GROUP VOLUNTARY ACCIDENT POLICY (GVAP1) CLAIM FORM

Allstate Benefits

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: 1-866-424-8482

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.

CERTIFICATE HOLDER / CLAIMANT INFORMATION:

CERTIFICATE NUMBER(s): _____ ; _____ ; _____

CERTIFICATE HOLDER: First Name: _____ MI: ____ Last Name: _____

Social Security Number: _____ Date of Birth: _____ Age: _____ ☐ Male ☐ Female

Mailing Address: _____ Apt#: _____

City: _____ State: _____ Zip: _____ ☐ **Check here if address is new**

Phone #: _____ E-mail: _____

Employer: _____ Occupation: _____ Salary: $_____

Were premiums for this certificate paid with pre-tax dollars? ☐ Yes ☐ No (If yes, FICA withholding will be deducted from the disability claim payment.)

CLAIMANT: (if different) First Name: _____ MI: ____ Last Name: _____

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

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

ACCIDENT CLAIM DETAILS: Please Provide the Following Accident Claim Details.

What is your Diagnosis/Condition? _____

Did your accidental injury occur while you were at work or working for pay or profit? ☐ Yes ☐ No

Have you ever had the same or similar condition? ☐ Yes ☐ No If yes, when: _____

Other conditions affecting your health: _____

Is your condition due to an accidental injury? ☐ Yes ☐ No Accident Date: ___/___/___ Time: _____ AM or PM

What was the accident or event that caused your injury? _____

What was the injury caused by your accident? _____

Where did your accidental injury happen? _____

Tell us exactly how your accidental injury happened: _____

Was a police report filed? ☐ Yes ☐ No For Motor Vehicle Accidents, you were the: ☐ Driver ☐ Passenger

When was your first physician visit for this accidental injury? ___/___/___ Last Visit: ___/___/___ Next Visit: ___/___/___

Were your hospitalized due to this accidental injury? ☐ Yes ☐ No Admission Date: ___/___/___ Discharge Date: ___/___/___

Did you miss work due to this accidental injury? ☐ Yes ☐ No What was the first date you were unable to work? ___/___/___

Describe why you are/were unable to work: _____

What job duties are/were you unable to perform? _____

Have you returned to work? ☐ Yes ☐ No Part time/Partial duties: ___/___/___ Full time/Full duties: ___/___/___

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. Please check to be sure all information is correct before signing. Please refer to the fraud notice specific to your state.

CLAIMANT'S NAME: _____ Date of Birth: _____

CERTIFICATE NUMBER(S): _____ Claim Number: _____

GVAP1 ACCIDENT BENEFITS: The following are benefits available under the **Accident Certificate**. Please select the **Benefits** you believe may be due **based upon the Covered Person's Accidental Injury** and attach the **Required Documentation**. The required bills from your provider include: UB04, HCFA 1500, or an itemized bill. We also need you to sign and submit the Authorization to Release Information to AHL form ABJ21476. You will be notified if additional information is needed. If your coverage includes additional benefits for which you have a claim, please also complete the appropriate claim form(s) for those benefits and submit with this claim form.

Benefits may vary by product and/or state. Please refer to your certificate and rider for specific benefits available under your Coverage.

☐ **NEW CLAIM** **or** ☐ **CONTINUED CLAIM**

- ☐ **Medical Expense Benefit:** Provide the bill(s) for medical expenses incurred. The bill(s) needs to include the diagnosis, date of service and the charges incurred.
- ☐ **Ambulance Benefit:** Provide the ambulance bill or documentation of an ambulance transfer. ☐ **Air** or ☐ **Ground**
- ☐ **Initial Hospitalization Benefit:** Provide the inpatient hospital bill including the diagnosis, dates of service and room and board charges.
- ☐ **Hospital Confinement Benefit:** Provide the inpatient hospital bill including the diagnosis, dates of service and room and board charges.
- ☐ **Intensive Care Benefit:** Provide the inpatient hospital bill including the diagnosis, dates of service and room and board charges for intensive care.
- ☐ **Fracture Benefit:** Provide the radiology report showing a fracture.
- ☐ **Dislocation Benefit:** Provide the radiology report showing a dislocation.
- ☐ **Dismemberment Benefit:** Provide the operative report showing dismemberment.
- ☐ **Death Benefit:** Complete AD&D Claim form located on www.allstatebenefits.com or call 1-800-348-4489.
- ☐ **Common Carrier Accidental Death Benefit:** Complete AD&D Claim form located on www.allstatebenefits.com or call 1-800-348-4489.
- ☐ **Outpatient Physician's Treatment Benefit:** Provide a copy or a bill or documentation of treatment provided by a physician, outside of the hospital.

PROVIDERS: Please list all Providers you have seen in the past 2 years including the providers treating you for this Condition.

1. _____ Attending Physician's Name | _____ Address | _____ Phone #
   _____ Specialty | _____ Dates Consulted | _____ Reasons for Visit/Condition
2. _____ Primary Care Physician's Name | _____ Address | _____ Phone #
   _____ Specialty | _____ Dates Consulted | _____ Reasons for Visit/Condition
3. _____ Other Physician/Specialist Name | _____ Address | _____ Phone #
   _____ Specialty | _____ Dates Consulted | _____ Reasons for Visit/Condition
4. _____ Hospital Name | _____ Address | _____ Phone #
   _____ Dates Hospitalized | _____ Reason for Hospitalization/Condition

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. **Please also remember to sign and date the attached authorization required to process your claim.**

Signature: _____ Print Name: _____ Date: _____

ASSIGNMENT OF BENEFITS (Not applicable 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.*

_____ Name | _____ Address

_____ Provider's Tax Identification Number: | _____ City | _____ State | _____ Zip

_____ Relationship | _____ Signature of Policy Owner | _____ Date

**** 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.***

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. Please check to be sure all information is correct before signing. Please refer to the fraud notice specific to your state.