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

Allstate Benefits

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!

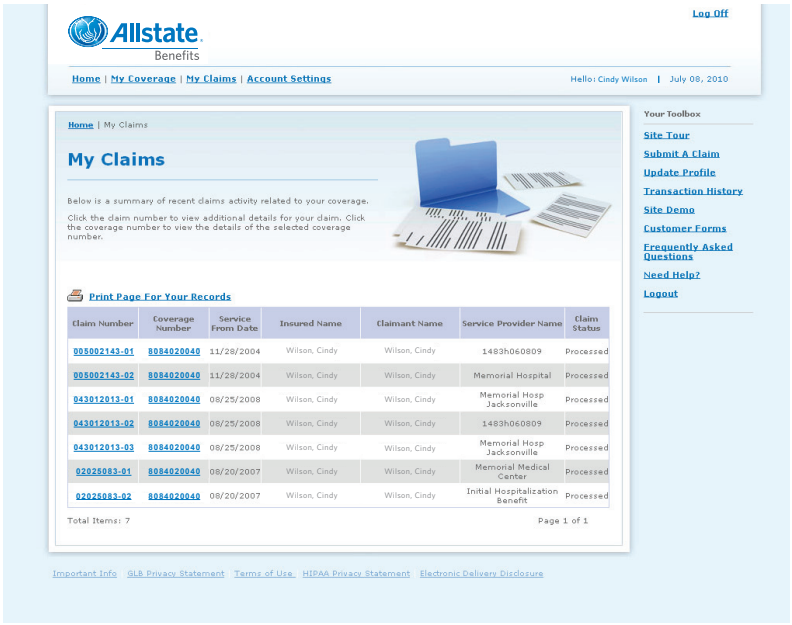
2. Claims Status and Filing -
Check claims status any time 24/7, instead of calling. Or, file a claim using our online forms submission process and upload all supporting documents. Expedited payment process available by filing online.

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.



Allstate Benefits

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 Services:
  ☐ Ground Ambulance
  ☐ Air Ambulance
☐ Accidental Death
☐ Common Carrier Accidental Death

- Providing the documentation requested below will ensure that your claim can be processed for benefit. The following is the documentation that is **required** for **ACCIDENT CLAIM:**
  - ☐ A copy of the itemized billing statement and a radiology report if filing for the fracture benefit.
- 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.
- You may **fax** your claim to us at **1-866-424-8482**. Please be assured that your claim will receive our prompt attention.
- 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.AllstateBenefits.com.
- If you are filing a claim within the first 12 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: (___) _____ **E-mail:** _____

PATIENT'S INFORMATION

3. Name: First: _____ Middle: _____ Last: _____
4. Date of Birth: ___/___/___ Age: _____ Social Security Number: _____ ☐ Male ☐ Female

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

GROUP ACCIDENT POLICY CLAIMS

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)

Patient'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.) ☐ Yes ☐ No _____

_____

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: ____/____/____ MO/DAY/YR Date discharged: ____/____/____ MO/DAY/YR

9. Referring Physician: _____ Phone: (____) _____

   Mailing Address: _____

PHYSICIAN VERIFICATION

Signed: _____, MD Date: ____/____/____ MO/DAY/YR Phone: (____) _____

Street Address: _____

City/Town: _____

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

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: _____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.

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.

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 have claim benefits automatically deposited into your bank account, please complete and send our ACH form (ABJ16661). This form can be found on our website at www.AllstateBenefits.com or www.AllstateBenefits.com/mybenefits.

POLICYHOLDER / CERTIFICATEHOLDER INFORMATION

POLICY NUMBER(s): 1)_____ 2)_____ 3)_____

POLICYHOLDER INFORMATION:

First Name: _____ MI: _____ Last Name: _____

Social Security Number: _____ Date of Birth: _____/_____/_____ Age: _____ □ Male □ Female

Mailing Address: _____ Apt#: _____

☐ **Check here if address is new**

City: _____ State: _____ Zip: _____

Phone #:(____)_____ E-mail: _____

PATIENT'S INFORMATION:

First Name: _____ MI: _____ Last Name: _____

Social Security Number: _____ Date of Birth: _____/_____/_____ Age: _____ □ Male □ Female

Relation to Insured: □ Self □ Spouse □ Child □ Other

OUTPATIENT PHYSICIAN'S TREATMENT BENEFIT

The benefit described below is available for Outpatient Physician's Treatment. Please attach the required documentation requested. If additional information is needed, you will be notified.

Outpatient Physician's Treatment Benefit

The outpatient physician treatment benefit is for treatment provided by a physician outside of the hospital. The visit may be provided for a sickness, accident, well exam, physical exam, eye exam or dental exam. Please refer to your policy for the specific benefit information.

REQUIRED DOCUMENTATION: Please provide the following:

Provider Name: _____

Provider Address: _____

_____

Date(s) of service: _____/_____/_____ and _____/_____/_____

Please attach a copy of a bill or documentation of treatment provided by a physician, outside of the hospital.

ASSIGNMENT OF BENEFITS (n/a 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. ***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

_____ Signature of Policy Owner

_____/_____/_____ Date

CERTIFICATION: Please read and sign below

I acknowledge the receipt of the Department of Insurance Claim Fraud Statements provided with this claim packet. I have read the notices and 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 claim form are true, complete, and correctly recorded. **In order to process your claim, sign and date the authorization on the following page.**

Signature:_____ **Print Name:** _____ **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:. (____)_____

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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 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: ___/___/___ MO/DAY/YR Age: ____ Social Security Number: _____ ☐ Male ☐ Female

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

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

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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.

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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.

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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.

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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.
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:** ____/____/____ MO/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 provider, patient's name, the date of the test, and exam performed. 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

_____ Provider's Tax Identification Number

_____ Relationship

_____ Address

_____ City State Zip

_____ Signature of Policy Owner Date

You may mail or fax your claim to:

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

Phone 1-800-348-4489 Fax 1-800-430-4188

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.)

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Claimant

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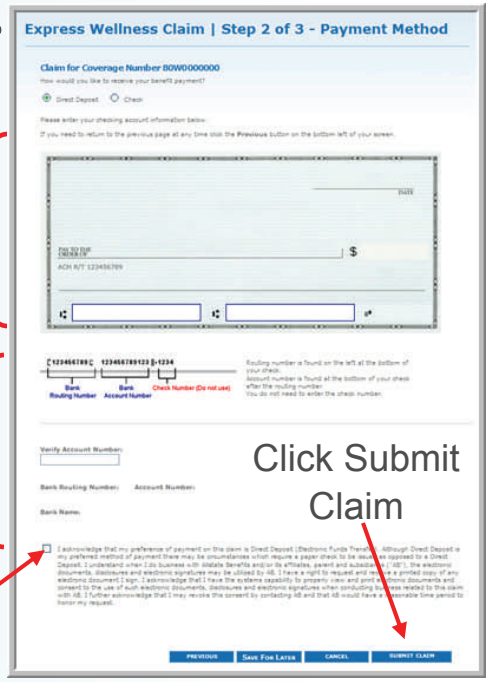
5.



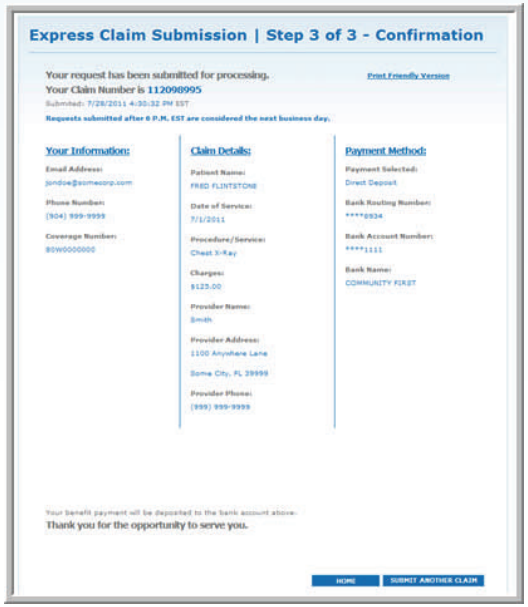
Enter in routing number and bank account number

Reenter bank account number and verify bank

Checkbox to give permission for AB to deposit funds

Click Submit Claim

6.

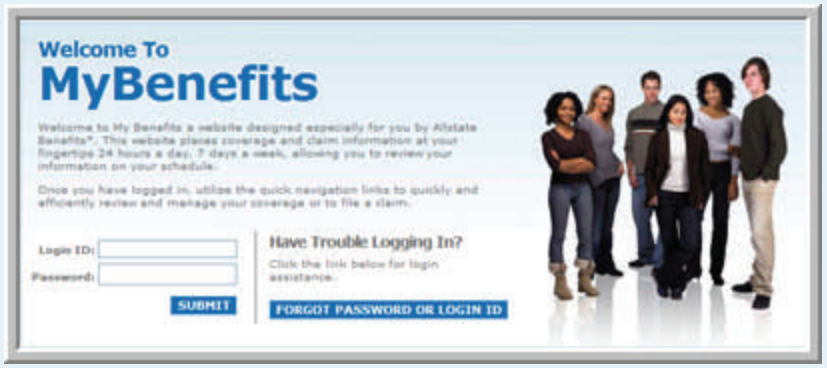


Confirmation page is printer friendly and provides claim number

Allstate Benefits

Express Wellness Claims Process

1.

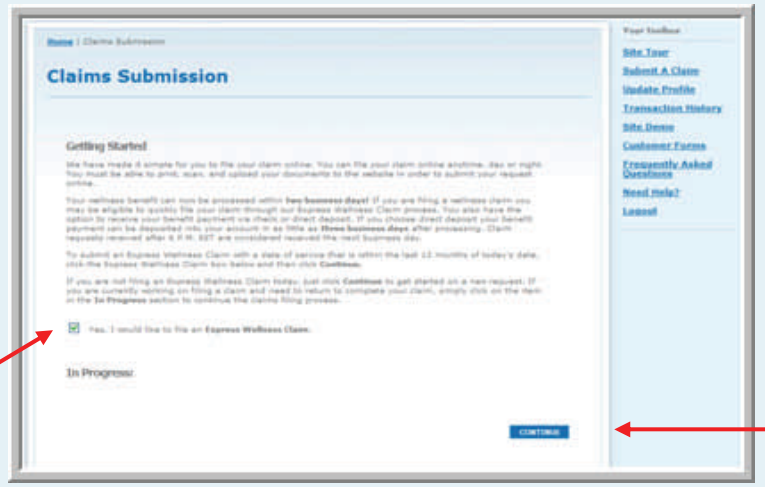


MyBenefits Login Screen
www.allstateatwork.com/mybenefits

2.

MyBenefits Home Screen,
click “Submit A Claim”

3.



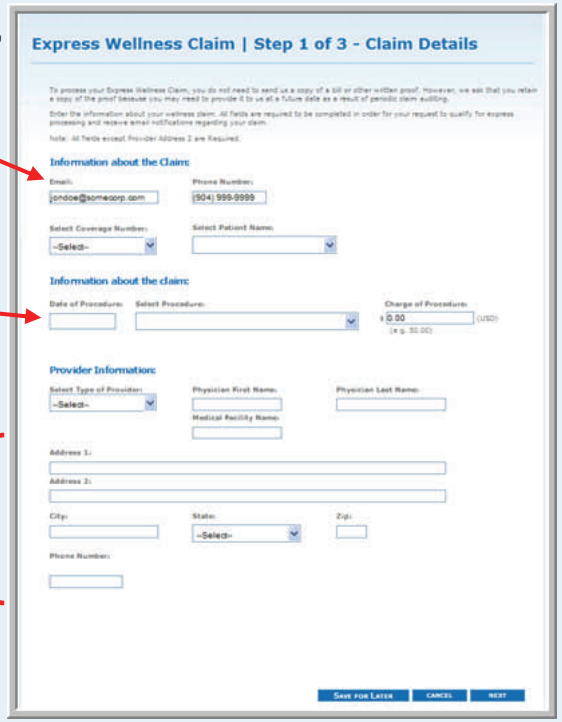
If Policyholder does not have a policy with a wellness benefit, Express Wellness would not be mentioned. Check box and click continue.

4.

Choose Policy

Enter in date of procedure, type of procedure and cost

Enter in physician or medical facility



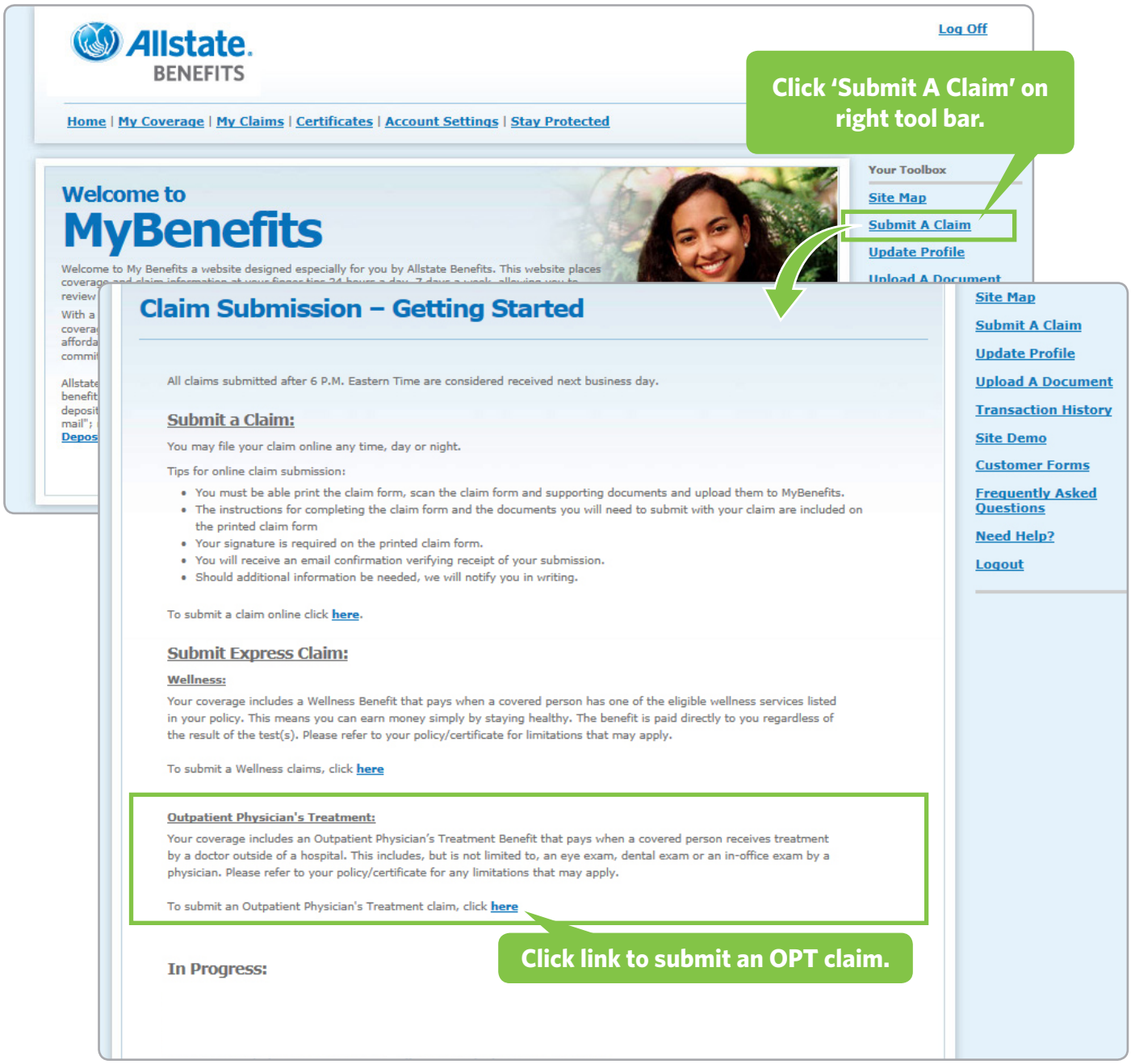
JOB AID

OPT Claims Submission

Allstate BENEFITS

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.

OPT Claims Submission

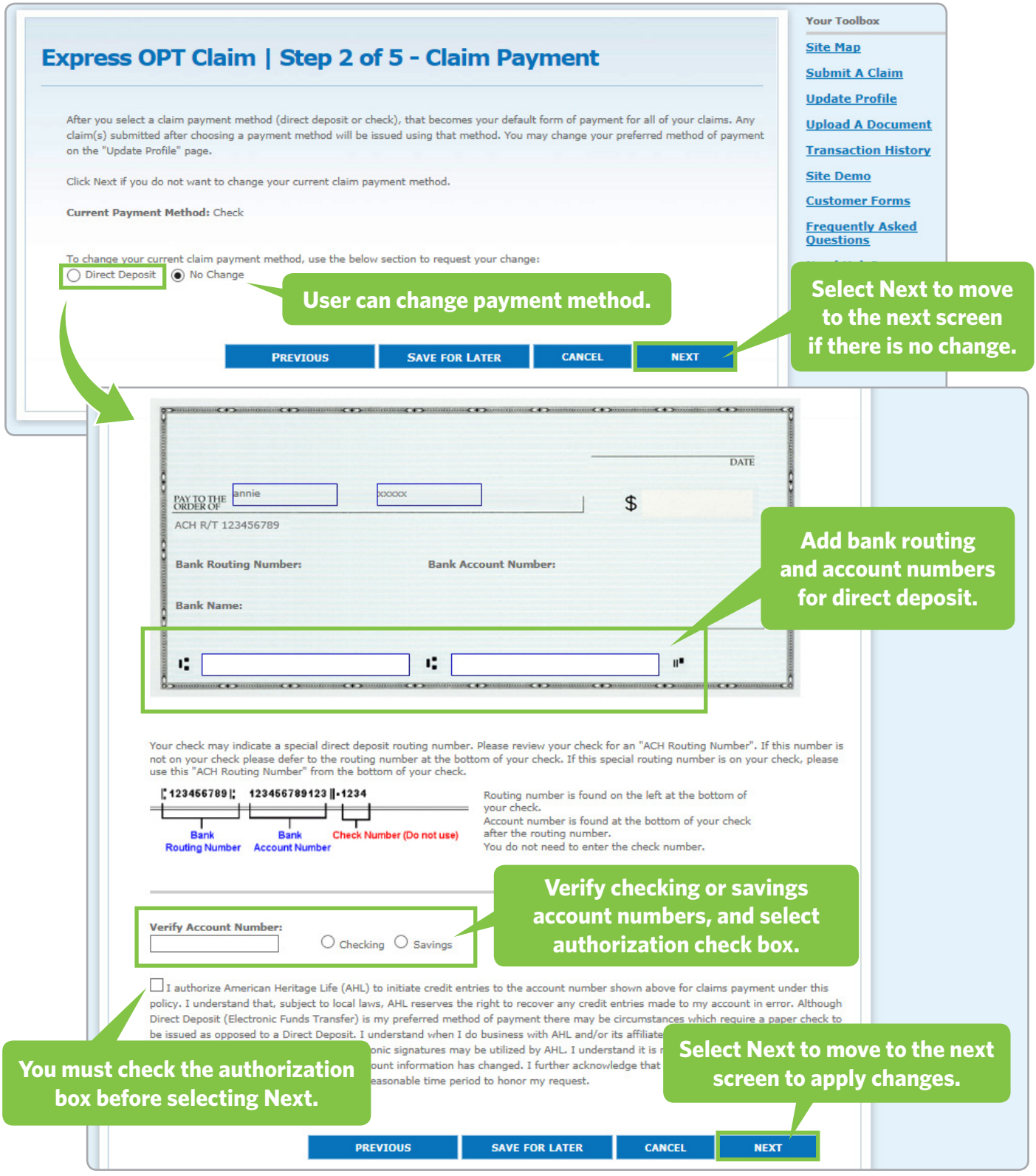
3 In Step 1 of 5 for the OPT Claim, there are three required sections to complete:

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

OPT Claims Submission

Allstate BENEFITS

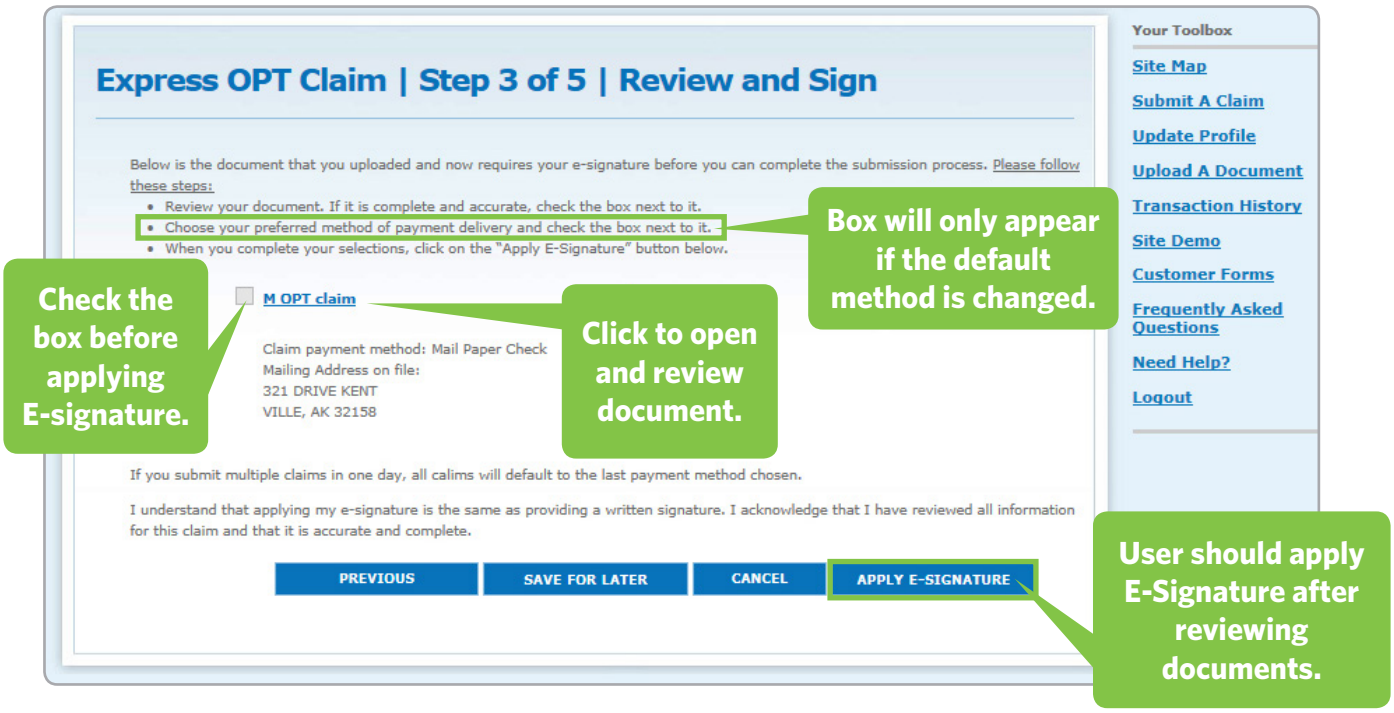
4 Step 2 of 5 allows the user to select a claim payment method: Direct Deposit or Check.



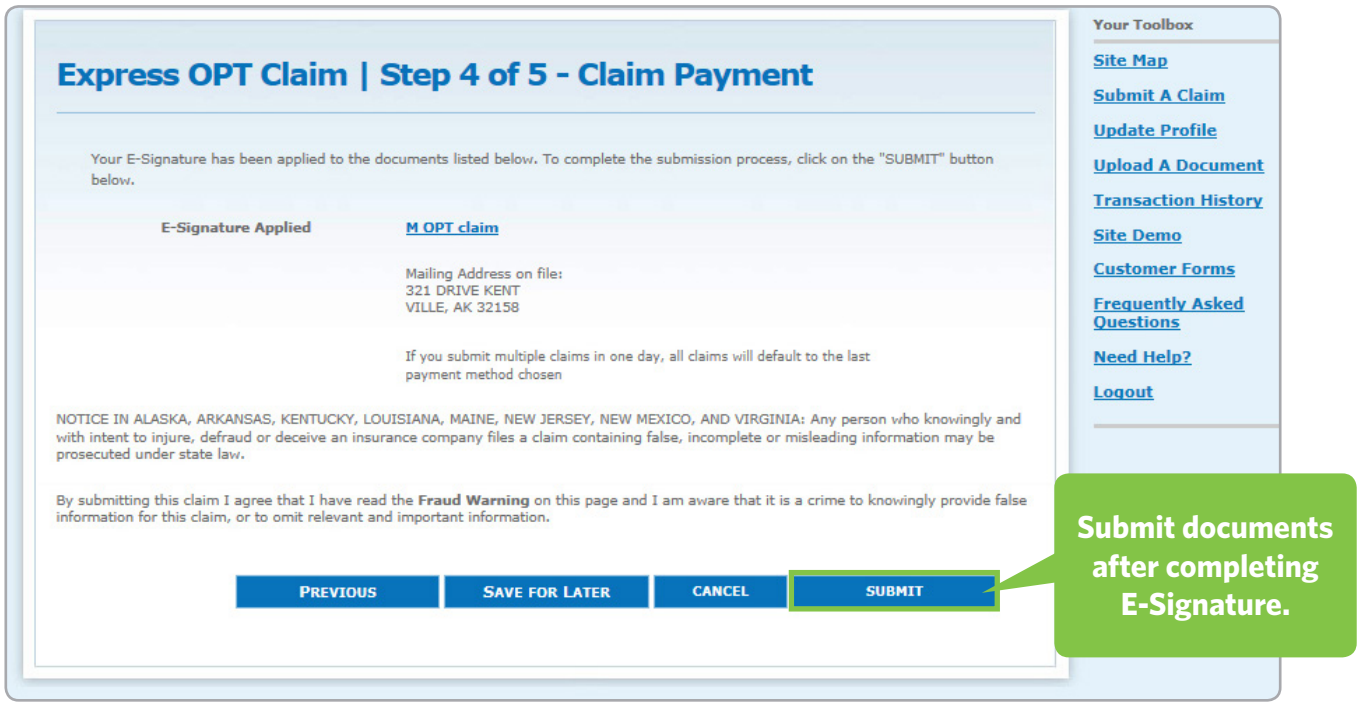
OPT Claims Submission

Allstate BENEFITS

5 Step 3 of 5 is where the user can review uploaded documents and apply the required E-Signature.



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



OPT Claims Submission

Allstate BENEFITS

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