GROUP VOLUNTARY ACCIDENT POLICY (GVAP6)
BENEFIT ENHANCEMENT RIDER (GP6BE) 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.

CERTIFICATE HOLDER / CLAIMANT INFORMATION:

CERTIFICATE NUMBER(s): _____ ; _____ ; _____

CERTIFICATE HOLDER: First Name: _____ MI: ____ Last Name: _____

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

Mailing Address: _____ Apt#: _____

City: _____ State: _____ Zip: _____ ☐ **Check here if address is new**

Phone #: _____ E-mail: _____

Employer: _____ Occupation: _____ Salary: $_____

CLAIMANT: (if different) First Name: _____ MI: ____ Last Name: _____

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

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

ACCIDENT CLAIM DETAILS: Please Provide the Following Accident Claim Details.

What is your Diagnosis/Condition? _____

When did you first notice symptoms of your condition? _____ Is your condition work related? ☐ Yes ☐ No

Have you ever had the same or similar condition? ☐ Yes ☐ No If yes, when: _____

Other conditions affecting your health: _____

Is your condition due to an accidental injury? ☐ Yes ☐ No Accident Date: _____ Time: _____ AM or PM

What was the accident or event that caused your injury? _____

What was the injury caused by your accident? _____

Where did your accidental injury happen? _____

Tell us exactly how your accidental injury happened: _____

Was a police report filed? ☐ Yes ☐ No For Motor Vehicle Accidents, you were the: ☐ Driver ☐ Passenger

When was your first physician visit for this accidental injury? _____ Last visit? _____ Next visit? _____

Were your hospitalized due to this accidental injury? ☐ Yes ☐ No Admission date: _____ Discharge 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.

CLAIMANT'S NAME: _____ **Date of Birth:** _____

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

GVAP6 ACCIDENT BENEFIT ENHANCEMENT RIDER **Please submit with a Completed GVAP6 Accident Policy Claim Form**

You may have elected the **Accident Benefit Enhancement Rider** with your **Accident Certificate**. The following are benefits available under the **Accident Benefit Enhancement Rider.** If you elected this rider, please check the **Benefits** below you believe may be due **based upon the Covered Person's Accidental Injury** and attach the **Required Documentation**. The required bills from your provider include: UB04, HCFA 1500, or an itemized bill. We also need you to sign and submit the Authorization to Release Information to AHL form ABJ21476. If additional information is needed you will be notified.
Benefits may vary by product and/or state. Please refer to your certificate and rider for specific benefits available under your Coverage.

☐ **Accident Follow Up Treatment**	Provide the bill or medical record showing follow up visits with the physician. The bill needs to include the diagnosis and dates of service. (Maximum 2 visits)
☐ **Laceration**	Provide a bill or medical record showing a laceration.
☐ **Burn**	Provide the bill or medical records, including the diagnosis and date of service, documenting a burn (other than sunburn).
☐ **Skin Graft**	Provide the bill or an operative report, including the diagnosis and date of service, documenting skin grafting due to a covered burn.
☐ **Brain Injury Diagnosis**	Provide the computed tomography (CT), magnetic resonance imaging (MRI), electroencephalogram (EEG), position emission tomography (PET), or x-ray showing a concussion, cerebral laceration, cerebral contusion, or intracranial hemorrhage.
☐ **CT Scan or MRI**	Provide a bill or medical record showing a CT scan or MRI Imaging.
☐ **Paralysis Benefit**	Provide medical records documenting a spinal cord injury resulting in the complete and permanent loss of use of two or more limbs.
☐ **Coma with Respiratory Assistance**	Provide medical records documenting a continuous state of profound unconsciousness for 7 or more days, requiring intubation and characterized by absence of spontaneous eye movements, response to painful stimuli and vocalization.
☐ **Open Abdominal or Thoracic Surgery**	Provide the operative report showing open abdominal / thoracic surgery to repair internal injuries.
☐ **Tendon, Ligament, Rotator Cuff or Knee Cartilage Surgery**	Provide the operative report showing surgical exploration or surgical repair of a torn, ruptured, or severed tendon, ligament, rotator cuff, or knee cartilage.
☐ **Ruptured Disc Surgery**	Provide the operative report showing the surgical repair of a ruptured disc.
☐ **Eye Surgery Benefit**	Provide the operative report or medical record showing eye surgery or the removal of a foreign object from the eye.
☐ **General Anesthesia**	Provide a bill for general anesthesia related to a covered surgery for which benefit is paid under this rider.
☐ **Blood and Plasma**	Provide the bill for blood or plasma, including the diagnosis and date of service.
☐ **Appliance**	Provide a bill or medical record showing a prescription for crutches, wheelchair or walker.
☐ **Medical Supplies**	Provide a bill for over the counter medical supplies.
☐ **Medicine**	Provide a bill for prescription or over the counter medicine.
☐ **Prosthesis**	Provide the bill for a prosthetic arm, leg, hand, foot, or eye to replace losses as a direct result of a covered accident.
☐ **Physical, Occupational or Speech Therapy**	Provide the therapy bill or medical records showing physical, occupational or speech therapy services provided by a licensed therapist. The documentation needs to include the diagnosis and date of service. (Maximum benefit: 6 visits)
☐ **Rehabilitation Unit**	Please provide a copy of the Rehabilitation Unit Bill immediately following an inpatient hospitalization.
☐ **Non-Local Transportation**	Provide documentation that non-local treatment was required at a hospital or other specialized freestanding treatment center and that the same or similar care could not be obtained locally. (Non-local means one way trip of 50 miles or more. Maximum 3 times per covered accident)
☐ **Family Member Lodging**	Provide bills for lodging of one adult family member when the covered person is confined in a hospital. (Not paid if the family member lives within 50 miles one way of the hospital)
☐ **Post Accident Transportation**	Provide the common carrier receipt and a hospital bill for at least 3 consecutive days resulting from an accident which occurs more than 250 miles from residence. The common carrier transportation home must be within 48 hours of discharge form the hospital. Payable for the injured covered person only and only if the daily hospital confinement benefit in the policy is paid.
☐ **Broken Tooth**	Provide a bill for a broken tooth repair by dental crown or filling. Payable for only 1 crown,1 filling or 1 extraction. The tooth must be sound and natural. Chewing and biting injury is not covered.
☐ **Residence/Vehicle Modification**	Provide physician certification of permanent structural modification to the covered person's primary residence or vehicle within 365 days of a covered accidental injury.
☐ **Pain Management (Epidural Injection)**	Provide a bill for an epidural injection in the spine to manage pain due to a covered accidental injury. (Maximum 1 per covered person per accident.)
☐ **Miscellaneous Outpatient Surgery**	Provide a bill for outpatient surgery performed by a physician due to a covered accident. (Not payable if the Open Abdominal or Thoracic Surgery, Tendon, Ligament, Rotator Cuff or Knee Cartilage Surgery, Ruptured Disc Surgery or Eye Surgery benefit is paid.)

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PROVIDERS: Please list all Providers you have seen in the past 2 years including the providers treating you for this Condition.

1. Attending Physician's Name | Address | Phone #
   Specialty | Dates Consulted | Reasons for Visit/Condition
2. Primary Care Physician's Name | Address | Phone #
   Specialty | Dates Consulted | Reasons for Visit/Condition
3. Other Physician/Specialist Name | Address | Phone #
   Specialty | Dates Consulted | Reasons for Visit/Condition
4. Hospital Name | Address | Phone #
   Dates Hospitalized | Reason for Hospitalization/Condition

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.**

Signature: _____ Print Name: _____ Date: _____

ASSIGNMENT OF BENEFITS (Not applicable 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.*

Name | Address
Provider's Tax Identification Number: | City | State | Zip
Relationship | Signature of Policy Owner | Date

**** 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.***

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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 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 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 or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or 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.

AMERICAN HERITAGE LIFE INSURANCE COMPANY

HOME OFFICE:
1776 AMERICAN HERITAGE LIFE DRIVE
JACKSONVILLE, FLORIDA 32224-6687

AUTHORIZATION TO RELEASE INFORMATION TO AHL

I hereby authorize any physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, health care provider, Pharmacy Benefit Manager, insurance company, the Medical Information Bureau (MIB) or other organization, institution or person that has any health related records or knowledge of me or minor dependents to disclose the entire medical record (excluding psychotherapy notes and in MAINE and VERMONT HIV related test results) to American Heritage Life Insurance Company (AHL), its duly authorized representatives, its subsidiaries or its reinsurers. This authorization extends to any minor dependent on whom insurance is requested or claim for benefits is being made.

The information to be obtained shall include insurance claim history from any Prescription Drug Database, pharmacy benefit manager, ambulance, insurance company, medical transport service, or the MIB. Also, I authorize any entity, person, or organization that has these records about me, including but not limited to my employer, employer representative and compensation sources, insurance company, financial institution or governmental entities, including departments of public safety and motor vehicle departments, to give any information or record it has about me, my employment, employment history or income to AHL.

I understand that this information will be used to evaluate and administer my claim for benefits or to evaluate my eligibility for insurance. 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 certain federal regulations governing privacy and confidentiality, though it may still be protected by state privacy laws or other applicable privacy laws. I also authorize AHL or its reinsurers to make a brief report of my health information to MIB.

This authorization shall remain in force for 24 months following the date of my signature below or termination of my coverage, whichever occurs first. A copy of this authorization is as valid as the original. I or my legal representative may request a copy of this authorization. I understand that I may revoke this authorization at any time by sending a written notification to: **Attn: Privacy Officer, American Heritage Life Insurance Company, 1776 American Heritage Life Drive, Jacksonville, FL 32224.**

I understand that a revocation of this authorization is not effective if AHL has relied on the protected health information or has a legal right to contest a claim under an insurance policy or to contest the policy itself. The revocation will not apply to any information AHL requests or discloses prior to AHL receiving my revocation request. If I choose not to sign this authorization or if I later revoke it, I understand that AHL may not be able to process my application for coverage, or if coverage has been issued, AHL may not be able to administer my claim for benefits and this may result in a denial of my claim for benefits or request for services.

_____ _____
Claimant/Applicant's Signature Date Signed (mm/dd/yyyy)

_____ _____
Claimant/Applicant's Printed Name Social Security Number

If signed by the legal representative, please describe the authority under which the representative is authorized to act and enclose any related documentation granting authority.

_____ _____
Signature of Legal Representative Relationship

_____ _____
Print Name of Legal Representative Date Signed (mm/dd/yyyy)