



CLAIM FORM AND INSTRUCTIONS

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

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.

INSTRUCTIONS FOR FILING ACCIDENT INCLUDING POLICY RIDERS/ DISABILITY/ WAIVER OF PREMIUM CLAIMS

- To avoid delays in processing please fill out the sections which apply to your specific claim.
- Include your policy number(s). To obtain your policy number call 1-800-348-4489.
- You may fax your claim to us at 1-888-424-8482. Please be assured that your claim will receive our prompt attention. If you would like to receive your claim proceeds even faster, Allstate Benefits can automatically deposit them into your bank account by completing and returning our ACH form (ASJ16961). This form can be found on our website at www.AllstateBenefits.com or electronically at www.AllstateBenefits.com/mybenefits. Additional claim forms are available on our website.
- You may mail your claim to:
American Heritage Life Insurance Company
P.O. Box 43067
Jacksonville, Florida 32203-3067
- If you are filing a claim within the first 24 months your policy is in force, additional information may be required.

POLICYHOLDER / CERTIFICATEHOLDER

Employer Name (Company/Address): _____ Occupation: _____

1. Policyholder's Name: First: _____ Middle: _____ Last: _____
Policy Number(s): 1) _____ 2) _____
Social Security Number: _____ Date of Birth: ____/____/____ ☐ Male ☐ Female

2. Home Number: (____) _____ Avg. Monthly Earnings: _____ E-mail: _____

PATIENT'S INFORMATION

3. Name: First: _____ Middle: _____ Last: _____

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

5. This person is your: _____ (ex: self, wife, son, etc.)

☐ FIRST CLAIM

☐ CONTINUED CLAIM

☐ ACCIDENT/DISABILITY Policy No.(s): _____

☐ Accident ☐ Outpatient Physicians Rider ☐ Waiver of Premium ☐ Benefit Enhancement Rider

☐ Disability ☐ Hospital Rider ☐ Routine Pregnancy

INSTRUCTIONS FOR FILING ACCIDENT CLAIMS

We need:

- ☐ (For Puerto Rico residents only) A copy of the Explanation of Benefits (EOB) from your health insurance carrier, if applicable, if this claim is for an emergency room visit.
- ☐ A copy of the hospital bill. Please make sure the bill includes your diagnosis and the number of days you were in the hospital. If you were treated in the emergency room or a doctor's office, please include a copy of these bills also.
- ☐ Attending Physician's Statement should be completed and signed by your doctor

We may also need:

- ☐ A copy of the accident report if the accident was investigated by the police or sheriff.
- ☐ A copy of the blood alcohol report or drug screening if the patient was tested for alcohol or drugs.
- ☐ A certified copy of the death certificate if the patient is deceased.

ACCIDENT POLICY CLAIMS

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

DATE OF ACCIDENT: ____/____/____ Time of accident: _____ ☐ a.m. ☐ p.m.
Where did it happen? _____ Tell us exactly how your accident/injury happened: _____

Did your injuries occur while you were working for pay or profit? ☐ Yes ☐ No ☐ On the job ☐ Off the job
Have you ever had a similar injury? _____ If so, please tell us when: ____/____/____

If you are claiming disability due to your accident, please have your physician complete the ATTENDING PHYSICIAN STATEMENT and your employer complete the EMPLOYER'S STATEMENT.

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David Kirk

A red circular graphic with a gradient, appearing as a partial circle or a thick arc, located to the right of the David Kirk text bar.

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