



Allstate

Workplace Division

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 GROUP VOLUNTARY STD / LTD / WAIVER OF PREMIUM CLAIMS

- To avoid delays in processing please fill out the sections which apply to your specific claim.
- Include your policy number(s). To obtain your policy number call **1-800-348-4489**.
- You may **fax** your claim to us at **1-972-510-1781**. 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 40795
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.

CERTIFICATEHOLDER

Employer Name (Company/Address): _____ Occupation: _____

1. Certificateholder's Name: First: _____ Middle: _____ Last: _____

E-mail: _____ Certificate Number: _____

Social Security Number: _____ Date of Birth: ____/____/____ Male Female
MO/DAY/YR

2. Home Number: (____) _____ Avg. Monthly Earnings: _____

PATIENT'S INFORMATION

3. Name: First: _____ Middle: _____ Last: _____

4. Date of Birth: ____/____/____ Age: _____ Social Security Number: _____ Male Female
MO/DAY/YR

This person is your: _____ (ex: self, wife, son, etc.)

FIRST CLAIM **CONTINUED CLAIM**

GROUP VOLUNTARY STD/LTD Policy No.(s): _____

Waiver of Premium

INSTRUCTIONS FOR FILING FIRST CLAIM FOR DISABILITY AND WAIVER OF PREMIUM:

We need:

- Attending Physician's Statement** should be completed and signed by your doctor.
- Employer's Statement** should be completed, including your monthly salary and pre-tax information, and signed by your employer. If you are self-employed, also send us a copy of your current business license and your most recent quarterly tax records. Additional information may be required.

Please submit a copy of your payment statement with this form. Please have your treating physician complete the ATTENDING PHYSICIAN STATEMENT and your employer complete the EMPLOYER'S STATEMENT.

DISABILITY AND WAIVER OF PREMIUM CLAIMS (CERTIFICATEHOLDER)

INJURY OR ILLNESS YOU ARE CLAIMING: _____

Date you were first treated for your illness or injury: _____ / _____ / _____ Date you were last treated for your illness or injury: _____ / _____ / _____
MO/DAY/YR MO/DAY/YR

Date of your accident or the date you first noticed the symptoms of your illness: _____ / _____ / _____
MO/DAY/YR

If you are claiming an injury, did your injury occur at work? Yes No

List all physicians seen in the past five (5) years:

Name	Address	Phone	Specialty	Dates Consulted	Reason for Consult
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_____	_____	_____	_____	_____	_____
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List all hospital confinements in the past five (5) years:

Name	Address	From/To	Reason Confined
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_____	_____	_____	_____
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List all pharmacies used in the past five (5) years: (include address and phone number)

I have been unable to work since: _____ / _____ / _____ I returned to work on a part-time full-time basis: _____ / _____ / _____
MO/DAY/YR MO/DAY/YR

Describe why you are unable to work: _____

Are you receiving Disability Benefits (Salary Continuation, Sick Pay, Social Security Disability Income, or Workers' Compensation) from any other source? If "yes," from whom? _____

DISABILITY CLAIM FOR ROUTINE PREGNANCY

Expected Recovery Period is 6 weeks for vaginal delivery, or 8 weeks for C-Section.

If disabled due to complications of pregnancy, before or after delivery, please complete Policyholder, Attending Physician's Statement, and Employer's Statement sections.

Date of Delivery: _____ / _____ / _____ First Date of Treatment: _____ / _____ / _____ Type of delivery: Vaginal C-Section
MO/DAY/YR MO/DAY/YR

Date of Hospital Confinement: _____ / _____ / _____ Name of Hospital: _____ Phone No.: (_____)
MO/DAY/YR

Physician's Name: _____ Phone: (_____)

Address: _____ Fax: (_____)

Treating Physician's Signature: _____ Date: _____ / _____ / _____ Tax Identification No.: _____
MO/DAY/YR

Referring Physician: _____ Phone No.: (_____)

Mailing Address: _____

EMPLOYER'S STATEMENT

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. Check to be sure that all information is correct before signing. Please refer to page 2 for notices specific to your state.

1. I hereby certify that _____ did not perform any part of his/her work from, _____ through, _____
2. Did insured work light duty or part-time? Yes No If yes, give dates _____
3. Prior to inability to work, he/she worked _____ hours per week and is considered exempt or non-exempt.
4. When recovered, will he/she resume work? Yes No If not why? _____
5. Is this a Workers' Compensation case? Yes No Date Workers' Compensation benefits began _____ / _____ / _____
MO/DAY/YR

Name of Workers' Compensation Company _____

6. Section 125: Were the premiums for our disability income policy paid with pre-tax dollars under a Section 125 Plan? Yes No
7. Is the employee receiving or has he/she received continued pay? Yes No If yes, please complete the following:

<u>From</u>	<u>Pay Period</u> <u>To</u>	<u>Amount</u>	<u>Source of Income</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

8. Current Salary or Hourly Rate: _____
 9. Name of Employer: _____ Date: _____ / _____ / _____
MO/DAY/YR
- Address: _____
- By: _____ Official Position: _____ Telephone number: (____) _____
10. The employee's job title or position is: _____
 11. Is the employee covered under any other disability policy through the company? _____
 12. Has employee returned to work? Yes No If yes, give date: _____ / _____ / _____
MO/DAY/YR

Remarks: _____

ATTENDING PHYSICIAN'S STATEMENT (PHYSICIAN)

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). _____

10. If retired or unemployed which activities of daily living (ADLs) is patient unable to perform? _____

11. Date patient last examined by you: _____ Frequency of visits: weekly monthly other _____

12. Is patient: ambulatory bed confined house confined other _____

13. If patient is hospitalized, give name and address of hospital.

Hospital: _____ City: _____ State: _____

14a. Date admitted: _____ / _____ / _____ Date discharged: _____ / _____ / _____
MO/DAY/YR MO/DAY/YR

14b. When do you expect patient to resume partial duties? _____ / _____ / _____ Full duties? _____ / _____ / _____
MO/DAY/YR MO/DAY/YR

14c. If patient is unemployed or retired, on what date would you expect a person of like age, gender and good health to resume his/her normal and necessary activities? _____ / _____ / _____
MO/DAY/YR

15. Is condition due to injury or sickness arising out of patient's employment? Yes No

If "yes," explain. _____

16. Referring Physician: _____ Phone: (____) _____

Mailing Address: _____

PHYSICIAN VERIFICATION

Signed: _____, MD Date: _____ / _____ / _____ Phone: (____) _____
MO/DAY/YR

Street Address: _____

City/Town: _____

State/Province: _____ Zip Code: _____