



MATERNITY DISABILITY 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: 1-866-424-8482

If you would like to have claim benefits automatically deposited into your bank account, please complete and send our ACH form (ABJ16661). This form can be found on our website at www.AllstateBenefits.com or www.AllstateBenefits.com/mybenefits.

POLICYHOLDER / CERTIFICATEHOLDER INFORMATION:

POLICY NUMBER(s): _____; _____; _____; _____

POLICYHOLDER INFORMATION:

First Name: _____ MI: _____ Last Name: _____

Social Security Number: _____ Date of Birth: ____/____/____ Age: _____ Male Female

Mailing Address: _____ Apt#: _____

Check here if address is new

City: _____ State: _____ Zip: _____

Phone #: _____ E-mail: _____

PATIENT INFORMATION: (If different)

First Name: _____ MI: _____ Last Name: _____

Social Security Number: _____ Date of Birth: ____/____/____ Age: _____ Male Female

Relation to Insured: Self Spouse Child Other

DISABILITY BENEFITS: Please complete the questions below and attach the required documentation for review of your Maternity Disability claim. If additional information is needed, you will be notified. For assistance, please contact our Customer Care Center at 1-800-348-4489.

Is your disability due to Delivery or Complications of Pregnancy?

If Complications of Pregnancy, please list: _____

What is your expected due date: ____/____/____ Delivery Date: ____/____/____ Normal Delivery C-Section

(Expected recovery following delivery is 6 weeks for vaginal delivery & 8 weeks for c-section delivery. This includes the elimination period)

What was the first date you were unable to work? ____/____/____ Have you returned to work? Yes No

Returned Part Time or Partial Duties on: ____/____/____ Returned Full Time or Full Duties on: ____/____/____

PLEASE HAVE YOUR PHYSICIAN COMPLETE AND SIGN THE **MATERNITY ATTENDING PHYSICIAN'S STATEMENT**.

PLEASE HAVE YOUR EMPLOYER COMPLETE AND SIGN THE **EMPLOYER'S STATEMENT**.

CERTIFICATION: 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.**

Patient's Signature: _____ Print Name: _____ Date: ____/____/____

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.

PATIENT'S NAME: _____ Date of Birth: ____/____/____
POLICY NUMBER(S): _____ Claim Number: _____

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

ICD 9/10 Code: _____ Primary Diagnosis: _____
ICD 9/10 Code: _____ Secondary Diagnosis: _____
List any diseases or infirmity affecting the present condition(s): _____
Please list any complications of pregnancy: _____
Recommended restrictions and Limitations: _____
Hospitalization: Admission Date: ____/____/____ Discharge Date: ____/____/____
Hospital: _____ City: _____ State: _____
1st Consult Date for Pregnancy: ____/____/____ **LMP:** ____/____/____ **Expected Due Date:** ____/____/____
Type of Delivery: **Vaginal** **C-Section** **Delivery Date:** ____/____/____
The patient is **UNABLE** to perform their job duties: FROM: ____/____/____ THROUGH: ____/____/____
When is the patient expected to RESUME WORK? Part Time/Partial Duties: ____/____/____ Full Time/Full Duties: ____/____/____
PHYSICIAN VERIFICATION:
Signed: _____, MD Date: ____/____/____
Print Name: _____ Specialty: _____ Phone #: _____
Address: _____
City: _____ State: _____ Zip: _____

EMPLOYER'S STATEMENT: To be completed and signed by your employer, if you are unemployed or self employed please complete and sign this form.

Employment Information/Job Description: If self employed, check this box
Employer/Company Name: _____
Date of Hire: ____/____/____ Employee's Job Title/Position: _____
Please attach a copy of the job description or list major job responsibilities.
Major 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 rate of pay: \$_____ Annual Salary: \$_____
*If you are self employed, we may require proof of income. We will notify you if additional documentation is required.
Dates Missed Work / Returned to Work:
I hereby certify that _____ did not perform any part of his/her work from, ____/____/____ through ____/____/____.
Did the employee work light duty or part time? Yes No If yes, what dates? _____
When recovered, will he/she resume work? Yes No If no, why? _____
Has the employee returned to work? Yes No Part Time/Partial Duties: ____/____/____ Full Time/Full Duties on: ____/____/____
Section 125: Were the premiums for this Policy paid with pre-tax dollars under Section 125? Yes* No
*If yes, FICA withholding will be deducted from the disability claim payment.
EMPLOYER VERIFICATION:
Signed by: _____ Date: ____/____/____ Print Name: _____
Title: _____ Company: _____
Address: _____ Phone #: (____) _____

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.