MATERNITY DISABILITY 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): _____; _____; _____; _____

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 INFORMATION: (If different)

First Name: _____ MI: _____ Last Name: _____

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

Relation to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

DISABILITY BENEFITS: Please complete the questions below and attach the required documentation for review of your Maternity Disability claim. If additional information is needed, you will be notified. For assistance, please contact our Customer Care Center at 1-800-348-4489.

Is your disability due to ☐ Delivery or ☐ Complications of Pregnancy?

If Complications of Pregnancy, please list: _____

What is your expected due date: _____/_____/_____ Delivery Date: _____/_____/_____ ☐ **Normal Delivery** ☐ **C-Section**
(Expected recovery following delivery is 6 weeks for vaginal delivery & 8 weeks for c-section delivery. This includes the elimination period)

What was the first date you were unable to work? _____/_____/_____ Have you returned to work? ☐ Yes ☐ No

Returned Part Time or Partial Duties on: _____/_____/_____ Returned Full Time or Full Duties on: _____/_____/_____

PLEASE HAVE YOUR PHYSICIAN COMPLETE AND SIGN THE **MATERNITY ATTENDING PHYSICIAN'S STATEMENT**.

PLEASE HAVE YOUR EMPLOYER COMPLETE AND SIGN THE **EMPLOYER'S STATEMENT**.

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. **Please also remember to sign and date the attached authorization required to process your claim.**

Patient's Signature:_____ **Print Name:** _____ **Date:** _____/_____/_____

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 check to be sure all information is correct before signing. Please refer to the fraud notice specific to your state.

PATIENT'S NAME: _____ **Date of Birth:** _____/_____/_____

POLICY NUMBER(S): _____ **Claim Number:** _____

ATTENDING PHYSICIAN'S STATEMENT: To be completed and signed by the Attending Physician

ICD 9/10 Code: _____Primary Diagnosis: _____

ICD 9/10 Code: _____Secondary Diagnosis: _____

List any diseases or infirmity affecting the present condition(s): _____

Please list any complications of pregnancy: _____

Hospitalization: Admission Date: _____/_____/_____ Discharge Date: _____/_____/_____

Hospital: _____ City: _____ State: _____

Last Menstrual Period: ____/____/____ Expected Due Date: _____/_____/_____ Delivery Date: _____/_____/_____

Type of Delivery: ☐ **Vaginal** ☐ **C-Section**

The patient is UNABLE to perform their job duties: FROM: _____/_____/_____ THROUGH: _____/_____/_____

When is the patient expected to RESUME WORK? Part Time/Partial Duties: _____/_____/_____ Full Time/Full Duties: _____/_____/_____

PHYSICIAN VERIFICATION:

Signed: _____, MD Date: _____/_____/_____

Print Name: _____ Specialty: _____ Phone #: _____

Address: _____

City: _____ State: _____ Zip: _____

EMPLOYER'S STATEMENT: To be completed and signed by your employer, if you are unemployed or self employed please complete and sign this form.

Employment Information/Job Description: If self employed, check this box ☐

Employer/Company Name: _____

Date of Hire: ____/____/____ Employee's Job Title/Position: _____

Please attach a copy of the job description or list major job responsibilities.

Major Responsibilities: _____

This job classification is: ☐ Sedentary, ☐ Light Work, ☐ Medium Work, ☐ Heavy Work, ☐ Very Heavy Work.

Prior to inability to work, he/she worked _____ hours per week. Hourly rate of pay: $_____ Annual Salary: $_____
*If you are self employed, we may require proof of income. We will notify you if additional documentation is required.

Dates Missed Work / Returned to Work:

I hereby certify that _____ did not perform any part of his/her work from, _____/_____/_____ through _____/_____/_____.

Did the employee work light duty or part time? ☐ Yes ☐ No If yes, what dates? _____

When recovered, will he/she resume work? ☐ Yes ☐ No If no, why? _____

Has the employee returned to work? ☐ Yes ☐ No Part Time/Partial Duties: ____/____/____ Full Time/Full Duties on: ____/____/___

Section 125: Were the premiums for this Policy paid with pre-tax dollars under Section 125? ☐ Yes* ☐ No
***If yes, FICA withholding will be deducted from the disability claim payment.**

EMPLOYER VERIFICATION:

Signed by: _____ Date: ____/____/____ Print Name: _____

Title: _____ Company: _____

Address: _____ Phone #: (_____)_____

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 check to be sure all information is correct before signing. Please refer to the fraud notice specific to your state.

Important: To avoid delay, please sign authorization below.

I authorize any physician, medical practitioner, hospital, clinic or other medical facility, Pharmacy Benefit Managers, insurance company, the Medical Information Bureau or other organization, institution or person, that has records or knowledge of me or my health including my prescription medication history to give to American Heritage Life Insurance Company (AHL) its subsidiaries or its reinsurers any information relating to my claim. I also authorize AHL, or its reinsurers, to make a brief report of my health information to MIB, Inc. I understand that there is a possibility of redisclosure of any information disclosed pursuant to this authorization and that information, once disclosed, may no longer be protected by federal rules governing privacy and confidentiality, but may still be protected by state laws. A copy of this authorization is as valid as the original. This authorization applies to any dependent on whom a claim is filed. 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 AHL in writing of my desire to do so. 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. (In **MAINE** – I understand that revocation of this authorization may be a basis for denying insurance benefits. Failure to sign an authorization statement may impair the ability of a regulated insurance agency to evaluate claims and may be a basis for denying a claim for benefits.)

Sign here: _____ Date: _____ ☐ **Check here if address is new**

Claimant

Mailing Address: _____ City: _____ State: _____ Zip: _____ Telephone No:. _____

ILLINOIS INTEREST STATEMENT: For contracts issued in and residents of Illinois, unless payment is made within fifteen (15) days from the date of receipt by the company of due proof of loss, interest shall accrue on the proceeds payable because of the death of the insured, from date of death, at the rate of 9% on the total amount payable or the face amount if payments are to made in installments until the total payment or the first installment is paid.

FRAUD WARNINGS BY STATE

NOTICE IN ALABAMA: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

NOTICE IN ALASKA, ARKANSAS, KENTUCKY, LOUISIANA, MAINE, NEW JERSEY AND NEW MEXICO: 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 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 DELAWARE, IDAHO, INDIANA, MINNESOTA, 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 DISTRICT OF COLUMBIA: FRAUD NOTICE: 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 MARYLAND: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NOTICE IN NEW HAMPSHIRE: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638.20.

NOTICE IN NEW YORK: 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 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.