STATEMENT OF CLAIM FOR GROUP LIFE INSURANCE and/or GROUP ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE

RETURN COMPLETED FORM TO EMPLOYER

American Heritage Life Insurance Company
1776 American Heritage Life Drive
Jacksonville, Florida 32224-6687

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 service department at 1-800-348-4489. You may fax your claim to us at 1-866-427-3706.

The Group Insurance Certificate and a Certified Copy of Death Certificate *must* accompany this form.

SECTION I – CLAIMANT STATEMENT TO BE COMPLETED IN FULL *(Please Print or Type)*

1. Employee's Name *Last First M.I.*	2. Employee's Social Security Number	3. Birth Date	4. Date of Death
If this claim is for an insured dependent: 5. Deceased Dependent's Name *Last First M.I.*	6. Dependent's Social Security Number	7. Dependent's Birth Date	8. Dependent's Date of Death
9. Deceased's Address: *Number/Street City State Zip Code*		10. Place of Death	

11. Cause of Death	12. Was death Accidental? ❑ Yes ❑ No *If yes, please answer questions 13 & 14*	13. Date of Accident	14. Was Accident a result of employment? ❑ Yes ❑ No
15. Are you the beneficiary named in the Certificate? ❑ Yes ❑ No	16. What is your relationship to the deceased insured?	17. What is your Date of Birth?	18. What is your Social Security Number?
19. Please print your name in full: *Last First M.I.*	20. What is your address? *Number/Street City State Zip Code*		

Complete Questions 21, 22, 23, and 24 if this is a Dismemberment Claim:

21. Date of Accident	22. Was Accident a result of employment? ❑ Yes ❑ No
23. Describe Accident in Detail:	
24. What injuries were sustained?	

SEE FRAUD WARNINGS APPLICABLE TO YOUR STATE ON REVERSE SIDE

I hereby authorize any hospital, practitioner, clinic, or other medically related facility, pharmacy, insurance company or government agency or other person who has attended the deceased to disclose or furnish American Heritage Life Insurance Company, or its designee, any and all medical information with respect to any illness or injury the Insured may have suffered including but not limited to medical history, drug/alcohol abuse, AIDS or AIDS related conditions; or other consultations, prescriptions, diagnosis and treatment; or any information regarding benefits provided, together with copies of all other medical records that may be requested. The information provided to American Heritage Life Insurance Company, or its designee is to be used solely for purposes of evaluating a claim. This Authorization is valid for a period of 24 months from the date signed. I understand that I may revoke this Authorization by notifying American Heritage Life in writing of my desire to do so. A photographic copy of the Authorization shall be as valid as the original, regardless of the date signed. I understand that 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 or its designee.

Signature of Claimant	Date Signed	Signature of Witness in whose presence signed or acknowledged	Date Witnessed

SECTION II – TO BE COMPLETED BY THE EMPLOYER *(Continued on reverse side)*

1. Group Policy Number	2. Group Policyholder				
3. Employee Name *Last First M.I.*	4. Date Employed	5. Place Employed (State)	6. Insurance Class	7. Effective Date of Insurance	

Allstate Benefits is the marketing name for American Heritage Life Insurance Company (home office: Jacksonville, Florida – www.allstatebenefits.com). All products are underwritten by American Heritage Life Insurance Company, a wholly-owned subsidiary of The Allstate Corporation (home office: Northbrook, Illinois - allstate.com).

SECTION II – TO BE COMPLETED BY THE EMPLOYER (CONTINUED)

8. Occupation	9. Present Weekly Earnings	10. Present Amount of Insurance	11. Date Last Worked
	$_____	Life $_____ AD&D $_____	

12. Was the employee on a leave of absence or lay-off when the loss occurred? ❑ Yes ❑ No If yes, on what date did the leave of absence or layoff start and for what reason?

13. Was the insurance terminated? ❑ Yes ❑ No If yes, give the date of termination and the reason:

14. Name of Insured Dependent (If Applicable) *Last* *First* *M.I.*	15. Effective Date of Dependent Insurance

16. Please provide any additional information which might assist in consideration of this claim:

SEE BELOW FOR FRAUD WARNINGS APPLICABLE TO YOUR STATE

We hereby certify that the above named employee (or his dependent, if applicable) was insured continuously in accordance with the provisions of the Group Policy from the effective date of the insurance on his life to the date the loss was incurred.

Date Signed _____ Signed By _____ Title _____ Tel. No. (_____)

Employer's Authorized Representative

ILLINOIS INTEREST STATEMENT: For contracts issued in and residents of Illinois, unless payment is made within thirty-one (31) 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 10% 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, 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 ARKANSAS: 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.

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.