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: 1-866-427-3693

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 / CERTIFICATE HOLDER / CLAIMANT INFORMATION:

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

POLICYHOLDER / CERTIFICATE HOLDER: _____
First Name MI Last Name

Social Security Number: _____ Date of Birth: _____ Age: _____ ☐ Male ☐ Female

Mailing Address: _____ Apt#: _____

City: _____ State: _____ Zip: _____ ☐ **Check here if address is new**

Phone #: _____ E-mail: _____

Employer: _____ Occupation: _____ Salary: $_____ ☐ Annually ☐ Monthly

Job Responsibilities: _____

Were premiums for this policy paid with pre-tax dollars? ☐ Yes ☐ No (If yes, FICA withholding will be deducted from the disability claim payment.)

CLAIMANT: (if different) First Name: _____ MI: _____ Last Name: _____

Social Security Number: _____ Date of Birth: _____ Age: _____ ☐ Male ☐ Female

Relation to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

DISABILITY CLAIM DETAILS: Please provide the following details regarding your condition and your ability to work.

What is your Diagnosis/Condition? _____

When did you first notice symptoms of your condition? _____ Is your condition work related? ☐ Yes ☐ No

Have you ever had the same or similar condition? ☐ Yes ☐ No If yes, when: _____

Other conditions affecting your health: _____

Is your condition due to an accidental injury? ☐ Yes ☐ No Accident Date: _____ Time: _____ ☐ AM or ☐ PM

How did your accidental injury happen? _____

Was a police report filed? ☐ Yes ☐ No For Motor Vehicle Accidents, you were the: ☐ Driver ☐ Passenger

When was your first physician visit for this condition? _____ Most Recent Visit: _____ Next Visit: _____

Were you hospitalized for your condition? ☐ Yes ☐ No Admission Date: _____ Discharge Date: _____

What was the first date you were unable to work? _____

Describe why you are/were unable to work: _____

What job duties are/were you unable to perform? _____

Have you returned to work? ☐ Yes ☐ No Part time/Partial duties: ___/___/___ Full time/Full duties: ___/___/___

Is your condition Pregnancy? ☐ Yes ☐ No Due Date: _____ Delivery Date: _____

☐ Normal Delivery ☐ C-Section

Are/were there complications of pregnancy? ☐ Yes ☐ No If yes, explain: _____

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.

CLAIMANT'S NAME: _____ **Date of Birth:** _____

POLICY / CERTIFICATE NUMBER(S): _____

PRIOR DISABILITY COVERAGE **Required** We may require proof of prior disability coverage for review.

Did you have prior disability income coverage that was canceled and replaced with this policy? ☐ Yes ☐ No (Provide details below)

Details: Prior Disability Insurance Company Name: _____

Effective Date of Other Coverage: _____ Termination Date of other Coverage (If Applicable): _____

Elimination Period: _____ Benefit Amount: $_____ (Monthly or Weekly) Maximum Benefit Period: _____ (years/months)

OTHER DISABILITY INCOME COVERAGE **Required** Please provide a copy of the approval or denial notification from any other disability income benefits carrier. We may also require proof of the other disability income coverage for review.

Do you have other Disability Income Coverage? ☐ Yes ☐ No (Provide details below.)

Have you applied for Disability Income benefits from another source? ☐ Yes ☐ No (Provide details below)

Are you receiving Disability Income Benefits for any other source? ☐ Yes ☐ No (Provide details below)

Type of coverage: ☐ Social Security Disability Income ☐ Workers' Compensation ☐ Other Disability Coverage ☐ Other: _____

Details: Other Disability Insurance Company Name: _____

Effective Date of Other Coverage: _____ Claim Begin Date: _____ Termination Date of other Coverage (If Applicable): _____

Elimination Period: _____ Benefit Amount: $_____ (Monthly or Weekly) Maximum Benefit Period: _____ (years / months)

DISABILITY POLICY BENEFITS: Please provide the following REQUIRED DOCUMENTATION. *You will be notified if additional information is needed.

☐ **NEW CLAIM** **or** ☐ **CONTINUED CLAIM**

☐ Please complete all sections of the **Disability Benefits Claim form**.

☐ Please have the **Attending Physician's Statement** completed and signed by your Attending Physician.

☐ Please have the **Employer's Statement** completed and signed by your Employer. (If you are self-employed or unemployed, you will need to complete and sign the statement.)

PROVIDERS: Please list all Providers you have seen in the past 2 years including the providers treating you for this Condition.

1. _____ (Attending Physician's Name) _____ (Address) _____ (Phone #)

_____ (Specialty) _____ (Dates Consulted) _____ (Reasons for Visit/Condition)

2. _____ (Primary Care Physician's Name) _____ (Address) _____ (Phone #)

_____ (Specialty) _____ (Dates Consulted) _____ (Reasons for Visit/Condition)

3. _____ (Other Physician/Specialist Name) _____ (Address) _____ (Phone #)

_____ (Specialty) _____ (Dates Consulted) _____ (Reasons for Visit/Condition)

4. _____ (Hospital Name) _____ (Address) _____ (Phone #)

_____ (Dates Hospitalized) _____ (Reason for Hospitalization/Condition)

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.**

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.

CLAIMANT'S NAME: _____ **Date of Birth:** _____

POLICY / CERTIFICATE NUMBER(S): _____

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: 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.

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.

CLAIMANT'S NAME: _____ **Date of Birth:** _____

POLICY / CERTIFICATE NUMBER(S): _____

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:

Name of Employer/Company: _____

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: $_____

***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: Premium: If yes, FICA withholding will be deducted from the disability claim payment.

Pre-Tax Premium: Were the **premiums** for this disability income policy/certificate paid with **Pre-Tax Dollars**? ☐ 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: _____

SECTION #6: CERTIFICATION: 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.

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.

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.

AMERICAN HERITAGE LIFE INSURANCE COMPANY

HOME OFFICE:
1776 AMERICAN HERITAGE LIFE DRIVE
JACKSONVILLE, FLORIDA 32224-6687

AUTHORIZATION TO RELEASE INFORMATION TO AHL

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.

_____ _____
Claimant/Applicant's Signature Date Signed (mm/dd/yyyy)

_____ _____
Claimant/Applicant's Printed Name 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)