AMERICAN HERITAGE LIFE INSURANCE COMPANY
LIFE COVERAGE WITH OPTIONAL RIDERS CLAIM FORM

Submit Claims to:
American Heritage Life Insurance Company
1776 American Heritage Life Drive, Jacksonville, FL 32224
Phone 1-800-348-4489 Fax 1-877-632-7901
Website www.allstatebenefits/mybenefits.com

For questions regarding the policy benefits, the supporting documentation, or for assistance with a claim, please contact our **Customer Care Center at 1-800-348-4489 or visit our website at www.allstatebenefits.com.**

This form is designed as a communication tool to assist the examiner in reviewing the claim for available benefit. Please complete this form in its totality and complete one form per claimant.

Incomplete or blank responses may result in a delay in processing the claim request.

POLICY/CERTIFICATE HOLDER AND CLAIMANT INFORMATION: This information helps us to identify the policy, covered members, mailing address and employer to ensure benefits are being considered under the correct coverage.

COVERAGE NUMBER(S): ______________________________

POLICY/CERTIFICATE HOLDER INFORMATION: First Name: ______________ MI: ____ Last Name: ______________

Social Security #: ______________ Birth Date: ______________ Age: ________ Gender: ________

☐ **Check here if address is new**

Address: ______________________________ Apt#: ________

City: ______________________ State: ____________ Zip: __________

Phone #: ______________ E-mail: ______________________

Employer: ______________________ Occupation: ______________________

DECEASED INFORMATION: (If different) First Name: ______________ MI: ______ Last Name: ______________

Date of Birth: __________ Age: ______ Gender: ________ Relation to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Domestic Partner ☐ Other ____________

Marital status at the time of death: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

PERSON MAKING THE CLAIM: First Name: ______________ MI: ____ Last Name: ______________

Social Security #: ______________ Birth Date: ______________ Age: ________ Gender: ________

Address: ______________________________ Apt#: ________

City: ______________________ State: ____________ Zip: __________

Phone #: ______________ E-mail: ______________________

Your relationship to the deceased: ☐ Self ☐ Spouse ☐ Child ☐ Domestic Partner ☐ Parent ☐ Other ____________

Are you the beneficiary named in the Coverage? ☐ Yes ☐ No ☐ Unknown. (If applicable, please provide documentation showing beneficiary information.)

CLAIM DETAILS: Please provide the following claim details. This information is very important as it tells the examiner the specific details of the claim and helps the examiner determine whether benefits are available. The condition/diagnosis is the condition that was diagnosed by the physician.

Death Claim: ☐ Yes ☐ No

Date of Death: ______________ Cause of Death: ______________________

List all Conditions/Diagnoses: ______________________________

Was the death due to a medical condition? ☐ Yes ☐ No When did symptoms of the condition first appear? ______________

Was the death due to an accidental Injury? ☐ Yes ☐ No Accident date: __________Time: ________ ☐ AM or ☐ PM

When did the deceased first see the physician for this condition? ______________ When was the last physician visit? ______________

When did the deceased last work? ____________ Where did the deceased last work? ______________________

Address: ______________________ City: ______________ State: ______ Zip: ________ Phone #: ____________

What was the accident or event? ______________________________

What were the injuries sustained? ______________________________

Where did the accidental injury happen? ______________________________

Tell us exactly how the accidental injury happened: ______________________________

Was a police or traffic report filed? ☐ Yes ☐ No (If yes, please provide.) For motor vehicle accidents, the claimant was the: ☐ Driver ☐ Passenger

Is the condition work related? ☐ Yes ☐ No

A Certified Copy of the Death Certificate including the cause of death must accompany this form.

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. Please check to be sure all information is correct before signing. Please refer to the fraud notice specific to your state.

AMERICAN HERITAGE LIFE INSURANCE COMPANY
LIFE COVERAGE WITH OPTIONAL RIDERS CLAIM FORM

CLAIMANT'S NAME: ______________________ **DATE OF BIRTH:** ____________

COVERAGE NUMBER(S): ______________________ **CLAIM NUMBER:** ____________

INSTRUCTIONS FOR REQUESTING AVAILABLE BENEFITS:

- Benefits may vary by product and/or state. In addition, all the available riders may not have been purchased and/or all the benefits listed may not be available. Please refer to the coverage document and riders for specific benefits available. An outline of benefits is available on page 3 of the coverage document.
- Available benefits are considered in accordance with your specific coverage, including all terms, conditions, provisions and applicable limitations and exclusions.
- Please select the benefits that may be due based upon the condition, services provided, and coverages available.
- Please submit supporting documentation. This documentation should include the claimant's name, diagnosis, and date(s) of service, if applicable.
- If asked to provide a bill as supporting documentation, please request an itemized bill, UB04 or HCFA 1500 from the provider.
- Medical records may include but are not limited to: physician's office visit notes, hospital records, emergency room records, diagnostic test results, radiology reports, therapy visit notes, prescription history, or physician consultation notes.
- We reserve the right to request additional information for review of the claim.

LIFE COVERAGE & RIDER BENEFITS: All benefits listed may not be available. Please refer to the coverage document and riders for specific benefits available.

BENEFIT (IF APPLICABLE)	SUPPORTING DOCUMENTATION
☐ **Death Benefit**	☐ Certified Copy of the Death Certificate If available, please provide: ☐ Accident Report ☐ Autopsy Report ☐ Toxicology Report ☐ Policy

LIFE COVERAGE RIDER BENEFITS: All benefits listed may not be available. Please refer to the coverage document and riders for specific benefits available.

BENEFIT (IF APPLICABLE)	SUPPORTING DOCUMENTATION
☐ **Long Term Care**	☐ Attending Physician's Statement ☐ Bill for Long Term Care Services as outlined in your policy
☐ **Living Benefit Rider** ☐ **Critical Illness Rider** ☐ **Accelerate Death Benefit for Terminal Illness Rider**	Attending Physician's Statement
☐ **Adult Dependent Care Survivor**	Documentation of court appointed guardianship or custodianship, or tax returns showing dependent claimed
☐ **Air Bag Use** ☐ **Seat Belt Use** ☐ **Spouse's Loss of Life as a Result of a Common Accident**	Traffic/Accident report
☐ **Carjacking**	Incident report or other written proof of carjacking certified by the investigating officer
☐ **Child Care**	Proof of child care expenses incurred
☐ **Child Education**	Proof of enrollment and tuition expenses (must be provided within 30 days of our request)
☐ **Children's Additional Indemnity for Dismemberment**	Medical record showing dismemberment
☐ **Common Carrier**	Receipt or other proof of fare-paying passenger
☐ **Consolidated Omnibus Budget Reconciliation Act Continuation**	Proof that the payment will be used for continuation of the surviving person's medical coverage pursuant to COBRA
☐ **Critical Burn**	Medical records showing burns over at least 25% of the body
☐ **Emergency or Disaster Response Team Member**	Official documentation of participation as a member of an emergency or disaster response team
☐ **Funeral Expense**	Proof of funeral expenses incurred
☐ **Hospital Confinement or Extended Care (monthly)**	Bill or medical record showing hospital confinement or extended care
☐ **Hepatitis** ☐ **Human Immunodeficiency Virus (HIV)**	Workers' Compensation injury report within 48 hours of the accident and blood test
☐ **Medical Evacuation Expense**	Bill or medical record showing air transport to a medical facility
☐ **Monthly Home Mortgage Payment**	Documentation of the eligible loan number and telephone number of the mortgage company
☐ **Rehabilitative Physical Therapy**	Proof of the prescribed therapy
☐ **Repatriation Expense**	Proof of the preparation and transportation of the body to a mortuary
☐ **Residence or Vehicle Modification**	Bill or documentation of modification
☐ **Spouse Education**	Proof of education expenses for the employee's spouse
☐ **Therapeutic Counseling**	Bill or medical records showing treatment or counseling provided by a licensed therapist or counselor registered or certified to provide psychological treatment of counseling. Notes from counseling session not required

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CLAIMANT'S NAME: ______________________ **DATE OF BIRTH:** ____________

COVERAGE NUMBER(S): ______________________ **CLAIM NUMBER:** ____________

LIFE COVERAGE RIDER BENEFITS (continued): All benefits listed may not be available. Please refer to the coverage document and riders for specific benefits available.

BENEFIT (IF APPLICABLE)	SUPPORTING DOCUMENTATION
☐ **Total Disability** ☐ **Total Disability - Premium Waiver** ☐ **Total and Permanent Disability (monthly)** ☐ **Total and Permanent Disability (single payment)**	☐ Attending Physician's Statement ☐ Employer's Statement
☐ **Travel**	Proof of travel expenses incurred
☐ **Workplace Felonious Assault**	Employer investigative report and police report

If this policy has been in effect for less than 2 years, please complete this section of the claimant statement.

PROVIDERS: Please list all providers the insured has seen in the past 5 years.

1. ____________ ____________ ____________
   Attending Physician's Name: Address: Phone #:
   ____________ ____________ ____________
   Specialty: Dates Consulted: Reason for Visit / Condition:

2. ____________ ____________ ____________
   Primary Care Physician's Name: Address: Phone #:
   ____________ ____________ ____________
   Specialty: Dates Consulted: Reason for Visit / Condition:

3. ____________ ____________ ____________
   Other Physician/ Specialist's Name: Address: Phone #:
   ____________ ____________ ____________
   Specialty: Dates Consulted: Reason for Visit / Condition:

4. ____________ ____________ ____________
   Hospital Name: Address: Phone #:
   ____________ ____________
   Dates Hospitalized: Reason for Hospitalization / Condition:

ASSIGNMENT OF BENEFITS: Please provide a fully executed assignment.

I would like to assign benefits to ☐ **Funeral Home** ☐ **Funding Company** ☐ **Other:**

Name: ______________________ Telephone #: ______________________

Address: ______________________

City:______________________ State: ____________ Zip: ____________

DIRECT DEPOSIT

Please provide the following information if you would prefer the direct deposit of claim proceeds into your personal bank account. You must ATTACH a copy of a voided, pre-printed check, including:

Account Holder's Name: ______________________

Bank Name: ______________________ Bank Phone Number: ______________________

Bank Address: ______________________ City, State, Zip: ______________________

Account Number: ______________________ Routing Number: ______________________

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COVERAGE NUMBER(S): ________________________ **CLAIM NUMBER:** ____________

Attending Physician's Statement: This statement only needs to be provided if stated in the benefit section as required supporting documentation. To be completed and signed by the attending physician.

ICD 9/10 Code: ___________ Primary diagnosis: ________________________

ICD 9/10 Code: ___________ Secondary diagnosis: ________________________

Other Condition(s): ________________________

When did symptoms first appear? ____________ If applicable, what is the accident date? ____________

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

Has the patient ever had the same/similar condition? ☐ Yes ☐ No When? ________________________

First consultation: __________ Most recent consultation: __________ Next consultation: __________ Released: __________

Is/Was diagnostic testing performed? ☐ Yes ☐ No Date: __________ Type of testing: ____________

Is/Was a surgical or medical procedure required? ☐ Yes ☐ No Date: __________ Procedure code: ____________

Procedure: ________________________

Is/was Hospitalization required? ☐ Yes ☐ No Admission date: __________ Discharge date: __________

Hospital: ________________________ City: ____________ State: ________

What is the current treatment plan? ________________________

____

The patient is unable to perform their job duties: From: __________ Through: __________

When is the patient expected to resume work? Part time/Partial duties: __________ Full time/Full duties: __________

Please provide the specific restrictions: ________________________

Please provide the specific limitations: ________________________

What clinical or diagnostic findings support these restrictions and limitations? ________________________

____

Referring physician's name: ________________________ Specialty: ____________

Address: ________________________ Phone #: ____________

I am aware that it is a crime to fill out this form with facts I know are false or to leave out facts I know are relevant and important. I certify that the answers given on this claim form are true, complete, and correctly recorded.

Attending physician signature: ________________________ Date: ____________

Print name: ________________________ Specialty: ____________ Phone #: ____________

Address: ________________________ City: ____________ State: ______ Zip Code: ________

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COVERAGE NUMBER(S): ____________________ **CLAIM NUMBER:** ____________

Employer's Statement: To be completed and signed by the Employer when a claim is filed within the first 2-years of coverage and for all Group coverage.

Check here if ☐ Self Employed or ☐ Unemployed If unemployed, provide last date worked: ____________

Name of employer/company: ____________________Date of hire: ____________

Employee's job title/position: ____________Major job responsibilities: ____________________

Weekly earnings: $____________ Amount of insurance: Life: $____________ Accidental death and dismemberment: $____________

I hereby certify that ____________________ last worked on ____________.

Was the employee on leave of absence or lay off when the event occurred ☐ Yes ☐ No If yes, why? ____________________

Was the insurance terminated? ☐ Yes ☐ No If yes, when? ____________

List Beneficiary(ies) on file (include a copy of beneficiary designation): ____________________

Was this a work-related condition/injury? ☐ Yes ☐ No

<u>WAIVER OF PREMIUM FOR DISABILITY:</u>

I hereby certify that ____________________ did not work from ____________ through ____________.

Has the employee returned to work? ☐ Yes ☐ No Part time/Partial duties(date): ____________ Full time/Full duties(date): ____________

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Signed by: ____________________ Print Name: ____________________ Date: ____________

Title: ____________________ Company: ____________________

Address: ____________________ Phone #: ____________________

Other Comments: ____________________

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AMERICAN HERITAGE LIFE INSURANCE COMPANY
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CLAIMANT'S NAME: ______________________________ **DATE OF BIRTH:** ______________

COVERAGE NUMBER(S): ______________________________ **CLAIM NUMBER:** ______________

AUTHORIZATION TO RELEASE INFORMATION TO AMERICAN HERITAGE LIFE INSURANCE COMPANY

I hereby authorize any physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, health care provider, Pharmacy Benefit Manager, insurance company, the Medical Information Bureau (MIB) or other organization, institution or person that has any health related records or knowledge of me or minor dependents to disclose the entire medical record (excluding psychotherapy notes and in MAINE and VERMONT HIV related test results) to American Heritage Life Insurance Company (AHL), its duly authorized representatives, its subsidiaries or its reinsurers. This authorization extends to any minor dependent on whom insurance is requested or claim for benefits is being made.

The information to be obtained shall include insurance claim history from any Prescription Drug Database, pharmacy benefit manager, ambulance, insurance company, medical transport service, or the MIB. Also, I authorize any entity, person, or organization that has these records about me, including but not limited to my employer, employer representative and compensation sources, insurance company, financial institution or governmental entities, including departments of public safety and motor vehicle departments, to give any information or record it has about me, my employment, employment history or income to AHL.

I understand that this information will be used to evaluate and administer my claim for benefits or to evaluate my eligibility for insurance. I understand that there is a possibility of redisclosure of any information disclosed pursuant to this authorization and that information, once disclosed, may no longer be protected by certain federal regulations governing privacy and confidentiality, though it may still be protected by state privacy laws or other applicable privacy laws. I also authorize AHL or its reinsurers to make a brief report of my health information to MIB.

This authorization shall remain in force for 24 months following the date of my signature below or termination of my coverage, whichever occurs first. A copy of this authorization is as valid as the original. I or my legal representative may request a copy of this authorization. I understand that I may revoke this authorization at any time by sending a written notification to: **Attn: Privacy Officer, American Heritage Life Insurance Company, 1776 American Heritage Life Drive, Jacksonville, FL 32224.**

I understand that a revocation of this authorization is not effective if AHL has relied on the protected health information or has a legal right to contest a claim under an insurance policy or to contest the policy itself. The revocation will not apply to any information AHL requests or discloses prior to AHL receiving my revocation request. If I choose not to sign this authorization or if I later revoke it, I understand that AHL may not be able to process my application for coverage, or if coverage has been issued, AHL may not be able to administer my claim for benefits and this may result in a denial of my claim for benefits or request for services.

Claims submitted on dependents 18 and older require an authorization signed by the dependent.

______________________________	______________________________
Claimant/Applicant's Signature	Date Signed (mm/dd/yyyy)
______________________________	_________XXX-XX-______________
Claimant/Applicant's Printed Name	Last Four Digits of Social Security Number

If signed by the legal representative, please describe the authority under which the representative is authorized to act and enclose any related documentation granting authority.

______________________________	______________________________
Signature of Legal Representative	Relationship
______________________________	______________________________
Print Name of Legal Representative	Date Signed (mm/dd/yyyy)

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CLAIMANT'S NAME: ______________________________	DATE OF BIRTH: ____________
COVERAGE NUMBER(S): ______________________________	CLAIM NUMBER: ____________

FRAUD WARNINGS BY STATE

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, 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 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 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 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 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 and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and 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 thousand dollars ($5,000), not to exceed ten thousand 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.

CERTIFICATION: The certificate/policy holder or claimant who completed the claim, form please read and sign below.

I acknowledge the receipt of the Department of Insurance Claim Fraud Statements provided with this claim packet. I have read the notices and I am aware that it is a crime to fill out this form with facts I know are false or to leave out facts I know are relevant and important. I certify that the answers given on this claim form are true, complete, and correctly recorded.

Please also remember to sign and date the attached authorization required to process your claim.

Signature: ______________________ **Print Name:** ______________________ **Date:** ____________

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CLAIMANT'S NAME: ______________________________ **DATE OF BIRTH:** ______________
COVERAGE NUMBER(S): ______________________________ **CLAIM NUMBER:** ______________

Note: Due to Internal Revenue Service requirements concerning social security number verification and backup withholding requirements, this form is required to be completed prior to claim payment.

Tax Payor Identification Number Certification

Federal law requires us to send to the Internal Revenue Service a percentage of any income you may be entitled to unless you certify under penalties of perjury that you have shown your correct Social Security Number and you have not been notified that you are subject to any Internal Revenue Service backup withholding order.

Under penalties of perjury, I certify that:

A. The Social Security Number shown on page 1 is my correct tax payor identification number (or I am waiting for a number to be issued to me), and
B. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) The IRS has notified me that I am no longer subject to backup withholding, and
C. I am a U.S. person (including a U.S. resident alien), and
D. The Foreign Account Tax Compliance Act (FATCA) code entered on this form (if any) indicating that the payee is exempt from FATCA reporting is correct.

The Internal Revenue Service does not require your consent to any provisions of this document other than the certification required to avoid backup withholding.

Claimant Signature: ______________________ Print Name: ______________________ Date: ______________

Complete Social Security Number/Tax Payor Identification Number: ______________________

☐ Check here if address is new

Address: ____

City: ______________________ State: __________ Zip: __________ Telephone #: ______________________

Beneficiary Information and Instructions for Life and Accidental Death Policies

We have prepared these instructions to assist you in filing a claim for death benefits. It is important that we receive all of the information requested.

Special Instructions

- **Accident Policy**: In addition to the documentation listed above, please provide copies of the Fire, Incident/Accident report, final Autopsy report or Coroner's report including Toxicology report (if performed), and any other documentation regarding the accident or incident if available.
- **Minor Beneficiary**: The claimant's statement must be completed by the court appointed Legal Conservator/ Guardian of the minor's Property/Estate. A certified copy of Letters of Conservatorship/ Guardianship of the Estate of the minor must accompany this form. If Legal Conservatorship/ Guardianship is not established, the Company will hold the proceeds at interest until the minor reaches the age of majority. If the Insured named a Custodian for the minor, under the Uniform Transfers or the Uniform Gifts to Minors Act (UTMA or UGMA), the Custodian may complete the claimant's statement.
- **Estate Beneficiary**: The claimant's statement must be completed by the court appointed Executor or Administrator of the Estate. The Tax Payor Identification Number for the Estate must be provided on the claimant statement and a certified copy of the Letters Testamentary or Letters of Administration must be submitted. Some estates may be administered with the use of a Small Estate Affidavit (or similar procedure). If you are making a claim as an individual under a Small Estate Affidavit (or similar procedure), the person entitled to the benefit pursuant to this procedure should submit fully completed claimant statement and provide a copy of the properly executed Affidavit or Order.
- **Contingent Beneficiary**: When the primary beneficiary(ies) has predeceased the Insured, the contingent beneficiary must provide a death certificate for the primary beneficiary(ies).
- **Trust Beneficiary**: The claimant's statement must be completed on behalf of the Trust by the designated Trustee(s). If any Trustee fails to make claim for the policy proceeds within 12 months after the Company is notified of the Insured's death, or if the Company receives satisfactory written evidence that the Trust is not in effect, payment will be made as if the Trust was not named as a Beneficiary. Before making payment to any Trust, the Company reserves the right to require satisfactory written evidence that the Trust is in effect and evidence of the identity of the Trustee(s) who are qualified to act on behalf of the Trust.
- **Ex-Spouse of Insured**: Under certain circumstances, state law provides for automatic revocation of a spouse as beneficiary upon divorce. Copies of the Petition for Divorce, any property settlement agreements, and the final Divorce Decree must be submitted.
- **Assignments for Funeral Expenses**: The claimant's statement and a signed notarized assignment form (supplied by the funeral home) must be completed by each beneficiary(ies). An itemized copy of the funeral expenses must be provided. A separate check in the amount of the assignment will be mailed directly to the funeral home.
- **Death outside the U.S.**: For U.S. citizens, the official death certificate must be accompanied by a "Consular Report of Death of a U.S. Citizen Abroad" report from the U.S. Department of State, in addition to the other required claim documents.
- If a Power of Attorney completes the claimant's statement on behalf of the beneficiary, a copy of the signed appointment document is required.
- When a class of people (e.g., lawful children) are designated as beneficiaries, a notarized affidavit stating the names, birth dates, social security numbers and residence addresses for all children is required. If any members of the class are deceased, a copy of their death certificate is required.

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- When the death has occurred within the first two years of the policy effective date, reinstatement, increase of coverage, or change of class, the claims details section on page 1 of the claimant's statement must be completed. We may request medical records from medical providers who treated the insured, as well as employment information.
- Your claim will receive our immediate attention once all this information has been received. If you have any questions regarding your claim or require additional information, please do not hesitate to contact our Customer Care Department at 1-800-348-4489. We are always happy to help you.

Mail all required documents to:
American Heritage Life Insurance Company
ATTN: Life Claims
1776 American Heritage Life Drive
Jacksonville, Florida 32224-6687

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