

**AMERICAN HERITAGE LIFE INSURANCE COMPANY**  
**ACCIDENT COVERAGE WITH OPTIONAL RIDERS CLAIM FORM**

Submit Claims to:

American Heritage Life Insurance Company  
1776 American Heritage Life Drive, Jacksonville, FL 32224

**Phone 1-800-521-3535 Fax 1-866-424-8482 or visit our website at [www.allstatebenefits.com/mybenefits](http://www.allstatebenefits.com/mybenefits)**

For questions regarding the policy benefits, the supporting documentation, or for assistance with a claim, please contact our **Customer Care Center at 1-800-348-4489 or visit our website at [www.allstatebenefits.com](http://www.allstatebenefits.com).**

To have claim benefits automatically deposited into the Policy/Certificate Holder's bank account, please complete and send our Direct Deposit form (ACH form). This form can be found on our website at [www.allstatebenefits.com](http://www.allstatebenefits.com) or [www.allstatebenefits.com/mybenefits](http://www.allstatebenefits.com/mybenefits).

This form is designed as a communication tool to assist the examiner in reviewing the claim for available benefit. Please complete this form in its totality and complete one form per claimant.

**Incomplete or blank responses may result in a delay in processing the claim request.**

**POLICY/CERTIFICATE HOLDER AND CLAIMANT INFORMATION:** This information helps us to identify the policy, covered members, mailing address and employer to ensure benefits are being considered under the correct Coverage.

**COVERAGE NUMBER(S):** \_\_\_\_\_

**POLICY/CERTIFICATE HOLDER INFORMATION:**

First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Last Name: \_\_\_\_\_

Last 4 of Social Security #: XXX-XX- \_\_\_\_\_ Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ Apt#: \_\_\_\_\_  **Check here if address is new**

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone #: \_\_\_\_\_ E-mail: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

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 INFORMATION:** (If different)

First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Last Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_ Relation to Insured:  Self  Spouse  Child  Domestic Partner  Other \_\_\_\_\_

**CLAIM DETAILS:** Please provide the following claim details. This information is very important as it tells the examiner the specific details of the claim and helps the examiner determine whether benefits are available. The Diagnosis/Condition is the condition that was diagnosed by the physician.

**Accident Claim** and/or  **Accidental Death Claim**

What are the Diagnoses/Condition(s) for this claim? (List all): \_\_\_\_\_

Is the condition due to an Accidental Injury?  Yes  No Accident Date: \_\_\_\_\_ Time: \_\_\_\_\_ AM or PM

What was the Accident or Event? \_\_\_\_\_

What was the Injury? \_\_\_\_\_  Right side /  Left side

Where did the Accidental Injury happen? \_\_\_\_\_

Tell us exactly how the Accidental Injury happened: \_\_\_\_\_

Has the claimant ever had the same or similar condition?  Yes  No If yes, when? \_\_\_\_\_

Other conditions affecting the claimant's health: \_\_\_\_\_

Was a Police or Traffic Report filed?  Yes  No (If yes, please provide.) For Motor Vehicle Accidents, the claimant was the:  Driver  Passenger

Is the condition Work Related?  Yes  No (If yes, provide Workers' Compensation Approval or Denial)

Was initial treatment provided in the  Hospital ER,  Urgent Care Center,  Physician's Office, or  Chiropractor's office?

When was the first physician visit for this Accidental Injury? \_\_\_\_\_ Most Recent Visit: \_\_\_\_\_ Next Visit: \_\_\_\_\_

Was the claimant hospitalized due to this Accidental Injury?  Yes  No Admission Date: \_\_\_\_\_ Discharge Date: \_\_\_\_\_

Did the claimant miss work due to this Accidental Injury?  Yes  No If yes, what is/was the first date work was missed? \_\_\_\_\_

Has the claimant returned to work?  Yes  No Part time/Partial duties: \_\_\_\_\_ Full time/Full duties: \_\_\_\_\_

Did the Accidental Injury result in Death?  Yes  No If yes, Date of Death: \_\_\_\_\_ Cause of Death: \_\_\_\_\_

Is the claimant covered by Medicaid?  Yes  No If yes, please provide a copy of the Medicaid Explanation of Benefits (EOB) and the Medicaid Number: \_\_\_\_\_

Please be advised if the claimant is covered by Medicaid, we may be required to Assign Benefits to Medicaid or the provider of service in accordance with State and Federal Regulations.

**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.**

**AMERICAN HERITAGE LIFE INSURANCE COMPANY**  
**ACCIDENT COVERAGE WITH OPTIONAL RIDERS CLAIM FORM**

**CLAIMANT'S NAME:** \_\_\_\_\_ **DATE OF BIRTH:** \_\_\_\_\_  
**COVERAGE NUMBER(S):** \_\_\_\_\_ **CLAIM NUMBER:** \_\_\_\_\_

**INSTRUCTIONS FOR REQUESTING AVAILABLE BENEFITS:**

- Benefits may vary by product and/or state. In addition, all the available Riders may not have been purchased and/or all the benefits listed may not be available. Please refer to the Coverage Document and Riders for specific benefits available. An outline of benefits is available on page 3 of the Coverage Document.
- Available benefits are considered in accordance with your specific Coverage, including all terms, conditions, provisions and applicable limitations and exclusions.
- Please select the benefits that may be due based upon the Claimant's Accidental Injury, services provided, and Coverages available.
- Please submit the supporting documentation. This documentation should include the claimant's name, diagnosis, and date(s) of service.
- If asked to provide a bill as supporting documentation, please request an itemized bill, UB04 or HCFA 1500 from the provider.
- Medical records may include but are not limited to: physician's office visit notes, hospital records, emergency room records, diagnostic test results, radiology reports, therapy visit notes, or physician consultation notes.
- We reserve the right to request additional information for review of the claim.

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

**ACCIDENT COVERAGE & RIDER BENEFITS:** These benefits are for the treatment of an Accidental Injury. All benefits listed may not be available. Please refer to the Coverage Document and Riders for specific benefits available.

BENEFIT (IF APPLICABLE)	SUPPORTING DOCUMENTATION
<input type="checkbox"/> <b>Medical Expenses</b>	Bills (including Diagnosis) documenting Expenses incurred for Treatment
<input type="checkbox"/> <b>Accident Physician Treatment</b> <input type="checkbox"/> <b>Emergency Room</b> <input type="checkbox"/> <b>Urgent Care</b> <input type="checkbox"/> <b>X-Ray Benefit</b>	Bills (including Diagnosis) or Medical Records documenting the listed Treatment/Testing
<input type="checkbox"/> <b>Ambulance</b>	Bill or Medical Records documenting an Ambulance Transfer <input type="checkbox"/> Air or <input type="checkbox"/> Ground
<input type="checkbox"/> <b>Initial Hospitalization</b> <input type="checkbox"/> <b>Daily Hospital Confinement</b> <input type="checkbox"/> <b>Extended Hospital Confinement</b> <input type="checkbox"/> <b>Sickness Hospital Confinement</b>	Inpatient Hospital Bill including Diagnosis and Room and Board Charges or Admission and Discharge Summaries (Hospitalization must be 24 hours or greater and supporting document needs to include the number of hours or the Admission and Discharge times.)
<input type="checkbox"/> <b>Hospital Intensive Care</b>	Inpatient Hospital Bill (including Diagnosis) and Intensive Care Room and Board Charges
<input type="checkbox"/> <b>Fracture</b>	Radiology Report or Medical Records showing a covered Fracture: <input type="checkbox"/> Femur (Thighbone) <input type="checkbox"/> Skull (except Face or Nose) <input type="checkbox"/> Pelvis (except Coccyx) <input type="checkbox"/> Upper Arm (Humerus) <input type="checkbox"/> Shoulder Blade (Scapula) <input type="checkbox"/> Lower Leg (Tibia/Fibula) <input type="checkbox"/> Ankle <input type="checkbox"/> Knee Cap (Patella) <input type="checkbox"/> Collar Bone (Clavicle) <input type="checkbox"/> Forearm (Radius/Ulna) <input type="checkbox"/> Foot (except Toes) <input type="checkbox"/> Hand or Wrist (except Fingers) <input type="checkbox"/> Lower Jaw (except Alveolar Process) <input type="checkbox"/> Two or more Ribs, Fingers, or Toes <input type="checkbox"/> Bones of Face or Nose <input type="checkbox"/> One Rib, One Finger or One Toe <input type="checkbox"/> Coccyx
<input type="checkbox"/> <b>Dislocation</b>	Radiology Report or Medical Records showing a covered Dislocation: <input type="checkbox"/> Hip Joint <input type="checkbox"/> Knee Joint (except Patella) <input type="checkbox"/> Bone or Bones of the Foot (except Toes) <input type="checkbox"/> Ankle Joint <input type="checkbox"/> Wrist Joint <input type="checkbox"/> Elbow Joint <input type="checkbox"/> Shoulder Joint <input type="checkbox"/> Bone or Bones of the Hand, other than Fingers <input type="checkbox"/> Collar Bone <input type="checkbox"/> Two or more Fingers <input type="checkbox"/> Two or more Toes <input type="checkbox"/> One Finger or One Toe
<input type="checkbox"/> <b>Dismemberment</b>	Operative Report or Medical Records showing covered Dismemberment: <input type="checkbox"/> Both Eyes <input type="checkbox"/> One Eye <input type="checkbox"/> Both Hands or Both Arms <input type="checkbox"/> Both Feet or Both Legs <input type="checkbox"/> One Hand or Arm & One Foot or Leg <input type="checkbox"/> One Hand or One Arm <input type="checkbox"/> One Foot or One Leg <input type="checkbox"/> One or more Entire Toes <input type="checkbox"/> One or more Entire Fingers
<input type="checkbox"/> <b>Functional Loss</b>	Documentation of Complete Loss of Hearing and/or Speech
<input type="checkbox"/> <b>Accident Disability Income</b> <input type="checkbox"/> <b>Extended Accident Disability Income</b> <input type="checkbox"/> <b>Sickness Disability Income</b>	<input type="checkbox"/> Physician Statement completed by physician; and <input type="checkbox"/> Employer's Statement completed by employer
<input type="checkbox"/> <b>Accidental Death</b> <input type="checkbox"/> <b>Common Carrier Accidental Death</b>	<input type="checkbox"/> Statement of Claim / Completed Claim Form; and <input type="checkbox"/> Certified Copy of Death Certificate If available, please provide: <input type="checkbox"/> Accident Report <input type="checkbox"/> Autopsy Report <input type="checkbox"/> Toxicology Report
<input type="checkbox"/> <b>Outpatient Physician's Treatment Benefit</b>	Bill or Documentation of Treatment provided by a Physician, outside of the hospital Reason for the Physician Treatment/Examination: <input type="checkbox"/> <b>Accident</b> <input type="checkbox"/> <b>Illness</b> <input type="checkbox"/> <b>Well/Preventative Exam</b>

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**CLAIMANT'S NAME:** \_\_\_\_\_ **DATE OF BIRTH:** \_\_\_\_\_  
**COVERAGE NUMBER(S):** \_\_\_\_\_ **CLAIM NUMBER:** \_\_\_\_\_

**ACCIDENT COVERAGE & RIDER BENEFITS: (Continued)** These benefits are for the treatment of an accidental injury. All benefits listed may not be available. Please refer to the Coverage Document and Riders for specific benefits available.

BENEFIT (IF APPLICABLE)	SUPPORTING DOCUMENTATION
<input type="checkbox"/> Strike or <input type="checkbox"/> Recurrent Strike	Proof of Strike from Employer or Union
<input type="checkbox"/> Layoff or <input type="checkbox"/> Recurrent Layoff	Written confirmation of Layoff from the Employer

**ACCIDENT ENHANCEMENT RIDER BENEFITS:** These benefits are for the treatment of an Accidental Injury All benefits listed may not be available. Please refer to the Coverage Document and Riders for specific benefits available.

BENEFIT (IF APPLICABLE)	SUPPORTING DOCUMENTATION
<input type="checkbox"/> Accident Follow Up Treatment <input type="checkbox"/> Physical Therapy <input type="checkbox"/> Occupational or Speech Therapy	Bill with Diagnosis or Visit Notes showing follow up Physician Treatment provided in the Physician's Office Bill with Diagnosis or Visit Notes showing Therapy provided by a Licensed Therapist (Some Coverages only provide a Physical Therapy Benefit)
<input type="checkbox"/> Hospital Admission	Inpatient Hospital Bill or Medical Records showing Inpatient Hospitalization (Room and Board Charges) This Benefit is for Coverage in force greater than 12 months.
<input type="checkbox"/> Rehabilitation Unit	Bill or Medical Records for Inpatient Rehabilitation immediately following Inpatient Hospitalization
<input type="checkbox"/> CT or MRI <input type="checkbox"/> Medicine (Prescription or Over the Counter) <input type="checkbox"/> Medical Supplies <input type="checkbox"/> Pain Management (Epidural Injection) <input type="checkbox"/> Blood and Plasma (Transfusion)	Bill with Diagnosis or Medical Records showing the listed Treatment or Testing Provided
<input type="checkbox"/> Laceration	Bill or Medical Records showing a Laceration (a Deep Cut)
<input type="checkbox"/> Brain Injury Diagnosis	CT, MRI, EEG, PET scan, X-Ray report or Medical Records showing a Concussion, Cerebral Laceration, Cerebral Contusion or Intracranial Hemorrhage
<input type="checkbox"/> Coma with Respiratory Assistance	Medical Records documenting a Coma lasting 7 or more days which requires Intubation for Respiratory Assistance and is Characterized by the Absence of Spontaneous Eye Movements, Response to Painful Stimuli, and Vocalization Medically Induced Comas are Excluded
<input type="checkbox"/> Paralysis	Medical Records documenting Complete and Permanent Loss (Paralysis) of 2 or more Limbs
<input type="checkbox"/> Burn	Medical Records documenting a 2 <sup>nd</sup> or 3 <sup>rd</sup> degree Burn
<input type="checkbox"/> Broken Tooth	Medical Records showing the Broken Tooth was Sound and Natural and the Fracture was Independent of Disease, Bodily Infirmary or Any Other Cause
<input type="checkbox"/> Appliance	Bill or Medical Record showing a Prescription for a covered Appliance: Crutches, Walker or Wheelchair
<input type="checkbox"/> Prosthesis	Bill or Medical Record showing a Prescription for a Covered Prosthesis: Arm, Leg, Hand, Foot or Eye
<input type="checkbox"/> Tendon, Ligament, Rotator Cuff or Knee Cartilage Surgery	Operative Report showing the Surgical Repair or Exploration of a Torn, Ruptured or Severed Tendon, Ligament, Rotator Cuff, or Knee Cartilage
<input type="checkbox"/> Ruptured Disc Surgery	Operative Report showing the Surgical Repair of a Ruptured Disc (Herniated Disc)
<input type="checkbox"/> Open Abdominal or Thoracic Surgery <input type="checkbox"/> Eye Surgery (or Removal of a Foreign Body) <input type="checkbox"/> Skin Graft (Due to a Covered Burn)	Operative Report showing the Listed Surgery provided
<input type="checkbox"/> Miscellaneous Outpatient Surgery	Bill or Medical Record Documenting Outpatient Surgery
<input type="checkbox"/> General Anesthesia	Bill or Operative Report showing General Anesthesia for a Covered Surgery
<input type="checkbox"/> Non-Local Transportation <input type="checkbox"/> Family Member Lodging	Documentation of Non-Local Transportation 50 or 100 miles or more (policy/certificate specific) for Services Not Available Locally Bills for Family Member Lodging (Some Coverages require approval of the Non-Local Transportation Benefit for this Benefit to be Payable)
<input type="checkbox"/> Post Accident Transportation	Receipt for Common Carrier Transportation (Plane, Train, or Bus) of 250 miles or more to the claimant's Residence. This transportation must be within 48 hours of a 3-day covered Hospitalization
<input type="checkbox"/> Residence/Vehicle Modification	Physician Certification of Permanent Residence or Vehicle Modification

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**COVERAGE NUMBER(S):** \_\_\_\_\_ **CLAIM NUMBER:** \_\_\_\_\_

**PROVIDERS:** Please list all Providers the claimant has seen in the past 2 years including the providers treating this Condition.

1.	_____	_____	_____
	<b>Attending Physician's Name:</b>	Address:	Phone #:
	_____	_____	_____
	Specialty	Dates Consulted:	Reason for Visit / Condition
2.	_____	_____	_____
	<b>Primary Care Physician's Name:</b>	Address:	Phone #:
	_____	_____	_____
	Specialty	Dates Consulted	Reason for Visit / Condition
3.	_____	_____	_____
	<b>Other Physician/ Specialist Name:</b>	Address:	Phone #:
	_____	_____	_____
	Specialty	Dates Consulted	Reason for Visit / Condition
4.	_____	_____	_____
	<b>Hospital Name:</b>	Address	Phone #:
	_____	_____	_____
	Dates Hospitalized:	Reason for Hospitalization / Condition:	

**ASSIGNMENT OF BENEFITS (Not applicable in New Hampshire)**

I request that American Heritage Life Insurance Company send benefits to someone other than me. Please send available benefits to the name and address shown below.\*

Name: \_\_\_\_\_ Address: \_\_\_\_\_  
Provider Tax ID #: \_\_\_\_\_  
Relationship: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

\*Please be advised that if the claimant is covered by MEDICAID, we may be required to Assign Benefits (except disability) to Medicaid or the provider of service in accordance with State and Federal Regulations.

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**COVERAGE NUMBER(S):** \_\_\_\_\_ **CLAIM NUMBER:** \_\_\_\_\_

**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 was the Accident Date? \_\_\_\_\_  
Has the patient ever had the same/similar condition?  Yes  No If yes, 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:** Please provide specific details/dates and understand responses such as "no work", "totally disabled", "undetermined" or "unknown" will not enable us to evaluate your patient's claim for benefits and may result in us having to contact you for clarification

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, (Dates): FROM: \_\_\_\_\_ THROUGH: \_\_\_\_\_  
When is the patient expected to **RESUME WORK?** (Dates) Part Time/Partial Duties: \_\_\_\_\_ Full Time/Full Duties: \_\_\_\_\_  
The patient **IS UNABLE** to:  Stand \_\_\_Hours;  Sit \_\_\_Hours;  Walk \_\_\_Hours;  Lift \_\_\_Pounds;  Carry \_\_\_Pounds;  Drive \_\_\_Hours;  
 Type;  Reach  Kneel  Squat  Climb  Crawl  
Please provide the specific **RESTRICTIONS:** \_\_\_\_\_  
Please provide the specific **LIMITATIONS:** \_\_\_\_\_  
The Restrictions and Limitations are:  Temporary: (How long? \_\_\_\_\_) or  Permanent  
What **CLINICAL** or **DIAGNOSTIC FINDINGS** support these Restrictions and Limitations? \_\_\_\_\_  
\_\_\_\_\_

**SECTION #4: REFERRING PHYSICIAN:**

Name: \_\_\_\_\_ Specialty: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone #: \_\_\_\_\_

**SECTION #5: ATTENDING PHYSICIAN VERIFICATION:**

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 form are true, complete and correctly recorded.

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Print Name: \_\_\_\_\_ Specialty: \_\_\_\_\_ Phone #: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

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**CLAIMANT'S NAME:** \_\_\_\_\_ **DATE OF BIRTH:** \_\_\_\_\_  
**COVERAGE NUMBER(S):** \_\_\_\_\_ **CLAIM NUMBER:** \_\_\_\_\_

**EMPLOYER'S STATEMENT: To be completed and signed by the Employer**

- Check here if you are Self Employed, then complete and sign this form.  
 Check here if you are Unemployed. Please provide the last date you worked \_\_\_\_\_ and prior employer's name then 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, they 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: Group Short Term Disability and Long Term Disability only:**

Is the insured receiving Continued Pay, Salary Continuation, Sick or Vacation Pay?  Yes  No

<u>Pay Period From Date</u>	<u>Through Date</u>	<u>Amount</u>	<u>Source of Income</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**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

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 form are true, complete and correctly recorded.

Signed by: \_\_\_\_\_ Print Name: \_\_\_\_\_ Date: \_\_\_\_\_  
 Title: \_\_\_\_\_ Company: \_\_\_\_\_  
 Address: \_\_\_\_\_ Phone #: \_\_\_\_\_  
 Other Comments: \_\_\_\_\_

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**AMERICAN HERITAGE LIFE INSURANCE COMPANY**  
ACCIDENT COVERAGE WITH OPTIONAL RIDERS CLAIM FORM

CLAIMANT'S NAME: _____	DATE OF BIRTH: _____
COVERAGE NUMBER(S): _____	CLAIM NUMBER: _____

**AUTHORIZATION TO RELEASE INFORMATION TO AMERICAN HERITAGE LIFE INSURANCE COMPANY**

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.

Claims submitted on dependents 18 and older require an authorization signed by the dependent.

\_\_\_\_\_  
Claimant/Applicant's Signature

\_\_\_\_\_  
Date Signed (mm/dd/yyyy)

\_\_\_\_\_  
Claimant/Applicant's Printed Name

\_\_\_\_\_  
XXX-XX-\_\_\_\_\_  
Last Four Digits of 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)

**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.**

**AMERICAN HERITAGE LIFE INSURANCE COMPANY**  
ACCIDENT COVERAGE WITH OPTIONAL RIDERS CLAIM FORM

<b>CLAIMANT'S NAME:</b> _____	<b>DATE OF BIRTH:</b> _____
<b>COVERAGE NUMBER(S):</b> _____	<b>CLAIM NUMBER:</b> _____

**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 a false or fraudulent claim for 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 and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and 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.

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