AMERICAN HERITAGE LIFE INSURANCE COMPANY

DISABILITY COVERAGE FOR MATERNITY CLAIM FORM

Submit Claims: Online at: **www.allstatebenefits.com** by Fax to: 1-866-424-8482 or by
Mail to: American Heritage Life Insurance Company 1776 American Heritage Life Drive, Jacksonville, FL 32224

For questions regarding the policy benefits, supporting documentation, or for claim assistance, instructions can be found on our website or contact our Customer Care Center at 1-800-521-3535. Please refer to the Coverage Documents for benefits available as well as applicable terms, conditions, exclusions, and limitations. Incomplete or blank responses may result in a delay in processing the claim request.

Direct Deposit: Please complete and submit our Direct Deposit (ACH) form located on our website.

Assignment of Benefits: To assign benefit to another individual or provider, please complete and submit our Assignment of Benefits form located on our website.

Section 1 – POLICY/CERTIFICATE HOLDER & CLAIMANT INFORMATION.

COVERAGE NUMBER(S): _____

POLICY/CERTIFICATE HOLDER INFORMATION:

First Name: _____ MI:_____ Last Name: _____ Last 4 of SS #: XXX-XX-_____

Birth Date:_____ Age: _____ Gender: _____ Phone #: _____ Email: _____

Mailing Address – We will update our system with this address and use this address to send future correspondence and checks.

Number & Street:_____

City: _____ State: _____ Zip: _____

Section 2 – CLAIM DETAILS.

The normal recovery period following delivery is 6 weeks for vaginal delivery & 8 weeks for c-section delivery. This includes the policy elimination period. Benefits could extend beyond the typical 6 – 8 weeks if disability continues beyond that time frame.

1. Tell us about the claim. This is a □ New Claim or □ Ongoing Claim.
2. What are the Diagnoses/Condition(s) for this claim (List all): _____
   Is your disability due to □ Delivery or □ Complications of Pregnancy?
   Due Date: _____ Delivery Date: _____ □ Normal Delivery or □ C-Section
   When was your first physician visit for this condition? _____ Most Recent Visit: _____ Next Visit: _____
   Were you hospitalized for your pregnancy/delivery? Admission Date: _____ Discharge Date: _____
3. Was the claimant actively employed when the disability began? □ Yes □ No If no, please provide Employment Separation Papers.
   What is the first date the claimant was unable to work? _____
   Has the claimant returned to work? □ Yes □ No Part time/Partial duties: _____Full time/Full duties: _____
4. Did this policy replace prior disability coverage? □ Yes □ No
   Prior Disability Carrier: _____
   Effective Date:_____ Elimination Period: _____
   Monthly Benefit $: _____ Maximum Benefit Period: _____
   If Applicable, Termination Date: _____

   Does the claimant have other active disability coverage? □ Yes □ No
   Other Active Disability Carrier: _____
   Effective Date: _____ Elimination Period: _____
   Monthly Benefit $: _____ Maximum Benefit Period: _____
   If Applicable, Termination Date: _____

   If applicable, please provide the other disability coverage approval, denial or statement for review.

Section 3 – MATERNITY ATTENDING PHYSICIAN'S STATEMENT. To be completed and signed by the Attending Physician

ICD 9/10 Code: _____Primary Diagnosis: _____

ICD 9/10 Code: _____Secondary Diagnosis: _____

List any diseases or infirmity affecting the present condition(s): _____

Please list any complications of pregnancy: _____

Last Menstrual Period: _____ Expected Due Date: _____ Delivery Date: _____ □ Vaginal or □ C-Section

The normal recovery period following delivery is 6 weeks for vaginal delivery & 8 weeks for c-section delivery. This includes the policy elimination period.

The patient is unable to perform their job duties: □ Yes □ No If yes, please provide the dates from: _____ through: _____

When is the patient expected to resume part time/partial duties: _____ full time/full duties: _____?

First Consultation: _____ Most Recent Consultation: _____ Next Consultation: _____ Released: _____

Hospital Admission Date: _____ Hospital Discharge Date: _____

Hospital: _____ City: _____ State: _____

PHYSICIAN VERIFICATION:

I am aware that it is a crime to fill out this form with facts I know are false or to leave out facts I know are relevant and important. I certify that the answers given on this form are true, complete and correctly recorded.

Signed: _____, MD Date: _____

Print Name: _____ Specialty: _____ Phone #: _____

Address: _____ City: _____ State: _____ Zip: _____

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CLAIMANT'S NAME: _____ **DATE OF BIRTH:** _____

COVERAGE NUMBER(S): _____ **CLAIM NUMBER:** _____

Section 4 – SUPPORTING CLAIM DOCUMENTATION. Send us any documentation showing the condition, treatment, and restrictions/limitations precluding you from working. This documentation must include the claimant's name, provider name, and date(s) of service.

Please provide a completed and signed: Attending Physician's Statement and Employer's Statement

Additional supporting documentation includes the following examples:

- Medical Documentation for the date of service that supports your claim such as: Hospital and/or Physician Office Records, Admission and Discharge Summaries, Diagnostic Test Results, Therapy Notes, Operative or Procedure Reports, Physician Consultation Notes and/or Home Nursing Visit Notes.
- **Additional Information (if applicable) such as:** Physician Letter or Certification, Job Description, Attendance Records, Itemized Bills, Explanation of Benefits, and/or any additional Information you would like us to review.

Section 5 – EMPLOYER'S STATEMENT. To be completed and signed by the Employer

Employment Information/Job Description:

□ Check here if you are self-employed, then complete and sign this form.

□ Check here if you are unemployed, please provide the last date you worked _____and prior employer's name then sign this form

Employer/Company Name: _____

Date of Hire: _____ Employee's Job Title/Position: _____

Please attach a copy of the job description or list major job responsibilities.

Major Responsibilities: _____

This job classification is: □ Sedentary, □ Light Work, □ Medium Work, □ Heavy Work, □ Very Heavy Work.

Prior to inability to work, he/she worked _____ hours per week. Hourly rate of pay: $_____ Annual Salary: $_____

*If you are self-employed, we may require proof of income. We will notify you if additional documentation is required.

Dates Missed Work / Returned to Work:

I hereby certify that _____ did not perform any part of his/her work from, _____ through _____.

Did the employee work light duty or part time? □ Yes □ No If yes, what dates? _____

When recovered, will he/she resume work? □ Yes □ No If no, why? _____

Has the employee returned to work? □ Yes □ No Part Time/Partial Duties: _____ Full Time/Full Duties on: _____

Section 125: Were the premiums for this Policy paid with pre-tax dollars under Section 125? □ Yes □ No

Employer Paid: Were premiums for this disability income policy/certificate Employer Paid? □ Yes □ No

If yes, FICA withholding will be deducted from the disability claim payment.

EMPLOYER VERIFICATION:

I am aware that it is a crime to fill out this form with facts I know are false or to leave out facts I know are relevant and important. I certify that the answers given on this form are true, complete and correctly recorded

Signed by: _____ Date: _____ Print Name: _____

Title: _____ Company: _____

Address: _____ Phone #: _____

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CLAIMANT'S NAME: _____ **DATE OF BIRTH:** _____

COVERAGE NUMBER(S): _____ **CLAIM NUMBER:** _____

Note: Don't forget to provide the supporting claim documentation.

Section 6 - CERTIFICATION: The Policy/Certificate Holder or Claimant who completed the claim form 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. **Please also remember to sign and date the attached authorization required to process your claim.**

Signature:_____ Print Name: _____ Date: _____

FRAUD WARNINGS BY STATE

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, 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 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 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: 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 thousand dollars ($5,000), not to exceed ten thousand 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 imprisonment.

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AUTHORIZATION TO RELEASE INFORMATION TO AMERICAN HERITAGE LIFE INSURANCE COMPANY

I hereby authorize any physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, health care provider, Pharmacy Benefit Manager, insurance company, the Medical Information Bureau (MIB) or other organization, institution or person that has any health related records or knowledge of me or minor dependents to disclose the entire medical record (excluding psychotherapy notes and in MAINE and VERMONT HIV related test results) to American Heritage Life Insurance Company (AHL), its duly authorized representatives, its subsidiaries or its reinsurers. This authorization extends to any minor dependent on whom insurance is requested or claim for benefits is being made.

The information to be obtained shall include insurance claim history from any Prescription Drug Database, pharmacy benefit manager, ambulance, insurance company, medical transport service, or the MIB. Also, I authorize any entity, person, or organization that has these records about me, including but not limited to my employer, employer representative and compensation sources, insurance company, financial institution or governmental entities, including departments of public safety and motor vehicle departments, to give any information or record it has about me, my employment, employment history or income to AHL.

I understand that this information will be used to evaluate and administer my claim for benefits or to evaluate my eligibility for insurance. I understand that there is a possibility of redisclosure of any information disclosed pursuant to this authorization and that information, once disclosed, may no longer be protected by certain federal regulations governing privacy and confidentiality, though it may still be protected by state privacy laws or other applicable privacy laws. I also authorize AHL or its reinsurers to make a brief report of my health information to MIB.

This authorization shall remain in force for 24 months following the date of my signature below or termination of my coverage, whichever occurs first. A copy of this authorization is as valid as the original. I or my legal representative may request a copy of this authorization. I understand that I may revoke this authorization at any time by sending a written notification to: **Attn: Privacy Officer, American Heritage Life Insurance Company, 1776 American Heritage Life Drive, Jacksonville, FL 32224.**

I understand that a revocation of this authorization is not effective if AHL has relied on the protected health information or has a legal right to contest a claim under an insurance policy or to contest the policy itself. The revocation will not apply to any information AHL requests or discloses prior to AHL receiving my revocation request. If I choose not to sign this authorization or if I later revoke it, I understand that AHL may not be able to process my application for coverage, or if coverage has been issued, AHL may not be able to administer my claim for benefits and this may result in a denial of my claim for benefits or request for services.

Your provider may require you to complete an additional authorization form. If asked to complete this authorization, your prompt response will help expedite the process.

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

_____ _____

Claimant/Applicant's Signature Date Signed (mm/dd/yyyy)

_____ _____XXX-XX-_____

Claimant/Applicant's Printed Name Last Four Digits of Social Security Number

If signed by the legal representative, please describe the authority under which the representative is authorized to act and enclose any related documentation granting authority.

_____ _____

Signature of Legal Representative Relationship

_____ _____

Print Name of Legal Representative Date Signed (mm/dd/yyyy)

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