

**CLAIM FORM**

If you have any questions regarding our determination of your claim, or if you would like to appeal any determination, please contact our customer service department at 1-800-348-4489  
8:15 A.M. to 4:30 P.M.  
Eastern Standard Time



Workplace Division

**CLAIMANT'S STATEMENT**

**American Heritage Life Insurance Company**  
1776 American Heritage Life Drive  
Jacksonville, Florida 32224-6688

**CLAIMANT'S STATEMENT TO BE COMPLETED IN FULL (Please print or type)**

PART A	PART B
<p>1a. Full Name of Deceased Insured</p> <p style="text-align: center;">_____</p> <p style="text-align: center;">(Last)                      (First)                      (M.I.)</p> <p>1b. Other names insured may be known by (i.e. maiden name, hyphenated name, nickname, alias): _____</p> <p>2. Legal residence at time of death</p> <p>Street _____</p> <p>City _____ State _____ Zip _____</p> <p>3. Date of Birth Month _____ Day _____ Year _____</p> <p>4. a. Male _____ Female _____ b. Marital Status _____</p> <p>c. Social Security Number _____</p> <p>5. Date of Death Month _____ Day _____ Year _____</p> <p>6. Place of Death City _____ State _____</p> <p>7. Cause of Death _____</p> <p>8. When did Deceased first complain of, or give other indications of his/her last illness? Date: _____</p> <p>9. When did Deceased first consult a physician for his/her last illness? Date: _____</p> <p>10. On what date did Deceased last attend his/her usual work? Date: _____</p>	<p><b>COMPLETE THIS PORTION FOR:</b></p> <p>A. Policies in force less than 2 years or REINSTATED within TWO years of death, OR</p> <p>B. Accidental Death, Homicide, Suicide, Self-Inflicted Injuries and Unusual Death. (SEE REVERSE SIDE)</p> <p>1. Full name and address of Deceased Insured's personal physician: _____</p> <p>2. Full name and address of any other doctors who treated the Deceased Insured during the last 5 years:</p> <p>_____</p> <p>_____</p> <p>3. Full name, address and telephone number of the Deceased Insured's Employer: _____</p> <p>_____</p> <p>_____</p> <p>4. Deceased's Driver's License # _____</p> <p>State of Issue _____</p>

PART C	ABOUT THE PERSON MAKING THE CLAIM
<p>1. Your full name: _____</p> <p style="text-align: center;">(Last)                      (First)                      (Middle)</p> <p>2. Your Social Security No. _____ / _____ / _____</p> <p>3. Your date of birth: _____</p> <p>4. Your residence/address _____ City/State _____ Zip Code _____</p> <p>5. Your relationship to the deceased _____ Your phone # _____</p>	

The undersigned hereby makes claim to said insurance issued by this Company and agrees that the written statements and affidavits of all the physicians who attended or treated the insured, and all other papers called for by the instructions hereon, shall constitute and are hereby made a part of this Claimant's Statement, and further agrees that by furnishing this form, or any other supplemental forms, by the Company shall not constitute nor be considered an admission that there was any insurance in force on the life in question, nor a waiver of any of its rights or defenses.

**AUTHORIZATION**

I hereby authorize any hospital, practitioner, clinic, or other medically related facility, pharmacy, insurance company or government agency or other person who has attended the deceased to disclose or furnish American Heritage Life Insurance Company, or its designee, any and all medical information with respect to any illness or injury the Insured may have suffered including but not limited to medical history, drug/alcohol abuse, AIDS or AIDS related conditions; or other consultations, prescriptions, diagnosis and treatment; or any information regarding benefits provided, together with copies of all other medical records that may be requested. The information provided to American Heritage Life Insurance Company, or its designee is to be used solely for purposes of evaluating a claim. This Authorization is valid for a period of 24 months from the date signed. I understand that I may revoke this Authorization by notifying American Heritage Life in writing of my desire to do so. A photographic copy of the Authorization shall be as valid as the original, regardless of the 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 or its designee. **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. 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 refer to the fraud notices on the reverse side for notice specific to your state. Check to be sure that all information is correct before signing.**

**Taxpayer Identification Number Certification**

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 line (2) of Part C 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).

**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. ( ) \_\_\_\_\_

Allstate Workplace Division is the marketing name for American Heritage Life Insurance Company (home office: Jacksonville, Florida - ahlcorp.com). All products are underwritten by American Heritage Life Insurance Company, a wholly-owned subsidiary of The Allstate Corporation (home office: Northbrook, Illinois - allstate.com).

**PART D***Please attach copy of Bank Deposit Slip*

Please complete the following information if you would prefer the direct deposit of claim proceeds into your personal bank account:

Bank Name: \_\_\_\_\_ Bank Telephone Number: \_\_\_\_\_

Bank Address: \_\_\_\_\_ City and State \_\_\_\_\_

Account Number: \_\_\_\_\_ Routing # \_\_\_\_\_

**NOTE: FAILURE TO COMPLETE THE FOLLOWING INFORMATION MAY DELAY THE CLAIM:  
FOR OTHER THAN NATURAL DEATH, GIVE DETAILED INFORMATION BELOW**

1. If an autopsy was made, where can a copy be obtained? \_\_\_\_\_

2. Was an investigation made?  Yes  No If so, by whom?

Law Enforcement Agency/Department: \_\_\_\_\_

Address \_\_\_\_\_ City & State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone No. ( \_\_\_\_\_ ) \_\_\_\_\_

3. State from whom you obtained the information and provide details. \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

LIST POLICY NUMBERS WITH AMERICAN HERITAGE LIFE INSURANCE COMPANY POLICY NUMBER	OTHER INSURANCE ON THE LIFE OF THE DECEASED LIST COMPANIES AND AMOUNTS COMPANY	AMOUNT
		\$
		\$

**NOTICE:** 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

**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 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 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 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 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 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 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.