



**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 A HOSPITAL INDEMNITY (SHOP) CLAIM

- 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(s) call **1-800-348-4489**.
- You may **fax** your claim to us at **1-972-510-1773**. 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 43067  
Jacksonville, Florida 32203-3067**
- Additional claim forms are available on our website at [www.allstateatwork.com](http://www.allstateatwork.com).
- If you are filing a claim within the first 24 months your policy is in force, additional information may be required.

### POLICYHOLDER

Employer Name (Company): \_\_\_\_\_ Occupation: \_\_\_\_\_

1. Policyholder's Name: First: \_\_\_\_\_ Middle: \_\_\_\_\_ Last: \_\_\_\_\_

E-mail: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  Male  Female  
MO/DAY/YR

2. Home Number: (\_\_\_\_) \_\_\_\_\_

### PATIENT'S INFORMATION

3. Name: First: \_\_\_\_\_ Middle: \_\_\_\_\_ Last: \_\_\_\_\_

4. Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Age: \_\_\_\_\_ Social Security Number: \_\_\_\_\_  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.

### INSTRUCTIONS FOR FILING HOSPITAL INDEMNITY (SHOP) CLAIMS:

- Please include a copy of your itemized hospital bill with the admitting diagnosis.
- Have your doctor complete the Attending Physician's Statement including the diagnosis treated. Attach an itemized bill showing the services provided, procedure codes and the actual charges made to you.
- Any other bills pertaining to this claim, such as anesthesia, ambulance and receipts for your prescription drugs.

### INSTRUCTIONS FOR FILING TRANSPORTATION CLAIMS:

- Please attach receipts for transportation (common carrier) and complete below for mileage.

Dates of Travel: \_\_\_\_\_ Location of Treatment: \_\_\_\_\_

Home Address: \_\_\_\_\_

## 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

**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 3 for notice specific to your state.**

## PHYSICIAN VERIFICATION

Signed: \_\_\_\_\_, MD Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_  
MO/DAY/YR

Street Address: \_\_\_\_\_

City/Town: \_\_\_\_\_

State/Province: \_\_\_\_\_ Zip Code: \_\_\_\_\_

## ASSIGNMENT OF BENEFITS

I request that American Heritage Life Insurance Company send benefits to someone other than me. Please send benefits available to the name and address shown below:

Name _____	Address _____
Provider's Tax Identification Number _____	City _____ State _____ Zip _____
Relationship _____	

Signature of Policy Owner \_\_\_\_\_

Date \_\_\_\_\_

