AMERICAN HERITAGE LIFE INSURANCE COMPANY
HOME OFFICE:
1776 AMERICAN HERITAGE LIFE DRIVE
JACKSONVILLE, FLORIDA 32224-6688
(904) 992-1776

DEATH CLAIM INSTRUCTIONS FOR INDIVIDUAL POLICIES

Please submit the following information with your claim:

1. A certified copy of the Insured person's Death Certificate
2. The Claimant's Statement completed by the beneficiary – all sections should be fully completed.
3. The Policy(ies)
4. Proof of death on the beneficiary (if applicable)
5. If there is no living beneficiary OR if the Estate is the named beneficiary – please provide Court documentation showing who has been appointed as the Executor of the Estate.
6. Proof of birth and Social Security number if the beneficiary is a minor (if applicable)
7. Legal Guardianship papers from the Court if the beneficiary is a minor (if applicable)
8. A copy of the Accident report (if applicable)
9. A copy of the Homicide report (if applicable)
10. A complete copy of Divorce papers between Insured and beneficiary (if applicable)

Your claim will receive our immediate attention once this information has been received. If you have any questions regarding your claim or require additional information, please do not hesitate to contact our Customer Care Department at 1-800-348-4489. We are always happy to help you.

Please mail your claim form to:

American Heritage Life Insurance
1776 American Heritage Life Drive
Jacksonville, Florida 32224-6688
ATTN: INDIVIDUAL LIFE CLAIMS

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 service department at 1-800-348-4489 8:15 A.M. to 4:30 P.M. Eastern Standard Time

Workplace Division

American Heritage Life Insurance Company

1776 American Heritage Life Drive
Jacksonville, Florida 32224-6688

CLAIMANT'S STATEMENT

CLAIMANT'S STATEMENT TO BE COMPLETED IN FULL (Please print or type)

PART A

1a. Full Name of Deceased Insured

____
(Last) *(First)* *(M.I.)*

1b. Other names insured may be known by (i.e. maiden name, hyphenated name, nickname, alias):______________
____

2. Legal residence at time of death

Street_________________________________

City ________________________ State _____Zip__________

3. Date of Birth Month_________ Day ________ Year ________

4. a. Male_______ Female_______ b. Marital Status__________

c. Social Security Number______________________________

5. Date of Death Month__________ Day_______ Year_______

6. Place of Death City____________________ State_________

7. Cause of Death ________________________________

8. When did Deceased first complain of, or give other indications of his/her last illness? Date:_______________

9. When did Deceased first consult a physician for his/her last illness? Date: ___________________

10. On what date did Deceased last attend his/her usual work? Date: __________________________

PART B

COMPLETE THIS PORTION FOR:

A. Policies in force less than 2 years or REINSTATED within TWO years of death, OR

B. Accidental Death, Homicide, Suicide, Self-Inflicted Injuries and Unusual Death. (SEE REVERSE SIDE)

1. Full name and address of Deceased Insured's personal physician:_________________________________

2. Full name and address of any other doctors who treated the Deceased Insured during the last 5 years:

____
____
____

3. Full name, address and telephone number of the Deceased Insured's Employer:_________________

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____
____

4. Deceased's Driver's License # __________________

State of Issue______________________________

PART C — ABOUT THE PERSON MAKING THE CLAIM

1. Your full name: ____
(Last) (First) (Middle)

2. Your Social Security No.________/_____/__________ 3. Your date of birth: ______________________

4. Your residence/address ______________________________City/State_______________ Zip Code __________

5. Your relationship to the deceased ______________________________________Your phone # _____________

The undersigned hereby makes claim to said insurance issued by this Company and agrees that the written statements and affidavits of all the physicians who attended or treated the insured, and all other papers called for by the instructions hereon, shall constitute and are hereby made a part of this Claimant's Statement, and further agrees that by furnishing this form, or any other supplemental forms, by the Company shall not constitute nor be considered an admission that there was any insurance in force on the life in question, nor a waiver of any of its rights or defenses.

AUTHORIZATION

I hereby authorize any hospital, practitioner, clinic, or other medically related facility, pharmacy, insurance company or government agency or other person who has attended the deceased to disclose or furnish American Heritage Life Insurance Company, or its designee, any and all medical information with respect to any illness or injury the Insured may have suffered including but not limited to medical history, drug/alcohol abuse, AIDS or AIDS related conditions; or other consultations, prescriptions, diagnosis and treatment; or any information regarding benefits provided, together with copies of all other medical records that may be requested. The information provided to American Heritage Life Insurance Company, or its designee is to be used solely for purposes of evaluating a claim. This Authorization is valid for a period of 24 months from the date signed. I understand that I may revoke this Authorization by notifying American Heritage Life in writing of my desire to do so. A photographic copy of the Authorization shall be as valid as the original, regardless of the date signed. I understand that 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 or its designee. **Important: To avoid delay, please sign authorization below.**

Note: Due to Internal Revenue Service requirements concerning social security number verification and backup withholding requirements, this form is required to be completed prior to claim payment. 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 refer to the fraud notices on the reverse side for notice specific to your state. Check to be sure that all information is correct before signing.

Taxpayor Identification Number Certification

Federal law requires us to send to the Internal Revenue Service a percentage of any income you may be entitled to unless you certify under penalties of perjury that you have shown your correct Social Security Number and you have not been notified that you are subject to any Internal Revenue Service backup withholding order.

Under penalties of perjury, I certify that:

A. The Social Security Number shown in line (2) of Part C is my correct taxpayor identification number (or I am waiting for a number to be issued to me), and

B. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) The IRS has notified me that I am no longer subject to backup withholding, and

C. I am a U.S. person (including a U.S. resident alien).

The Internal Revenue Service does not require your consent to any provisions of this document other than the certification required to avoid backup withholding.

Sign here ______________________________ Date:____________________ ☐ Check here if address is new
Claimant

Street Address:_________________________City:________________State:________ Zip: ________Telephone No. ( ) __________

Allstate Workplace Division is the marketing name for American Heritage Life Insurance Company (home office: Jacksonville, Florida - ahlcorp.com). All products are underwritten by American Heritage Life Insurance Company, a wholly-owned subsidiary of The Allstate Corporation (home office: Northbrook, Illinois - allstate.com).

(See Reverse Side)