Allstate Benefits

GROUP VOLUNTARY ACCIDENT POLICY (GVAP1) 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: 1-866-424-8482

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.

AMERICAN HERITAGE LIFE INSURANCE COMPANY
HOME OFFICE:
1776 AMERICAN HERITAGE LIFE DRIVE
JACKSONVILLE, FLORIDA 32224-6687

AUTHORIZATION TO RELEASE INFORMATION TO AHL

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.

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

____________________________ ________________________
Claimant/Applicant's Printed Name — 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)