Workplace Division

CLAIM FORM AND INSTRUCTIONS

If you have any questions regarding our determination of 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 CANCER / SPECIFIED DISEASE / ICU / HEART / STROKE CLAIMS

- To avoid processing delays, please fill out the sections which apply to your specific claim.
- Include your policy number(s). To obtain your policy number(s) call **1-800-348-4489**.
- You may **fax** your claim to us at **1-972-510-1773**. Please be assured that your claim will receive our immediate attention. You will usually receive a response from us in the mail within 10 business days following the receipt of your claim. The length of time in the mail will depend on your location.
- You may mail your claim to: **American Heritage Life Insurance Company**
  P.O. Box 43067
  Jacksonville, Florida 32203-3067
- Additional claim forms are available on our website at www.allstateatwork.com.
- If you are filing a claim within the first 24 months your policy is in force, additional information may be required.

POLICYHOLDER

Employer Name (Company): NC FLEX - 83126 ______________ Occupation: ______________

1. Policyholder's Name: First: __________ Middle: __________ Last: ______________

   E-mail: ______________ **Policy Number:** ______________

   Social Security Number: __________ Date of Birth: ____/____/____ (MO/DAY/YR) ☐ Male ☐ Female

2. Home Number: (____) ______________

PATIENT'S INFORMATION

3. Name: First: __________ Middle: __________ Last: ______________
4. Date of Birth: ____/____/____ (MO/DAY/YR) Age: ______ Social Security Number: __________ ☐ Male ☐ Female
5. This person is your: __________ (ex: self, wife, son, etc.) Is he/she a full-time student? ☐ Yes ☐ No
   If yes, please submit proof of student status.

INSTRUCTIONS FOR FILING CANCER, SPECIFIED DISEASE, INTENSIVE CARE, AND HEART / STROKE CLAIMS

CANCER CLAIMS:

- ☐ A pathology report diagnosing cancer **must** accompany your first claim for that diagnosis of cancer. (The hospital or doctor will furnish this report to you at your request.) If the diagnosis of cancer was made by clinical information instead of pathological means, please submit the clinical evidence that established a positive diagnosis of cancer.
- ☐ Include a copy of your itemized hospital billing if you were hospitalized.
- ☐ Have the doctor complete **Attending Physician's Statement** and attach an itemized billing showing the diagnosis, services provided and the actual charges made to you.
- ☐ Any other bills pertaining to this claim, such as anesthesia, chemotherapy or radiation treatments, ambulance, lodging, or travel, may be forwarded to this office.
- ☐ *Transportation and Lodging* - Please review your policy to determine what expenses are covered. Send us a statement detailing your transportation and lodging expenses. This information should include mileage, where you traveled from and to, lodging receipts and medical verification of treatment for this time.

SPECIFIED DISEASE:

- ☐ The results of tissue specimen, culture(s) and/or titer(s) or other diagnostic studies, which initially diagnosed the specified disease, must accompany your first claim. Include a copy of your itemized hospital billing and **Attending Physician's Statement.**

HOSPITAL INCOME AND INTENSIVE CARE CLAIMS:

- ☐ Please send a copy of your hospital bill showing charges and number of days in the intensive care unit.
- ☐ If the hospital bill fails to give the diagnosis, **Attending Physician's Statement** must be completed by the doctor.
- ☐ A copy of the police report is required for all accidents investigated by any law enforcement agency.

HEART STROKE CLAIMS:

- ☐ Submit diagnostic test result showing a diagnosis of disease of the heart, heart attack or stroke.

INSTRUCTIONS FOR FILING TRANSPORTATION AND LODGING CLAIMS:

- ❑ Please attach receipts for lodging and transportation (common carrier).

TRANSPORTATION AND LODGING

Name of Patient: ______ Condition Treated: ______

Dates of Travel: ______ Dates of Lodging: ______

Home Address: ______ Location of Treatment: ______

ATTENDING PHYSICIAN'S STATEMENT

Patient's Name: ______ Age: ______

1. Diagnosis: ______
2. If condition is due to pregnancy, what is expected delivery date? Date ___/___/___ MO/DAY/YR
3. When did symptoms first appear or accident happen? Date ___/___/___ MO/DAY/YR
4. When did patient first consult you for this condition? Date ___/___/___ MO/DAY/YR
5. Has patient ever had same or similar condition? (If "yes," state when and describe.) ❑ Yes ❑ No ______
6. Describe any other diseases or infirmity affecting present condition. ______
7. Nature of surgical or obstetrical procedure, if any (describe fully). ______
8. Is patient unable to perform job duties? ❑ Yes ❑ No If yes, from ______ through ______

9a. What specific job duties is patient unable to perform? ______

9b. Specific RESTRICTIONS (What the patient should not do and why). Please quantify in hours, weight, etc. ______

9c. Specific LIMITATIONS (What the patient cannot do and why). ______

10. If retired or unemployed which activities of daily living (ADLs) is patient unable to perform? ______
11. Date patient last examined by you: ______ Frequency of visits: ❑ weekly ❑ monthly ❑ other______
12. Is patient: ❑ ambulatory ❑ bed confined ❑ house confined ❑ other______
13. If patient is hospitalized, give name and address of hospital.
    Hospital: ______ City: ______ State: ______

14a. Date admitted: ___/___/___ MO/DAY/YR Date discharged: ___/___/___ MO/DAY/YR

14b. When do you expect patient to resume partial duties? ___/___/___ MO/DAY/YR Full duties? ___/___/___ MO/DAY/YR

14c. If patient is unemployed or retired, on what date would you expect a person of like age, gender and good health to resume his/her normal and necessary activities? ___/___/___ MO/DAY/YR

15. Is condition due to injury or sickness arising out of patient's employment? ❑ Yes ❑ No
    If "yes," explain. ______
    Name and address of referring physician if any.
    Name: ______ Address: ______
    City: ______ State: ______ Zip ______
16. Have you completed paperwork for any other insurance company? ❑ Yes ❑ No Social Security Disability? ❑ Yes ❑ No

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. Please refer to page 3 for notice specific to your state.

PHYSICIAN VERIFICATION

Signed: ______ , MD Date: ___/___/___ MO/DAY/YR Phone: (   ) ______

Street Address: ______

City/Town: ______

State/Province: ______ Zip Code: ______

ASSIGNMENT OF BENEFITS

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

______
Name

______
Provider's Tax Identification Number

______
Relationship

______
Address

______
City State Zip

______
Signature of Policy Owner Date

Important: To avoid delay, please sign authorization below.

I authorize any physician, medical practitioner, hospital, clinic or other medical facility, insurance company, the Medical Information Bureau or other organization, institution or person, that has records or knowledge of me or my health to give to American Heritage Life Insurance Company (AHL), its subsidiaries or its reinsurers any information relating to my claim. A copy of this authorization is as valid as the original. This authorization applies to any dependent on whom a claim is filed. This authorization is valid for a period of 24 months from the date signed. I understand that I may revoke this authorization at any time by notifying AHL in writing of my desire to do so. I or my representative may receive a copy of this authorization by supplying policy number(s) and Insured's name in a written request to the company. (In **MAINE** – I understand that revocation of this authorization may be a basis for denying insurance benefits. Failure to sign an authorization statement may impair the ability of a regulated insurance agency to evaluate claims and may be a basis for denying a claim for benefits.)

Sign here: ____ Date:_______________________ ☐ **Check here if address is new**
Claimant
Mailing Address:_________________________________City:___________________State:_______ Zip: __________Telephone No:. (____)________

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 ALASKA, ARKANSAS, KENTUCKY, LOUISIANA, MAINE, NEW JERSEY, NEW MEXICO, AND VIRGINIA: 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 DELAWARE, IDAHO, INDIANA, MINNESOTA, NEW HAMPSHIRE, 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 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 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 DISTRICT OF COLUMBIA: WARNING: 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 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 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.