claim as an individual under a Small Estate Affidavit (or similar procedure), the person entitled to the benefit pursuant to this procedure should submit fully completed Claimant Statement and provide a copy of the properly executed Affidavit or Order.
- **Contingent Beneficiary:** When the primary beneficiary(ies) has predeceased the Insured, the contingent beneficiary must provide a death certificate for the primary beneficiary(ies).
- **Trust Beneficiary:** The Claimant's Statement must be completed on behalf of the Trust by the designated Trustee(s). If any Trustee fails to make claim for the policy proceeds within 12 months after the Company is notified of the Insured's death, or if the Company receives satisfactory written evidence that the Trust is not in effect, payment will be made as if the Trust was not named as a Beneficiary. Before making payment to any Trust, the Company reserves the right to require satisfactory written evidence that the Trust is in effect and evidence of the identity of the Trustee(s) who are qualified to act on behalf of the Trust.
- **Ex-Spouse of Insured:** Under certain circumstances, state law provides for automatic revocation of a spouse as beneficiary upon divorce. Copies of the Petition for Divorce, any property settlement agreements, and the final Divorce Decree must be submitted.

• **Assignments for Funeral Expenses:** The Claimant's Statement and a signed notarized assignment form (supplied by the funeral home) must be completed by the beneficiary. An itemized copy of the funeral expenses must be provided. A separate check for the amount of the assignment will be mailed directly to the funeral home.

• **Death outside the U.S.:** For U.S. citizens, the official death certificate must be accompanied by a "Consular Report of Death of a U.S. Citizen Abroad" report from the U.S. Department of State, in addition to the other required claim documents.

• If a Power of Attorney completes the Claimant's Statement on behalf of the beneficiary, a copy of the appointment document is required.

• When a class of people (e.g., lawful children) are designated as beneficiaries, a notarized affidavit stating the names, birth dates, social security numbers and residence addresses for all children is required. If any members of the class are deceased, a copy of their death certificate is required.

• When the death has occurred within the first two years of the policy effective date, reinstatement, increase of coverage, or change of class, Part B of the Claimant's Statement must be completed. We may request medical records from medical providers who treated the Insured.

Your claim will receive our immediate attention once this information has been received. If you have any questions regarding your claim or require additional information, please do not hesitate to contact our Customer Care Department at 1-800-348-4489. We are always happy to help you.

Mail all required documents to: American Heritage Life Insurance
ATTN: Life Claims
1776 American Heritage Life Drive
Jacksonville, Florida 32224-6687