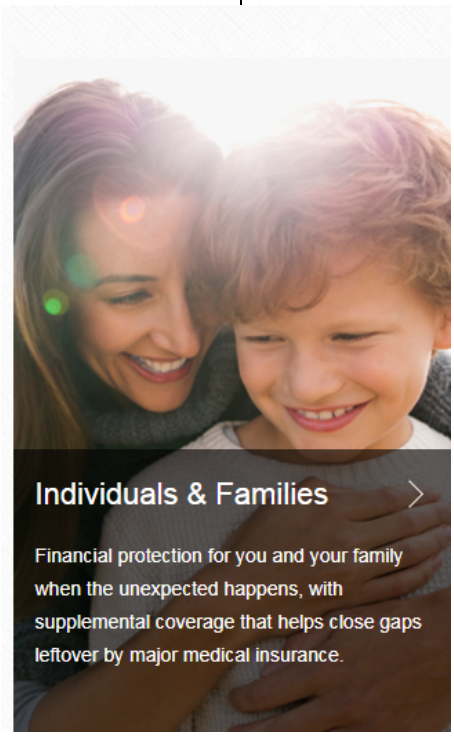
CLAIMS HOW-TO GUIDE

If you need your policy number, please call 1-800-348-4489

STEP 1	Obtain Claims Form Via Website

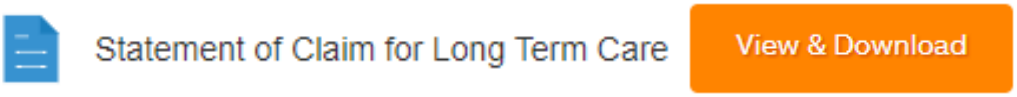
A) Go to https://www.allstatebenefits.com/

B) Click on "Individuals & Families" towards the left-middle of the page



C) At the top, click on "Forms"

D) Scroll down to "Statement of Claim for Long Term Care" and click the orange box labeled "View & Download"



STEP 2	Obtain Claims Form Via Fax (OPTIONAL)

Call phone number **1-800-348-4489** and have our Customer Call Center send a fax to a fax number of your choosing.

STEP 3 | Fill Out Claims Form

A) Fill out the "policyholder / certificateholder" section of the form
B) If you do not know your policy number, please call **1-800-348-4489**

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.)

STEP 4 | Fill Out Claims Form

C) Continue with the next section labeled "Accelerated Death Benefit For Long Term Care Claims"
D) Be Sure to check the "First Claim" box

ACCELERATED DEATH BENEFIT FOR LONG TERM CARE CLAIMS

☐ **FIRST CLAIM** ☐ **CONTINUED CLAIM**

INJURY OR ILLNESS YOU ARE CLAIMING: _____

Date you were first treated for your illness or injury: ___/___/___ Date you were last treated for your illness or injury: ___/___/___

Date of your accident or the date you first noticed the symptoms of your illness: ___/___/___

If you are claiming an injury, did your injury occur at work? ☐ Yes ☐ No

List all physicians seen in the past five (5) years:

Name	Address	Phone	Specialty	Dates Consulted	Reason for Consult

List all hospital confinements in the past five (5) years:

Name	Address	From/To	Reason Confined

List all pharmacies used in the past five (5) years: (include address and phone number)

_____

_____

I have been unable to work since: ___/___/___ (MO/DAY/YR) I returned to work on a ☐ part-time ☐ full-time basis: ___/___/___ (MO/DAY/YR)

Describe why you are unable to work: _____

Are you receiving Disability Benefits (Salary Continuation, Sick Pay, Social Security Disability Income, or Workers' Compensation) from any source? If "yes," from whom? _____

STEP 5 ATTENDING PHYSICIAN'S STATEMENT

A) The next section is to be filled out by your attending physician

ATTENDING PHYSICIAN'S STATEMENT (PHYSICIAN)

Patient's Name:_____ Policy Number: _____

1. Diagnosis: _____
2. When did symptoms first appear or accident happen? Date ____/____/____ MO/DAY/YR
3. When did patient first consult you for this condition? Date ____/____/____ MO/DAY/YR
4. Has patient ever had same or similar condition? (If "yes," state when and describe.) ☐ Yes ☐ No _____
   _____
5. Describe any other diseases or infirmity affecting present condition. _____
6. Nature of surgical or obstetrical procedure, if any (describe fully). _____
   _____
7. Is patient disabled? ☐ Yes ☐ No
   7a. If yes, please provide first date of disability. ____/____/____ MO/DAY/YR Expected end date of disability. ____/____/____ MO/DAY/YR
8. If retired or unemployed which activities of daily living (ADLs) is patient unable to perform? _____
9. Date patient last examined by you: _____ Frequency of visits: ☐ weekly ☐ monthly ☐ other_____
10. Is patient: ☐ ambulatory ☐ bed confined ☐ house confined ☐ other_____
11. If patient is hospitalized, give name and address of hospital, assisted living or other facility.
    Facility: _____ City: _____ State: _____
12. Date admitted: ____/____/____ MO/DAY/YR Date discharged: ____/____/____ MO/DAY/YR
13. Referring Physician: _____ Phone: (____) _____
    Mailing Address: _____

STEP 6 SUBMITTING YOUR FIRST CLAIM

A) Once everything is signed and completed, you may submit your claim

1. The online portal at www.AllstateBenefits.come/my benefits
2. Fax to **1-866-427-3706**
3. Mail: American Heritage Life Insurance Company
   P.O. Box 43067
   Jacksonville, Florida 32203-4489

STEP 7 SUBMITTING CONTINUOUS CLAIM

You do not have to resubmit claims form. After completing it once, all you need to do is attach your billing statements for long term care.

BE SURE TO INCLUDE YOUR POLICY NUMBER(S)