

If you have an existing policy through Allstate the following section will help guide you through changes, cancellations, and claims. You can also go to [www.allstateatwork.com](http://www.allstateatwork.com) for help with policy changes and claim forms.

You can call SBS at **877-819-3514** for questions and help regarding your policy information as well.

### **CLAIMS for Supplemental Insurance:**

#### Short Term Disability -

To claim a disability benefit, your physician must deem you unable to perform your job duties. The entire physician statement needs to be completed. Please send the claim form along with proof of your income before the disability to SBS. You can fax the claim to 614-793-8663 or mail to : 9000 Francine Lane, Powell, OH 43065

#### Accident Claim –

To claim an accident benefit you need to submit the actual charges of the initial injury treatment (doctor charges, x-ray, lab, etc). The physician needs to complete the physician statement or you need specific documentation detailing the injury (ER report, doctor's notes, etc.) If you are hospitalized, you will need an itemized hospital bill. You can fax the claim to 614-793-8663 or mail to : 9000 Francine Lane, Powell, OH 43065

**For all claims, please contact SBS for help and information  
about filing your claim**

### **CLAIMS for the Mini medical plan –**

All claims for the medical insurance should be filed by the provider. Be sure to bring your medical card with you to the provider. If you have questions in regards to your mini medical plan please call Allstate direct at 1-800-937-7039.



Workplace Division

# CLAIM FORM AND INSTRUCTIONS

**If you have any questions regarding our determination of 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 **614-793-8663**. Please be assured that your claim will receive our prompt attention. You will usually receive a response from us in the mail within 10 business days following the receipt of your claim. The length of time in the mail will depend on your location.
- You may mail your claim to: **SBS**  
9000 Francine Lane  
Powell, Ohio 43065
- Additional claim forms are available on our website at [www.allstateatwork.com](http://www.allstateatwork.com).
- 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.) Is he/she a full-time student?  Yes  No  
If yes, please submit proof of student status.

### FIRST CLAIM CONTINUED CLAIM

ACCIDENT/DISABILITY Policy No.(s): \_\_\_\_\_ / \_\_\_\_\_

Accident  Outpatient Physicians Rider  Waiver of Premium

Disability  Hospital Rider  Routine Pregnancy

Benefit Enhancement Rider

### INSTRUCTIONS FOR FILING ACCIDENT CLAIMS

#### We need:

- 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.**



## ASSIGNMENT OF BENEFITS FOR ACCIDENT COVERAGE

I request that American Heritage Life Insurance Company send benefits to someone other than me. Please send benefits available to the name and address shown below:

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

### INSTRUCTIONS FOR FILING FIRST CLAIM FOR DISABILITY (due to Accident or Sickness) AND WAIVER OF PREMIUM:

We need:

- Attending Physician's Statement** should be completed and signed by your doctor.
- Employer's Statement** should be completed, including your monthly salary and pre-tax information, and signed by your employer. If you are self-employed, also send us a copy of your current business license and your most recent quarterly tax records. Additional information may be required.

**Please submit a copy of your payment statement with this form. Please have your treating physician complete the ATTENDING PHYSICIAN STATEMENT and your employer complete the EMPLOYER'S STATEMENT.**

## DISABILITY AND WAIVER OF PREMIUM CLAIMS (POLICYHOLDER / CERTIFICATEHOLDER)

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

Name	Address	From/To	Reason Confined
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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 other source? If "yes," from whom? \_\_\_\_\_

### DISABILITY CLAIM FOR ROUTINE PREGNANCY Expected Recovery Period is 6 weeks for vaginal delivery, or 8 weeks for C-Section.

If disabled due to complications of pregnancy, before or after delivery, please complete Policyholder, Attending Physician's Statement, and Employer's Statement sections.

Date of Delivery: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ First Date of Treatment: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Type of delivery:  Vaginal  C-Section

Date of Hospital Confinement: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Name of Hospital: \_\_\_\_\_ Phone No.: (\_\_\_\_) \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_

Treating Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Tax Identification No.: \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Phone No.: (\_\_\_\_) \_\_\_\_\_

Mailing Address: \_\_\_\_\_

## ATTENDING PHYSICIAN'S STATEMENT (PHYSICIAN)

Patient's Name: \_\_\_\_\_ Policy Number: \_\_\_\_\_

1. Diagnosis: \_\_\_\_\_

2. If condition is due to pregnancy, what is expected delivery date? Date      /      /       
MO/DAY/YR

3. When did symptoms first appear or accident happen? Date      /      /       
MO/DAY/YR

4. When did patient first consult you for this condition? Date      /      /       
MO/DAY/YR

5. Has patient ever had same or similar condition? (If "yes," state when and describe.)  Yes  No \_\_\_\_\_

6. Describe any other diseases or infirmity affecting present condition. \_\_\_\_\_

7. Nature of surgical or obstetrical procedure, if any (describe fully). \_\_\_\_\_

8. Is patient unable to perform job duties?  Yes  No If yes, from \_\_\_\_\_ through \_\_\_\_\_

9a. What specific job duties is patient unable to perform? \_\_\_\_\_

9b. Specific RESTRICTIONS (What the patient should not do and why). Please quantify in hours, weight, etc. \_\_\_\_\_

9c. Specific LIMITATIONS (What the patient cannot do and why). \_\_\_\_\_

10. If retired or unemployed which activities of daily living (ADLs) is patient unable to perform? \_\_\_\_\_

11. Date patient last examined by you: \_\_\_\_\_ Frequency of visits:  weekly  monthly  other \_\_\_\_\_

12. Is patient:  ambulatory  bed confined  house confined  other \_\_\_\_\_

13. If patient is hospitalized, give name and address of hospital.

Hospital: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

14a. Date admitted:      /      /      Date discharged:      /      /       
MO/DAY/YR MO/DAY/YR

14b. When do you expect patient to resume partial duties?      /      /      Full duties?      /      /       
MO/DAY/YR MO/DAY/YR

14c. If patient is unemployed or retired, on what date would you expect a person of like age, gender and good health to resume his/her normal and necessary activities?      /      /       
MO/DAY/YR

15. Is condition due to injury or sickness arising out of patient's employment?  Yes  No

If "yes," explain. \_\_\_\_\_

16. Referring Physician: \_\_\_\_\_ Phone: (     ) \_\_\_\_\_

Mailing Address: \_\_\_\_\_

## PHYSICIAN VERIFICATION

Signed: \_\_\_\_\_, MD Date:      /      /      Phone: (     ) \_\_\_\_\_  
MO/DAY/YR

Street Address: \_\_\_\_\_

City/Town: \_\_\_\_\_

State/Province: \_\_\_\_\_ Zip Code: \_\_\_\_\_

## 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:

<u>Pay Period</u>		<u>Amount</u>	<u>Source of Income</u>
<u>From</u>	<u>To</u>		
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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: \_\_\_\_\_