



Allstate

Benefits

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 1-866-424-8482

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.

POLICYHOLDER / CERTIFICATEHOLDER INFORMATION

POLICY NUMBER(s): 1) _____ 2) _____ 3) _____

POLICYHOLDER INFORMATION:

First Name: _____ MI: _____ Last Name: _____

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

Mailing Address: _____ Apt#: _____

Check here if address is new

City: _____ State: _____ Zip: _____

Phone #: (____) _____ E-mail: _____

PATIENT'S INFORMATION:

First Name: _____ MI: _____ Last Name: _____

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

Relation to Insured: Self Spouse Child Other

OUTPATIENT PHYSICIAN'S TREATMENT BENEFIT The benefit described below is available for Outpatient Physician's Treatment. Please attach the required documentation requested. If additional information is needed, you will be notified.

Outpatient Physician's Treatment Benefit

The outpatient physician treatment benefit is for treatment provided by a physician outside of the hospital. The visit may be provided for a sickness, accident, well exam, physical exam, eye exam or dental exam. Please refer to your policy for the specific benefit information.

REQUIRED DOCUMENTATION: Please provide the following:

Provider Name: _____

Provider Address: _____

Date(s) of service: ____/____/____ and ____/____/____

Please attach a copy of a bill or documentation of treatment provided by a physician, outside of the hospital.

ASSIGNMENT OF BENEFITS (n/a 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. **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.**

Name _____

Address _____

Provider's Tax Identification Number: _____

City _____ State _____ Zip _____

Relationship _____

Signature of Policy Owner _____ Date ____/____/____

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. **In order to process your claim, sign and date the authorization on the following page.**

Signature: _____ Print Name: _____ Date: ____/____/____

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 OREGON: Any person who makes intentional misstatement that is material to the risk may be found guilty of insurance fraud by a court of law.

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 PUERTO RICO: Any person who knowingly and with the intention to defraud includes false information in an application for insurance or file, assist or abet in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousands dollars (\$5,000), not to exceed ten thousands dollars (\$10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.

NOTICE IN TENNESSEE AND WASHINGTON: 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.

NOTICE IN WEST VIRGINIA AND RHODE ISLAND: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison