



DISABILITY POLICY CLAIMS CHECKLIST

Disability

Claim Form

- ◆ All of the claim form needs to be completed including the HIPAA
- ◆ Page 3 of 6: Section E ***Only if filing due to pregnancy.
- ◆ Page 4 of 6: Part 2, Attending Physician's Statement *** This must be **COMPLETELY** filled out! **A beginning date must appear on line 8 and an ending date must appear on either line 8 or line 14b.** If you are out further than the ending date provided, then you can submit another Physician's Statement with updates.
- ◆ Page 4 of 6: Physician Verification. *** This must be **COMPLETELY** filled out and signed by the Physician.
- ◆ Page 5 of 6: Employer's Statement ***Taylor Insurance will request from your HR department. You do not need to complete this section.

You may fax your claim to Taylor Insurance at (229) 247-6864, ATTN: Claims. Please include a coversheet with a contact number and current address.

** This is not an all inclusive list. It is meant to be used as an aid in filing a claim.

** Please allow 10 to 14 business days for processing.


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 CLAIMS

- Please fill out the sections which apply to your specific claim.
- Enclose the information requested and include your policy number. To obtain your policy number call **1-800-348-4489**.
- You may **fax** your claim to us at **1-904-992-2899**. Please allow 3 business days for our records to be updated with information confirming receipt of your fax or claim; or
- You may mail your claim to:

Allstate Workplace Division
Attn: Claim Department
1776 American Heritage Life Drive
Jacksonville, Florida 32224-6687
- Additional claim forms are available on our website at www.ahcorp.com.
- If you are filing a claim within the first 12 to 24 months your policy is in force, additional information may be required. Please notify your doctor we will be contacting him/her and provide him/her with a copy of your authorization to release information to us.
- **FOR ALL CLAIMS (First Claim or Continued Claim):**
 - Complete PART 1: Section A – POLICYHOLDER and,
 - Sign the Authorization (Page 2)

PART 1

Section A POLICYHOLDER/ CERTIFICATEHOLDER

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

1. Name: First: _____ Middle: _____ Last: _____

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

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

PATIENT

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

 4. Date of Birth: _____ / _____ / _____ Age: _____ Male Female
MO/DAY/YR

 5. This person is your: _____ (ex: self, wife, son, etc.) Is he/she a full-time student? Yes No If yes, please submit proof of student status.

Section B TYPE OF CLAIM: FIRST CLAIM CONTINUED CLAIM

_____ ACCIDENT/DISABILITY Policy No.(s): _____

-
- Routine Pregnancy
-
-
- Ongoing Disability

-
- Outpatient Physicians Benefit
-
-
- Hospital Income Benefit

_____ CANCER Policy No.(s): _____

-
- Wellness Benefit
-
-
- Intensive Care

_____ HEART/STROKE Policy No.(s): _____

_____ HOSPITAL INDEMNITY Policy No.(s): _____

_____ CRITICAL ILLNESS Policy No.(s): _____

_____ WAIVER OF PREMIUM Policy No.(s): _____

➔ PLEASE NOTE: Failure to complete this information will cause a delay in the processing of your claim.

Allstate Workplace Division is the marketing name for American Heritage Life Insurance Company (home office: Jacksonville, Florida), a wholly-owned subsidiary of The Allstate Corporation (home office: Northbrook, Illinois)

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. Check to be sure that all information is correct before signing.

1. **Section 125:** Were the premiums for your **disability income policy** paid with pre-tax dollars under a Section 125 Plan? Yes No (if in doubt, please ask your employer.)

Taxpayer Identification Number Certification

2. **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 Section A line (1) is my correct taxpayer 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).**

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medically related facility, insurance company or other organization, institution or person that has any records or knowledge of me (or my dependents) to give such information to American Heritage Life Insurance Company or its designee. 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 American Heritage Life in writing of my desire to do so. A photographic copy of this authorization shall be as valid as the original, regardless of 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.

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.: () _____

NOTICE IN ALASKA, ARKANSAS, KENTUCKY, LOUISIANA, MAINE, NEW JERSEY, NEW MEXICO, AND VIRGINIA:

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 DELAWARE, IDAHO, INDIANA, MINNESOTA, NEW HAMPSHIRE, 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 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 DISTRICT OF COLUMBIA: WARNING: 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.

NOTICE IN OHIO: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

NOTICE IN PENNSYLVANIA: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

NOTICE IN TENNESSEE: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

NOTICE IN TEXAS: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

INSTRUCTIONS FOR FILING ACCIDENT CLAIMS

We need:

- A copy of the hospital bill. Make sure the bill includes your diagnosis and the number of days you were in the hospital. If you were treated in the emergency room or a doctor's office, please include a copy of these bills also.
- PART 2: Attending Physician's Statement** should be completed and signed by your doctor

We may also need:

- A copy of the **accident report** if the accident was investigated by the police or sheriff.
- A copy of the **blood alcohol report** or **drug screening** if the patient was tested for alcohol or drugs.
- A **certified copy of the death certificate** if the patient is deceased.

Section C ACCIDENT POLICY CLAIMS

Please attach itemized bill(s), including date(s) of service, diagnosis code(s), procedure codes(s) and charge(s).

Date of accident: ____/____/____ Injury: ____/____/____ Time of accident: _____ a.m. p.m.
MO/DAY/YR MO/DAY/YR

Where did it happen? _____ Tell us exactly how your accident/injury happened: _____

Did your injuries occur while you were working for pay or profit? Yes No On the job Off the job
Have you ever had a similar injury? _____ If so, please tell us when: ____/____/____
MO/DAY/YR

If you are claiming disability due to your accident, please have your physician complete the ATTENDING PHYSICIAN STATEMENT, PART 2 and your employer complete the EMPLOYER'S STATEMENT, PART 4.

INSTRUCTIONS FOR FILING FIRST CLAIM FOR DISABILITY (due to Accident or Sickness) AND WAIVER OF PREMIUM:

PART 2: Attending Physician's Statement should be completed and signed by your doctor.

- PART 4: 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.

Section D DISABILITY AND WAIVER OF PREMIUM CLAIMS

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

List all hospital confinements in the past five (5) years:

Name	Address	From/To	Reason Confined

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? _____

Please submit a copy of your payment statement with this form. Please have your treating physician complete the ATTENDING PHYSICIAN STATEMENT, PART 2 and your employer complete the EMPLOYER'S STATEMENT, PART 4.

Section E DISABILITY CLAIM FOR ROUTINE PREGNANCY (6 weeks for vaginal delivery, or 8 weeks for C-Section)

If disabled due to complications of pregnancy, before or after delivery, please complete Section D.

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: _____

If you are filing a claim for disability or waiver of premium, please have your employer and physician complete PARTS 2 & 4.

PART 2 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). _____
 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. _____
- Name and address of referring physician if any.
Name: _____ Address: _____
City: _____ State: _____ Zip _____
16. Have you completed paperwork for any other insurance company? Yes No Social Security Disability? Yes No

If you are claiming CONTINUING DISABILITY, please have your employer and physician complete PARTS 3 & 4.

PART 3 ATTENDING PHYSICIAN'S STATEMENT FOR CONTINUING DISABILITY

FIRST CLAIM FOR DISABILITY due to Accident or to Sickness: _____ / _____ / _____
MO/DAY/YR

1. Is this claim for continuation of a previous disability? Yes No
 - 2a. Diagnosis: _____
 3. Describe any other diseases or infirmity affecting present condition. _____
 4. Date of initial disability due to this diagnosis _____ / _____ / _____
MO/DAY/YR
 5. Is patient unable to perform job duties? Yes No If yes, may return to work part-time full-time on : _____ / _____ / _____
MO/DAY/YR
- List any work restrictions: _____ If No, date expected to return to work: _____ / _____ / _____
MO/DAY/YR

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 notice specific to your state.

PHYSICIAN VERIFICATION

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

Street Address: _____

City/Town: _____

State/Province: _____ Zip Code: _____

PART 4**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 notice 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:

Pay Period		Amount	Source of Income
From	To		
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

8. Is the employee covered under any other disability policy through the company? _____

9. Has employee returned to work? Yes No If yes, give date: _____ / _____ / _____
MO/DAY/YR

10. The employee's job title or position is: _____

11. Current Salary or Hourly Rate: _____

Remarks: _____

Name of Employer: _____ Date: _____ / _____ / _____
MO/DAY/YR

Address: _____

By: _____ Official Position: _____ Telephone number: (_____) _____

NOTE: Please make a copy of the patient's signed authorization to release information for your records.

