



AMERICAN HERITAGE LIFE INSURANCE COMPANY

1776 American Heritage Life Drive
Jacksonville, Florida 32224

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 1-800-858-4570.

CREDIT ACCIDENT AND HEALTH INSURANCE CLAIM FORM
(ALL SECTIONS OF FORM MUST BE COMPLETED BEFORE CLAIM CAN BE PROCESSED)
THE PATIENT IS RESPONSIBLE FOR THE COMPLETION OF THIS FORM WITHOUT EXPENSE TO AMERICAN HERITAGE LIFE INSURANCE COMPANY

A. STATEMENT OF THE INSURED:

Name in Full _____ Date of Birth _____ SSN _____ - _____ - _____ Ht. _____ Wt. _____

- 1. Complete STATEMENT OF THE INSURED (Section A). SIGN BELOW.
2. Have your physician complete and sign the ATTENDING PHYSICIAN'S STATEMENT (Section B).
3. Have your creditor complete the CREDITOR'S STATEMENT (Section C).
4. Have your employer complete the EMPLOYER'S STATEMENT (Section D).
5. What is the nature of your illness or injury?
6. When and where were you first treated by a physician for this condition?
7. Physician's name, address and phone number.
8. Were you confined in the hospital?
9. Period of time for which you were totally disabled and unable to work: From To
10. Have you ever been treated for the same or similar illness before?
11. List of all Doctors/Hospitals seen in the last 2 years.

Table with 5 columns: Doctor's Name, Doctor's Full Address, Doctor's Phone, Condition Treated, Dates Treated

- 12. Please list all medications you are currently taking
13. What was the first full day you missed work due to this disability? Date
14. What is your occupation? Primary Duties
15. Employer's Name Employer's Phone No.
16. Have you had a previous claim with our company? Yes No If yes, claim #

I hereby certify that the foregoing answers are complete and true. It is agreed that the furnishing of this form or its acceptance by the Company as proof of claim, does not constitute an admission of any liability nor a waiver of any of the conditions of the insurance contract.

Signature of the Insured (claim cannot be processed without signature) Date

Home Address (please print) City State Zip Code Phone No.

PLEASE READ THE NOTICES AS APPLICABLE TO YOUR STATE ON THE BACK PAGE

B. ATTENDING PHYSICIAN'S STATEMENT OF DISABILITY: (To be completed by your physician)

Name of Patient _____ Social Security # _____ - _____ - _____ DOB _____

1. DIAGNOSIS

- a) Please list all disabling conditions
b) If disability is due to an accident, please provide date of accident Cause of accident
c) What was the date that the patient became unable to work due to current condition?
d) Please list any past treatment date(s) related to current condition(s)
e) Please list any past medical history unrelated to current condition(s)
f) Please list any medications currently being taken by patient
g) If disability is due to pregnancy, please list any complications and actual delivery date(s)

2. TREATMENT

- a) Dates of treatment (List of all treatments/visits related to current disability)
b) Name of treatment (including type and date of surgery, and medications prescribed for current condition, if any)
c) Has patient been hospital confined? Yes No If yes, confined from to
d) If yes, give name and address of hospital

3. PROGNOSIS

- a) Is patient unable to return to work due to disability? Patient's Job Any other work
b) If not now totally disabled, please provide date patient was able to resume work. Full-time Part-time Full-time Part-time
c) Restrictions: Lifting Lbs. Standing Hrs. Sitting Hrs. Walking % per day

(PLEASE SEE REVERSE SIDE)

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- d) What specific medical restrictions prevent the patient from returning to his/her previous occupation? _____
- e) What level of work is the patient capable of performing? Heavy Medium Light Sedentary None
- f) Period of time patient was unable to work as a result of this disability: From _____ To _____
- g) Expected duration of disability keeping patient from performing current job? _____ Any other work? _____
- h) Is patient a candidate for rehabilitation program? _____ Yes _____ No

Date	Physician's Name (please print)	Degree/Specialty	Signature	
Street Address	City	State	Zip	Telephone Number

C. CREDITOR'S STATEMENT: (To be completed by your creditor)

1. Full Name of Insured _____ SSN _____ - _____ - _____
 2. Insured's Address _____ City _____ State _____ Zip _____
 3. Policy issued by _____
 4. Policy Number _____ Effective Date of Policy _____
 Policy Term _____ Months Monthly Payment _____ Loan Due Date _____
 5. Is loan delinquent? _____ Yes _____ No If yes, what is delinquency period ___ 30 days ___ 60 days ___ 90 days
 6. Creditor _____ Loan No. _____
 7. Address _____ City _____ State _____ Zip _____
- Date _____ Completed By _____ Phone No. _____

D. EMPLOYER'S STATEMENT (To be completed by your employer)

1. Employee Name _____ Original Employment Date _____
2. What was the first full day employee **missed** work due to disability? _____
 Has employee returned to work? ___ Yes ___ No If yes, date _____
3. Job Requirements: *Lifting* ___ Lbs. *Standing* ___ Hrs. *Sitting* ___ Hrs. *Walking* ___ % per day
Repetitive Bending Yes No *Squatting* Yes No *Stooping* Yes No
Repetitive Hand Motions Yes No
4. When recovered, will he/she resume work with you? _____ Yes _____ No If yes, when? _____
 If no, why not? _____
5. Was employee off work for any other illness or injury between the original date of employment and the last date worked? _____ Yes _____ No If yes, please provide the date and reason off work _____
6. Is there light duty work available for this employee? _____ Yes _____ No If yes, what job? _____
7. Is this a Worker's Compensation case? ___ Yes ___ No If yes, provide Worker's Compensation Insurance Co. _____
8. Name of Medical Insurance Company _____ Phone No. _____
9. Name of Employer _____ Phone No. _____
10. Employer's Full Address _____
 Date _____ Signature _____ Position _____

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.