Mail To: American Heritage Life Insurance Company • 1776 American Heritage Life Drive • Jacksonville, Florida 32224

CLAIM FORM

1-800-348-4489

8:15 A.M. to 4:30 P.M.
Eastern Standard Time
Toll Free Claims Number

Has a claim been filed before? Yes ☐ No ☐

This claim is for:

- ☐ Accident
- ☐ Individual Disability Income
- ☐ Hospital Income
- ☐ Sickness
- ☐ Group Voluntary Disability

AMERICAN HERITAGE LIFE
A member of the Allstate Group

The furnishings 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.

This report is to be returned to our office at the end of each 30 days disability or immediately if you have returned to work.

PLEASE PRINT CLEARLY AND COMPLETE FORM ENTIRELY IN ORDER TO AVOID A DELAY IN THE PROCESSING OF YOUR CLAIM.

A POLICYHOLDER

Policy Number: _____ Present Occupation: _____

Employer Name (Company/Address) _____

1. Name: First _____ Middle _____ Last _____
   Social Security Number ___ - ___ - ____ Date of Birth ___/___/___ ☐ Male ☐ Female
2. Work Number: ( ) _____ Average Monthly Earnings: _____

PATIENT

3. Name: First _____ Middle _____ Last _____
4. Date of Birth ___/___/___ Age _____ ☐ Male ☐ Female
5. This person is your _____ (example: self, wife, son, etc.) Is he/she a full-time student? ☐ Yes ☐ No

Please attach itemized bill(s), including date of service(s), diagnosis code(s), procedure code(s) and charge(s)

B

6. What sickness or injury are you claiming? _____
7. List all doctors who have treated you for this condition: Name/Address - _____

_____ Phone number: _____

8. Have you received treatment, medication or advice from a doctor in the past for this or a similar condition? _____ Date: _____
   Name: _____ Address: _____
9. Phone number: ( ) _____

IF ACCIDENTAL INJURY

10. (A) Date injured _____ (B) Where did it happen? _____ (C) Time of accident _____ ☐ a.m. ☐ p.m.
11. (D) Tell us exactly how your accident happened: _____

_____

12. (E) ☐ on the job ☐ _____ off the job (F) _____ Did your injuries occur while you were working for pay or profit? _____

If yes, please include a copy of your workers compensation earnings.

C

13. Dates unable to work: _____ ☐ a.m. ☐ p.m. to _____ ☐ a.m. ☐ p.m.
14. Dates confined to your house _____ ☐ a.m. ☐ p.m. to _____ ☐ a.m. ☐ p.m.
15. Have you returned to your main (or principal) duties? Date returned part-time _____ Date returned full-time _____
16. Are you receiving Disability Benefits (Salary Continuation or Sick Pay) from any other source? If "yes," from who? _____
    Please submit a copy of your payment statement with this form.

Important: To avoid delay, please sign authorization below.

Note: Due to Internal Revenue Service requirements concerning social security number verification and backup withholding requirements, this form is required to be completed prior to claim payment. 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. Check to be sure that all information is correct before signing.

1. Section 125: Were the premiums for your **disability income policy** paid with pre-tax dollars under a Section 125 Plan? ☐ Yes ☐ No ***(if in doubt - please ask your employer)***

1a. 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:
1. The Social Security Number shown in line (1) is correct, and
2. ☐ I have ☐ I have not been notified by the Internal Revenue Service that I am subject to backup withholding order.

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medically related facility, insurance company or other organization, institution or person that has any records or knowledge of me (or my dependents) to give such information to American Heritage Life Insurance Company or its designee. A photographic copy of this authorization shall be as valid as the original, regardless of date signed.

Sign here _____
Claimant

Date: _____ ☐ Check here if address is new

Street Address: _____

_____

City: _____

State: Zip: _____

Telephone number ( ) _____

ATTENDING PHYSICIAN'S STATEMENT

INDIVIDUAL INSURANCE for: ☐ Accident ☐ Individual Disability Income ☐ Sickness ☐ Group Voluntary Disability ☐ Hospital Income

Patient's Name _____ Age _____

1. Diagnosis: (Describe complications if any) Is condition due to pregnancy? ☐ Yes ☐ No. _____

   If "yes," what was approximate date of commencement of pregnancy? Date - MO/DAY/YR: _____
2. When did symptoms first appear or accident happen? Date - MO/DAY/YR: _____
3. When did patient first consult you for this condition? Date - MO/DAY/YR: _____
4. Has patient ever had same or similar condition? (If "yes," state when and describe) ☐ Yes ☐ No _____
5. Describe any other diseases or infirmity affecting present condition. _____
6. Nature of surgical or obstetrical procedure, if any (describe fully). _____

   Charge for this procedure and where performed? $ _____ Date - MO/DAY/YR: _____

   _____ If in hospital, ☐ in patient ☐ outpatient
7. Is patient still under your care for this condition? ☐ Yes ☐ No

   If discharged give date _____ Date - MO/DAY/YR: _____
8. If patient hospitalized, give name and address of hospital.

   Hospital: _____ City: _____ State: _____

   Date admitted - MO/DAY/YR: _____ Date discharged - MO/DAY/YR: _____
9. How long was or will patient be continuously totally disabled (unable to work) From Date - MO/DAY/YR: _____ through _____
10. If still disabled, when do you expect patient to resume full duties? _____
11. Is condition due to injury or sickness arising out of patient's employment? ☐ Yes ☐ No

    If "yes," explain. _____
12. Name and address of referring physician if any

    Name _____ Address _____

    City _____ State _____ Zip _____

EMPLOYER'S STATEMENT

1. I hereby certify that _____ did not perform any part of his/her work from, _____
   to, _____ _____
2. When recovered, will he/she resume work? _____ If not why? _____ _____
3. Is this a Workers' Compensation case? _____ Date Worker's Compensation benefits began _____
   Name of Company _____
4. Section 125: Were the premiums for our disability income policy paid with pre-tax dollars under a Section 125 Plan? ☐ Yes ☐ No

Remarks _____

_____

Name of Employer _____ Date _____ Address _____

By _____ Official Position _____ Telephone number ( ) _____