CLAIM FORM AND INSTRUCTIONS

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

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 CANCER / SPECIFIED DISEASE / ICU / HEART / STROKE CLAIMS

- To avoid processing delays, 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 **1-972-510-1773**. Please be assured that your claim will receive our immediate attention. You will usually receive a response from us in the mail within 10 business days following the receipt of your claim. The length of time in the mail will depend on your location.
- 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.allstateatwork.com.
- 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:** ______________________________

INSTRUCTIONS FOR FILING TRANSPORTATION AND LODGING CLAIMS:

£ Please attach receipts for lodging and transportation (common carrier).

TRANSPORTATION AND LODGING

Name of Patient: ______________________ Condition Treated: ______________________

Dates of Travel: ______________________ Dates of Lodging: ______________________

Home Address: ______________________ Location of Treatment: ______________________

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).______________________

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