

GUIDE TO CLAIMS FILING FOR FLORIDA SOUTHWESTERN STATE COLLEGE

CLAIMS PROCESS

Claims can be filed in a variety of ways to fit the unique preferences of our policyholders:

Paper Forms

Paper claim forms can be mailed or faxed to the contact information listed on the form. See attached claim forms:

Accident Claim Form – use this form to file a claim related to an accidental injury or death. Required documentation: A copy of the itemized billing statement and a radiology report if filing for the fracture benefit. Page 2 of the claim form is not needed if you attach a copy of these items.

Critical Illness Claim Form – use this form to file a claim related to a critical illness diagnosis. See claim form for required documentation.

Outpatient Physician Treatment Claim Form – this form is used to file a claim for the outpatient physician treatment benefit associated with the Accident plan. Required documentation: Print out from the visit such as a bill or form showing treatment received, provider information, patient and date of service.

Wellness Claim Form – this form is used to file a claim for the wellness benefit associated with the Critical Illness plan. Required documentation: Print out from the visit showing provider's name, address, patient's name, date of test and exam performed.

Call: 1-800-348-4489 or email: ClaimsResearch@allstate.com for claims status or questions.

MyBenefits

File claims on-line utilizing the employee portal, MyBenefits. See attached instructions for this website. You can use this portal to review policy information, file claims, check claims status and review claims history. This portal is also utilized for the Express Wellness and Express Outpatient Physician Benefit claims process. MyBenefits website demo: http://video.allstatebenefitsmedia.com/demos/corp/mb_demo.swf

Immediate Value Benefits

As a reminder, the plans have a benefit that can be used each year – regardless of injury or illness. Encourage your employees to file these claims each year:

Accident

Outpatient Physician Benefit - The Accident plan pays \$50 per visit- 2 visits per year per individual, 4 visits per year per family for any office visit to a licensed physician outside of a hospital. It could be a well visit, sick visit, eye doctor or dentist. You can file this claim via the paper claim form mentioned above and attached. If you file via the paper form, you will require the documentation mentioned above. The employees will also have the option of filing an express Outpatient claim through the MyBenefits employee portal. No documentation is required when filing through the portal. See procedure for filing the claim in this manner attached.

Critical Illness

Wellness Benefit - \$50 per each family member insured per year after completing one of the covered tests. See brochure for full list of tests. You can file this claim via the paper claim form mentioned above and attached. If you file via the paper form, you will require the documentation mentioned above. If you file the claim using the Express Wellness claims process, you will not be required to submit documentation. Express Wellness claims are filed using the MyBenefits website. See procedure for filing the claim in this manner attached. Express Wellness demo: http://video.allstatebenefitsmedia.com/websites/ew/index.htm

Claim Payment

Standard claims are paid within 5-7 business days from the time that all documentation is received. Express Wellness and Outpatient claims are paid within 48 hours. Claims can be paid via paper check, or can be directly deposited into the employee's checking or savings account. Employees would utilize the MyBenefits employee portal to set up the direct deposit account.

My Benefits

Benefits at Your Fingertips 24/7

Accessing benefit information has never been easier

- File Claims
- Check claim status
- Get benefit coverage details
- Review claims history
- Make changes to personal information

How to Get Access

- Go online to www.allstateatwork.com/mybenefits
- Sign up for access using the secure online registration process. Create a User ID and Password.
- Be prepared to provide your SS#, zip code, and birthdate.
- Need help registering? Just click on "Need Help" in the menu to the right.
- Once registered, full access to all benefits and website is available day or night, 24/7, it's that simple!

To read more about what the My Benefits site can offer, see the information on reverse.



MY BENEFITS the right tool • your benefits • full access

My Benefits

Our secure online access offers benefit information 24/7

Below is a quick overview of the **My Benefits** innovative online capabilities

1. Online Access 24/7 -

Through online access, upload a claim request, review coverage details, track claim status or update personal information with ease!

2. Claims Status and Filing -

Check claims status any time 24/7, instead of calling. Or, file a claim using our online forms submission process and upload all supporting documents. Expedited payment process available by filing online.

3. Policy Information -

Print or view policy information, coverage details or certificates on existing coverage. Also review other product options available.

4. Update Information -

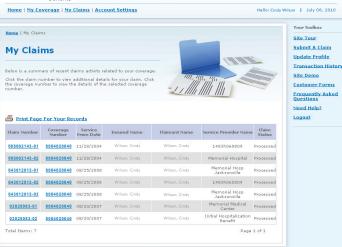
You can keep your physical address, e-mail address and telephone number up-to-date and accept electronic delivery of documents.

5. Need Help? -

The Need Help? section provides a listing of telephone numbers to contact Allstate Benefits, ask a question online, or submit questions through an e-mail form.

Logon today! Experience the ease of taking advantage of Allstate Benefits's valuable coverage.





Important Info <u>GLB Privacy Statement</u> Terms of Use <u>HIPAA Privacy Statement</u> Electronic Delivery Disclosure



Allstate Benefits is the marketing name used by American Heritage Life Insurance Company (Home Office, Jacksonville, FL). ©2011 Allstate Insurance Company. www.allstate.com or allstateatwork.com.



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 YOUR GROUP ACCIDENT CLAIM

•	Please check the box or boxes that best describes your current claim:							
	 Dismemberment Dislocation/Fracture Initial Hospitalization Confinement Medical Expenses 		Ambulance	 Accidental Death Common Carrier Accidental Death 				
	Drouiding the decumentation request			respond for bonefit. The following				
•	Providing the documentation request is the documentation that is required		your claim can be p	processed for benefit. The following				
	□ A copy of the itemized billing sta	atement and a radiology	report if filing for the	fracture benefit.				
٠	Include your policy number(s). To obtain your policy number call 1-800-348-4489 . Please be assured that your claim will receive our prompt attention.							
٠	You may fax your claim to us at 1-866-424-8482. Please be assured that your claim will receive our prompt attention.							
•		erican Heritage Life Insu Box 43067 sonville, Florida 32203						
•	 Additional claim forms are available on our website at <u>www.AllstateBenefits.com</u>. 							
•	 If you are filing a claim within the first 12 months your policy is in force, additional information may be required. 							
	POLICYHOLDER / CERTIFICATEHOLDER							
Em	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				

Employer Name (Company/Address).			
1. Policyholder's Name: First:	Middle:		Last:
Policy Number(s): 1)		2)	
Social Security Number:	Date of Birth:	/ /	Male
2. Home Number: <u>()</u>	E-mail:		
PATIENT'S INFORMATION			
3. Name: First:	Middle:		_ Last:
4. Date of Birth: / / /	Age: Social Se	curity Number:	Male 🛛 Female
This person is your:	(ex: self, wife,	son, etc.)	
	GROUP ACCIDEN	T POLICY C	LAIMS
DATE OF ACCIDENT: ///	Time of accident:	🗆	a.m. 🗆 p.m.
Where did it happen?	Tell	us exactly how your	accident/injury happened:

ATTENDING PHYSICIAN'S STATEMENT (PHYSICIAN)

Pat	ient's Name:	Policy Number:					
1.	Diagnosis:						
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.)						
5.	Describe any other diseases or infirmity affecting present condition.						
6.	Nature of surgical procedure, if any (describe fully).						
7.	If patient is hospitalized, give name and address of hospital.						
	Hospital: City:	State:					
8.	Date admitted: / / Date discharged: / / / MO/DAY/YR Date discharged: / / /						
9.	Referring Physician:	Phone: ()					
	Mailing Address:						
	PHYSICIAN VERIFICATION						
Sig	ned:, MD Date:/ MO/DAY/Y	/ Phone: ()					
Street Address:							
City	City/Town:						
Sta	State/Province: Zip Code:						

ASSIGNMENT OF BENEFITS (n/a in New Hampshire)

Please complete this section ONLY if you wish for Allstate to send your benefit to your medical provider instead of to you.

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	Address		
Provider's Tax Identification Number	City	State	Zip
Relationship			
Signature of Policy Owner		Date	

I authorize any physician, medical pr organization, institution or person, tha subsidiaries or its reinsurers any inforr dependent on whom a claim is filed. authorization at any time by notifying a policy number(s) and Insured's name is for denying insurance benefits. Failur may be a basis for denying a claim for	at has records or knowledge of nation relating to my claim. A co This authorization is valid for a AHL in writing of my desire to d in a written request to the compa e to sign an authorization stater	me or my health to opy of this authoriza a period of 24 mont o so. I or my repre- any. (In MAINE – I	give to Ameri tion is as valid ths from the di sentative may understand that	ican Heritage Li l as the original. late signed. I un receive a copy at revocation of	fe Insurance Com This authorization nderstand that I m of this authorizatio this authorization r	pany (AHL) its applies to any ay revoke this n by supplying nay be a basis
Sign here:		Date:			HERE IF ADDRES	SS IS NEW
Claima	ant					
Mailing Address:	City:	St	tate:Z	Zip:	Phone No:. (_)

ILLINOIS INTEREST STATEMENT: For contracts issued in and residents of Illinois, unless payment is made within fifteen (15) days from the date of receipt by the company of due proof of loss, interest shall accrue on the proceeds payable because of the death of the insured, from date of death, at the rate of 9% on the total amount payable or the face amount if payments are to made in installments until the total payment or the first installment is paid.

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, 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 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 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.

Allstate
Benefits

OUTPATIENT PHYSICIAN'S TREATMENT 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.

		<u>,</u>					
Mail or Fax Your Claim to: American Heritage Life Insurance Company 1776 American Heritage Life Drive, Jacksonville, FL 32224 Fax 1-866-427-3730							
If you would like to ha	ave claim bene	fits automati	ically depo	sited into v	our bank acco	ount. please co	mplete and
send our ACH form							
www.AllstateBenefits.							
	POLICYHO	LDER / CER	TIFICATE	HOLDER	INFORMATIO	N	
POLICY NUMBER(s): 1)		2)			3)		
POLICYHOLDER INFORI	MATION:						
First Name:			MI:	Last Name:			
Social Security Number:			Date of Birth:	//_	Age:	DAle	Female
Mailing Address:						Apt#: _	· · · · · · · · · · · · · · · · · · ·
Check here if							
address is new	City:				_ State:	Zip:	
	Phone #:()		E-mail:				
PATIENT'S INFORMATIC							
First Name:			MI:	Last Name:			
Social Security Number:			Date of Birth:	//_	Age:	□ Male	Female
Relation to Insured:	Self Spou	use 🗆 Child	Other				
OUTPATIENT PHYSIC	CIAN'S TREA	TMENT BEN	EFIT The be	enefit describ	ed below is avail	able for Outpatien	t Physician's
Treatment. Please attach							
Outpatient Physician's					lease provide f		
Benefit					·	•	
The outpatient physician to							
benefit is for treatment pro		Provider Addr	ess:			·····	
physician outside of the ho visit may be provided for a							
accident, well exam, physi							
exam or dental exam. Ple		. ,			and		
your policy for the specific					mentation of tre	atment provided	by a
information.		physician, ou	itside of the	hospital.			
	ASSIC	GNMENT OF	BENEFIT	ິ S (n/a in Nev	v 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. PLEASE BE ADVISED THAT IF YOU ARE COVERED BY MEDICAID, WE MAY BE REQUIRED TO ASSIGN BENEFITS (except disability) TO THE PROVIDER OF SERVICE IN ACCORDANCE WITH STATE AND FEDERAL REGULATIONS.							
Name			Address				
Provider's Tax Identification Number: City State Zip							
Relationship			Signatur	e of Policy Ow	ner	// Date	_/
	CER		I: Please r	ead and sig	gn below		
I acknowledge the receipt of the that it is a crime to fill out this fo claim form are true, complete, a	orm with facts I know	are false or to leav	ve out facts I kn	ow are relevant	t and important. I ce	rtify that the answers	given on this
Signature:		Prin	t Name:			Date:	//

important.	i o avolu uelay, please s	sign authoriza	ation below	•	
I authorize any physician, medical practitioner, hos organization, institution or person, that has records subsidiaries or its reinsurers any information relating dependent on whom a claim is filed. This authoriz authorization at any time by notifying AHL in writing policy number(s) and Insured's name in a written rec for denying insurance benefits. Failure to sign an au may be a basis for denying a claim for benefits.)	or knowledge of me or my hea to my claim. A copy of this aut ation is valid for a period of 24 of my desire to do so. I or my uest to the company. (In MAI	alth to give to An horization is as v months from th representative m IE – I understand	nerican Heritag alid as the origi e date signed. nay receive a c d that revocatio	e Life Insurance Compa nal. This authorization a I understand that I ma opy of this authorization n of this authorization m	any (AHL), its applies to any ay revoke this by supplying ay be a basis
Sign here:	Date:		🗌 Ch	eck here if address is I	new
Claimant					
Mailing Address:	City:	State:	Zip:	Telephone No:. ()

we automate. To avoid delay, where a sine another institute heles.

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CLAIM FORM AND INSTRUCTIONS

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INSTRUCTIONS FOR FILING A CRITICAL ILLNESS CLAIM

- 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(s) call 1-800-348-4489.
- You may fax your claim to us at 1-866-424-8482. Please be assured that your claim will receive our immediate 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 (ABJ16661). 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						
Employer Name (Company): 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: / / Age:	Social Security Nu	mber:	🗆 Male 🛛 Female			
5. This person is your:	(ex: self, wife, so	n, etc.)				

INSTRUCTIONS FOR FILING CRITICAL ILLNESS CLAIMS:

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

ATTENDING PHYSICIAN'S STATEMENT

Patient's Name: Age:
1. Diagnosis:
 If condition is due to pregnancy, what is expected delivery date? Date // /
3. When did symptoms first appear or accident happen? Date ////
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.
 Nature of surgical or obstetrical procedure, if any (describe fully).
8. Is patient unable to perform job duties?
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: / / Date discharged: / /
MO/DAY/YR MO/DAY/YR 11h W/bon do you expect patient to recurse partial duties?
14b. When do you expect patient to resume partial duties? / / Full duties? / / MO/DAY/YR MO/DAY/YR MO/DAY/YR 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 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:/ / Phone: ()
Street Address:
City/Town:
State/Province: Zip Code:

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:. ()

ILLINOIS INTEREST STATEMENT: For contracts issued in and residents of Illinois, unless payment is made within fifteen (15) days from the date of receipt by the company of due proof of loss, interest shall accrue on the proceeds payable because of the death of the insured, from date of death, at the rate of 9% on the total amount payable or the face amount if payments are to made in installments until the total payment or the first installment is paid.

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, 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 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 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.

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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.



WELLNESS CLAIM FORM

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.

Benefits

Claim forms and other valuable information may be found on 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.

POLICYHOLDER / CERTIFICATEHOLDER

Insured's Name:		Patient:	🗆 Male 🛛 Female
Policy Number(s): 1)		2)	
Insured's Social Security Number:		Patient's Date of Birth:	/ / M0/DAY/YR
Home Number: ()	E-mail:		

Filing a claim for your calendar year Wellness Benefit is easy! If you have had one of the listed preventative tests or HPV Vaccination shown below, please check the appropriate boxes and attach any documentation you may have showing the <u>provider</u>, <u>patient's name</u>, the <u>date of the test</u>, and <u>exam performed</u>. If your policy was issued in Pennsylvania or California, please send us the actual bill and the Explanation of Benefits from your Major Medical Carrier.

Thank you for selecting Allstate Benefits and for having your annual wellness exam!

WELLNESS	SCREENINGS
Biopsy for skin cancer	Flexible sigmoidoscopy
Blood test for triglycerides	Hemocult stool analysis
Bone Marrow Testing	HPV (Human Papillomavirus) Vaccination
CA125 (cancer antigen 125 - blood test for ovarian cancer)	Lipid Panel (total cholesterol count)
CA15-3 (cancer antigen 15-3 - blood test for breast cancer)	Mammography, including Breast Ultrasound
CEA (carcinoembryonic antigen – blood test for colon cancer)	Pap Smear, including ThinPrep Pap Test
Chest X-ray	PSA (prostate specific antigen – blood test for prostate cancer)
Colonoscopy	Serum Protein Electrophoresis (test for myeloma)
Doppler screening for carotids	Stress test on bike or treadmill
Doppler screening for peripheral vascular disease	□ Thermography
Echocardiogram	Ultrasound screening of the abdominal aorta for abdominal aortic aneurysms
EKG (Electrocardiogram)	

ASSIGNMENT OF BENEFITS FOR WELLNESS COVERAGE (n/a in New Hampshire)

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

Address

Provider's Tax Identification Number

City

State

Date

Zip

Relationship

Signature of Policy Owner

You may mail or fax your claim to: American Heritage Life Insurance Company

1776 American Heritage Life Drive, Jacksonville, FL 32224

Important:	To avoid delay, please	sign authoriza	ation bel	ow.	
I authorize any physician, medical practitioner, hos organization, institution or person, that has records subsidiaries or its reinsurers any information relating dependent on whom a claim is filed. This authoriz authorization at any time by notifying AHL in writing policy number(s) and Insured's name in a written rec for denying insurance benefits. Failure to sign an au may be a basis for denying a claim for benefits.)	or knowledge of me or my he to my claim. A copy of this au ation is valid for a period of 2 of my desire to do so. I or m quest to the company. (In MAI	ealth to give to Am uthorization is as va 24 months from the y representative m INE – I understand	nerican Her alid as the o e date sign nay receive I that revoc	ritage Life Insurance Company (AHL), its original. This authorization applies to any ned. I understand that I may revoke this a copy of this authorization by supplying ration of this authorization may be a basis	s y g s
Sign here:Claimant	Date:			Check here if address is new	
Mailing Address:	City:	State:	Zip:	Phone No:. ()	-

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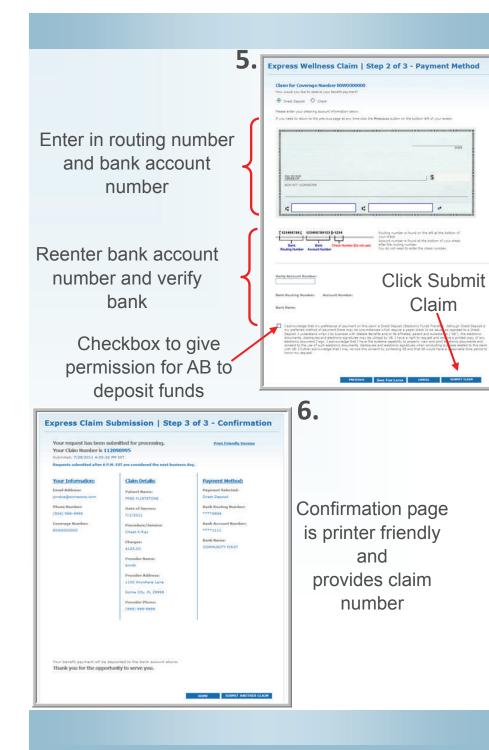
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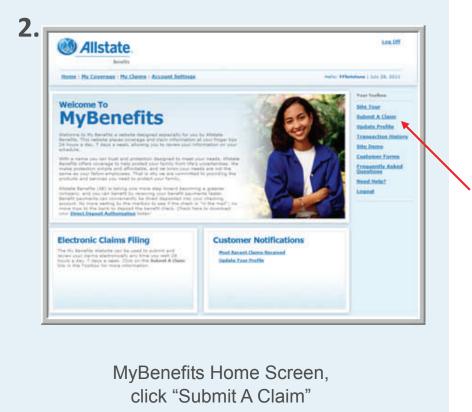


Express Wellness Claims Process



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MyBenefits Login Screen www.allstateatwork.com/mybenefits



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If Policyholder does not have a policy with a wellness benefit, Express Wellness would not be mentioned. Check box and click continue.

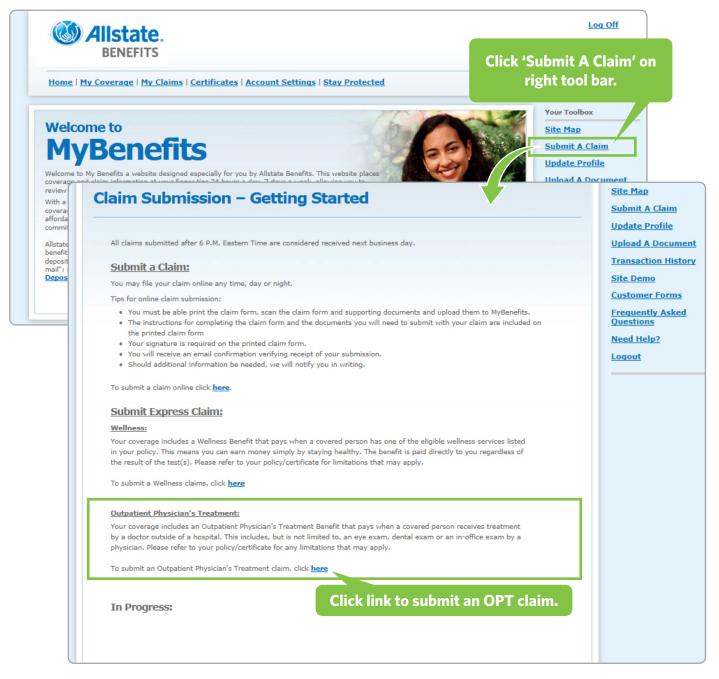
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The Agent Website now offers web enhancements for submitting Outpatient Physician's Treatment (OPT) and Wellness Benefits Claims. The screen shots below highlight the process for submitting an OPT claim.

1

First, login on the MyBenefits home page. Next, find the **Your Toolbox** section at the top right of the Welcome page and click **Submit A Claim**.



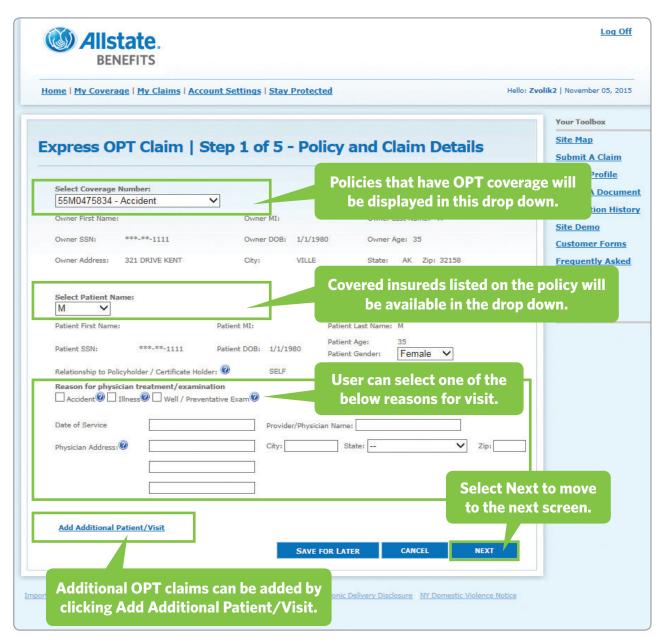
2 The Claims Submission page will open from the link with an option to submit an OPT claim.

Allstate Benefits is the marketing name used by American Heritage Life Insurance Company, a subsidiary of The Allstate Corporation. ©2015 Allstate Insurance Company. <u>www.allstate.com</u> or <u>allstatebenefits.com</u>.



In Step 1 of 5 for the OPT Claim, there are three required sections to complete:

- Select Coverage (drop-down)
- Select Patient Name (drop down)
- Reason for Visit



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4 Step 2 of 5 allows the user to select a claim payment method: Direct Deposit or Check.

press OPT (Claim Step 2	of 5 - Cla	im Payment			<u>Site Map</u> Submit A Clai	im
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5 Step 3 of 5 is where the user can review uploaded documents and apply the required E-Signature.

	na applying my ensignature is the so nd that it is accurate and complete. PREVIOUS	SAVE FOR LATER	CANCEL	e that I have reviewed all information	User should ap E-Signature af reviewing documents.	ter
these steps: • Review you • Choose you • When you Check the box before applying E-signature. If you submit m	A complete and a complete and a complete your selections, click on the	eccurate, check the box next to i livery and check the box next to he "Apply E-Signature" button b Click to and rev docume will default to the last payment	t. it elow. open riew ent. method chosen.	e the submission process. <u>Please follow</u> Box will only appear if the default method is changed.	<u>Site Demo</u> Customer Forms	
Express	OPT Claim Ste	p 3 of 5 Revie	ew and S	Sign	<u>Site Map</u> Submit A Claim	
					Your Toolbox	

6 Step 4 of 5 allows the user to complete the submission process.

ly submitting this claim I agree that I have n formation for this claim, or to omit relevant PREVIOU	and important information.	I am aware that it is a crime t	SUBMIT	Submit documer after completin E-Signature.
IOTICE IN ALASKA, ARKANSAS, KENTUCKY, /ith intent to injure, defraud or deceive an in rosecuted under state law.	surance company files a claim containing fa	alse, incomplete or misleading	g information may be	
	If you submit multiple claims in one day payment method chosen	y, all claims will default to the la	ast	Need Help? Logout
	Mailing Address on file: 321 DRIVE KENT VILLE, AK 32158			Customer Forms Frequently Asked Questions
E-Signature Applied	M OPT claim			Site Demo
Your E-Signature has been applied to th below.	e documents listed below. To complete the	submission process, click on	the "SUBMIT" button	Upload A Document Transaction History
Express OPT Claim	Step 4 of 5 - Clain	n Payment		Submit A Claim
	Chan 4 of E Claim	Desmant		Site Map

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7 Step 5 of 5 confirms that the user has successfully submitted the claim.

			Submit A Cla
You have successfully submitted your claim. You	can view and print the forms below for you records.		Upload A Do
All submissions received after 6 P.M. Easter	n Time are considered received on the next business day.		
			Transaction
M OPT claim	DCN: 153098982		Site Demo
			Customer Fo
If you submit multiple claims in one	a day, all claims will		
default to the last payment method	chosen		Frequently A Ouestions
· · · · · ·	nat provides a Wellness Benefit. The Wellness Benefit is paid when Please visit the Claims Submission – Getting Started page for deta		<u>Need Help?</u> Logout
	SUBMIT ANOTHER CLAIM	номе	

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