Allstate.
You're in good hands.

ALLSTATE ACCIDENT CLAIM INSTRUCTIONS

WHEN FILING AN ALLSTATE ACCIDENT CLAIM, THE FOLLOWING ITEMS ARE NEEDED:

- Completed claim form, page 1 and the bottom portion of page 2, release for medical information. Please disregard the employer portion on page 2.
- Completed HIPPA form
- All itemized medical bills for the treatment of the injury. The bills must be itemized and contain a breakdown of charges and a diagnosis code. This can often be obtained be requesting a UB04 or 1500 form from the medical provider
- If the injury resulted in a fracture, please provide the radiology report
- If the injury was the result of an auto accident, please include the police report
- If there was an ambulance transport, please include the bill showing the total mileage and charge
- Once the claim is complete, please return to Creative Worksite Solutions by fax 843.971.9015 or email, bpresley@creativeworksitesolutions.com
- Your claim will then be reviewed, submitted and monitored by our office
- Please be sure to include a contact phone number or email

CREATIVE worksite solutions

Bonnie Presley Claims Manager
1.866.971.9715

CLAIM FORM AND INSTRUCTIONS

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

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 ACCIDENT INCLUDING POLICY RIDERS/ DISABILITY/ WAIVER OF PREMIUM CLAIMS

- 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 call **1-800-348-4489**.
- You may **fax** your claim to us at **1-866-424-8482**. Please be assured that your claim will receive our prompt attention. If you would like to receive your claim proceeds even faster, Allstate Benefits can automatically deposit them into your bank account by completing and returning our ACH form (ABJ16661). This form can be found on our website at www.AllstateBenefits.com or electronically at www.AllstateBenefits.com/mybenefits. Additional claim forms are available on our website.
- You may mail your claim to: **American Heritage Life Insurance Company**
  P.O. Box 43067
  Jacksonville, Florida 32203-3067
- If you are filing a claim within the first 24 months your policy is in force, additional information may be required.

POLICYHOLDER / CERTIFICATEHOLDER

Employer Name (Company/Address): _____ Occupation: _____

1. Policyholder's Name: First: _____ Middle: _____ Last: _____
   Policy Number(s): 1)_____ 2)_____
   Social Security Number: _____ Date of Birth: ___/___/___ ☐ Male ☐ Female
2. Home Number: (___) _____ Avg. Monthly Earnings: _____ **E-mail:** _____

PATIENT'S INFORMATION

3. Name: First: _____ Middle: _____ Last: _____
4. Date of Birth: ___/___/___ Age: _____ Social Security Number: _____ ☐ Male ☐ Female
5. This person is your: _____ (ex: self, wife, son, etc.)

☐ FIRST CLAIM ☐ CONTINUED CLAIM

☐ **ACCIDENT/DISABILITY** Policy No.(s): _____ / _____

☐ Accident ☐ Outpatient Physicians Rider ☐ Waiver of Premium ☐ Benefit Enhancement Rider

☐ Disability ☐ Hospital Rider ☐ Routine Pregnancy

INSTRUCTIONS FOR FILING ACCIDENT CLAIMS

We need:

- ☐ (For Puerto Rico residents only) A copy of the Explanation of Benefits (EOB) from your health insurance carrier, if applicable, if this claim is for an emergency room visit.
- ☐ A copy of the hospital bill. Please make sure the bill includes your diagnosis and the number of days you were in the hospital. If you were treated in the emergency room or a doctor's office, please include a copy of these bills also.
- ☐ **Attending Physician's Statement** should be completed and signed by your doctor

We may also need:

- ☐ A copy of the **accident report** if the accident was investigated by the police or sheriff.
- ☐ A copy of the **blood alcohol report** or **drug screening** if the patient was tested for alcohol or drugs.
- ☐ A certified copy of the death certificate if the patient is deceased.

ACCIDENT POLICY CLAIMS

Please attach itemized bill(s), including date(s) of service, diagnosis code(s), procedure codes(s) and charge(s).

DATE OF ACCIDENT: ___/___/___ **Time of accident:** _____ ☐ **a.m.** ☐ **p.m.**

Where did it happen? _____ Tell us exactly how your accident/injury happened: _____

Did your injuries occur while you were working for pay or profit? ☐ Yes ☐ No ☐ On the job ☐ Off the job

Have you ever had a similar injury? _____ If so, please tell us when: ___/___/___

***If you are claiming disability due to your accident, please have your physician complete the* ATTENDING PHYSICIAN STATEMENT and your employer complete the EMPLOYER'S STATEMENT.**

EMPLOYER'S STATEMENT

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 2 for notices specific to your state.

Policy Number: _____

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

2. Did insured work light duty or part-time? ☐ Yes ☐ No If yes, give dates _____

3. Prior to inability to work, he/she worked _____ hours per week and is considered ☐ exempt or ☐ non-exempt.

4. When recovered, will he/she resume work? ☐ Yes ☐ No If not why? _____

5. Is this a Workers' Compensation case? ☐ Yes ☐ No Date Workers' Compensation benefits began ___/___/___ MO/DAY/YR

   Name of Workers' Compensation Company _____

6. Section 125: Were the premiums for our disability income policy paid with pre-tax dollars under a Section 125 Plan? ☐ Yes ☐ No

7. Is the employee receiving or has he/she received continued pay? ☐ Yes ☒ No If yes, please complete the following:

Pay Period From	Pay Period To	Amount	Source of Income

8. Current Salary or Hourly Rate: _____

9. Name of Employer: _____ Date: ___/___/___ MO/DAY/YR

   Address: _____

   By: _____ Official Position: _____ Telephone number: (___) _____

10. The employee's job title or position is: _____

11. Is the employee covered under any other disability policy through the company? _____

12. Has employee returned to work? ☐ Yes ☐ No If yes, give date: ___/___/___ MO/DAY/YR

13. Remarks: _____

Important: To avoid delay, please sign authorization below.

1. **Section 125:** Were the premiums for your **disability income policy** paid with pre-tax dollars under a Section 125 Plan? ☐ Yes ☐ No **(if in doubt, please ask your employer.)**

I authorize any physician, medical practitioner, hospital, clinic or other medical facility, insurance company, the Medical Information Bureau or other organization, institution or person, that has records or knowledge of me or my health to give to American Heritage Life Insurance Company (AHL) its subsidiaries or its reinsurers any information relating to my claim. 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: _____ Phone No:. (___) _____

AMERICAN HERITAGE LIFE INSURANCE COMPANY ("AHL")
1776 American Heritage Life Drive
Jacksonville, FL 32224

Telephone: (800) 521-3535
Facsimile: (866) 428-2517

Allstate
Workplace Division

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Individual's Name _____
Last First Middle

Home Address

_____
Street City State/Zip Code

Home Telephone _____ **Date of Birth** _____

Policy Number(s) _____

MY HEALTH INFORMATION: The health information that is subject to this Authorization consists of:

❑ All Health information about me created or received by AHL, except for the following:

_____

❑ Other (for example: policy benefit amounts, all claims information, etc.). Please specify below:

_____

AUTHORIZED DISCLOSURE

I authorize AHL to disclose my health information described above to the recipient named below:

Name ("Recipient") Creative Worksite Solutions

Address 3404 Salterbeck St. Ste 207, Mt. Pleasant, SC 29466

bpresley@creativeworksitesolutions.com

TERM: This Authorization will remain in effect until:

❑ I revoke it in writing.

❑ the _____day of_____, 20_____.

I authorize disclosure in the manner described above, and understand that:

- AHL will not condition my enrollment or eligibility for insurance benefits on my provision of this Authorization.
- AHL does not guarantee that Recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.
- I may revoke this Authorization in writing at any time.
- This Authorization will remain in effect until the Term of the Authorization expires or I provide a written notice of revocation to AHL at the address listed above. The revocation will be effective upon AHL's receipt of my written notice.

_____ _____ _____
Signature of Individual Date Signature of Witness

American Heritage Life Insurance Company
1776 American Heritage Life Drive
Jacksonville, Florida 32224

Allstate Benefits

CLAIMS ADMINISTRATION DIRECT DEPOSIT AUTHORIZATION FORM

TRANSACTION TYPE: ☐ New Setup ☐ Cancellation ☐ Change Financial Institution ☐ Change Account Number

POLICY/CERTIFICATE HOLDER INFORMATION:

Policy/Certificate Holder Name: _____ Home Phone: _____

Policy/Certificate Number(s): _____

Social Security Number: _____

FINANCIAL INSTITUTION: ☐ Checking ☐ Savings

Financial Institution Name: _____

Financial Institution Address: _____

Account Number: _____ *Electronic Routing Transit Number: _____

*Some banks use a separate routing number specifically for electronic ACH deposits. Please verify the routing number with your bank.

You may also visit www.allstatebenefits.com/mybenefits to complete this form electronically.

A Voided Check or a Letter From Your Bank Must be Attached In Order to Credit Your Account for Claims Payments

Voided Check Requirements:
- Deposit slips are not accepted;
- Credit and debit cards are not accepted;
- Account holder's pre-printed name and address;
- Pre-printed account and transit number.

Bank Letter Requirements:
- Letter must be on bank letterhead;
- Include Account holder's name;
- Include Account holder's account number:
- Include Account holder's transit number.

Acceptable Accounts and Signatures:
- Beneficiary
- Owner
- Power of Attorney
- Insured
- Payor
- Spouse

Authority is hereby given to American Heritage Life Insurance Company (AHL) to credit the account number shown below for claims payment for all of your AHL policies (unless benefits are assigned). AHL will make any adjustments, including the initiation of any credit or debit entries on the account, for the limited purpose of claims payment due to the account holder or due to AHL. Once the deposit transaction occurs, AHL has five days to withdraw only the amount deposited if an error has occurred.

Signing this Authorization will allow AHL to deposit claims payments for all eligible policies. Direct deposit benefit checks will apply to all products underwritten by AHL, excluding Life. Unfortunately, if an insured has assigned benefits to a physician, hospital, another person, etc. the benefit check cannot be direct deposited.

Although direct deposit (Electronic Funds Transfer) is my preferred method of payment there may be circumstances which require a paper check to be issued as opposed to a direct deposit. I understand when I do business with AHL and/or its affiliates, parent and subsidiaries, the electronic documents, disclosures and electronic signatures may be utilized by AHL. This authority is to remain in full force and effect until AHL has received written notification revoking the authority. Your policy/certificate holder information and your financial institution information above must be complete and accurate and must be that of the policy/certificate holder on file. To ensure accuracy, a voided check or a bank letter must be attached. Please notify AHL immediately if your financial institution or account information has changed by sending written notification to the address indicated below. Should you have any questions, please contact us at 1-800-348-4489.

Authorization Signature: _____ Date: _____

Print Name: _____

Deliver the completed and signed authorization form with voided check or bank letter to:

Fax to: 1-866-424-8482 OR **Mail to:** Allstate Benefits
Attention: Claims ACH Department
1776 American Heritage Life Drive
Jacksonville, FL 32224-6687