



OUTPATIENT PHYSICIAN'S TREATMENT 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 1-866-427-3730

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.

POLICYHOLDER / CERTIFICATE HOLDER:

POLICY / CERTIFICATE NUMBER(s): _____

POLICYHOLDER / 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: _____

PATIENT'S INFORMATION:

First Name: _____ MI: _____ Last Name: _____

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

Relation to Policyholder / Certificate Holder: Self Spouse Child Other

OUTPATIENT PHYSICIAN'S TREATMENT BENEFIT

Your coverage includes an Outpatient Physician's Treatment Benefit that pays a benefit when a covered person receives treatment by a physician outside of a hospital. Please refer to your policy / certificate for limitations that may apply.

Reason for the physician treatment / examination:

- Accident
- Illness
- Well/Preventative Exam

Please provide the following:

Provider Name: _____

Provider Address: _____

Date(s) of service: _____

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.*

FRAUD WARNINGS BY STATE

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 ALASKA, ARKANSAS, KENTUCKY, LOUISIANA, MAINE, NEW JERSEY AND NEW MEXICO: 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 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 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 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.