CLAIM FORM

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 8:15 A.M. to 4:30 P.M. Eastern Standard Time

Allstate Benefits

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

CLAIMANT'S STATEMENT

PART A

1. a. Full Name of Deceased Insured

_____
(Last) (First) (M.I.)

b. Policy Number(s) _____

2. Legal residence at time of death

Street _____

City _____ State _____ Zip _____

3. Date of Birth Month _____ Day _____ Year _____

4. Male ❑ Female ❑ Marital Status _____ Social Security Number _____

5. Date of Death Month _____ Day _____ Year _____

6. Place of Death City _____ State _____

7. Cause of Death _____

8. When did Deceased first complain of, or give other indications of his/her last illness? Date: _____

9. When did Deceased first consult a physician for his/her last illness? Date: _____

10. On what date did Deceased last attend his/her usual work? Date: _____

PART B

COMPLETE THIS PORTION FOR:

A. Policies in force less than 2 years or REINSTATED within TWO years of death, please complete the following:

1. Full name and address of Deceased Insured's personal physician:

_____

2. Full name and address of any other doctors who treated the Deceased Insured during the last 5 years:

_____

_____

_____

3. Full name, address and telephone number of the Deceased Insured's Employer:

_____

_____

_____

4. Deceased's Driver's License # _____ State of Issue _____

PART C **ABOUT THE PERSON MAKING THE CLAIM**

1. Your full name: _____
(Last) (First) (Middle)

2. Your Social Security No. _____ 3. Your date of birth: _____

4. Your residence/address _____ City/State _____ Zip _____

5. Your mailing address _____ City/State _____ Zip _____

6. Your relationship to the deceased _____ Your phone # _____

The undersigned hereby makes claim to said insurance issued by this Company and agrees that the written statements and affidavits of all the physicians who attended or treated the insured, and all other papers called for by the instructions hereon, shall constitute and are hereby made a part of this Claimant's Statement, and further agrees that by furnishing this form, or any other supplemental forms, by the Company shall not constitute nor be considered an admission that there was any insurance in force on the life in question, nor a waiver of any of its rights or defenses.

AUTHORIZATION

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. (In MAINE – I understand that revocation of this authorization may be a basis for denying insurance benefits. Failure to sign an authorization statement may impair the ability of a regulated insurance agency to evaluate claims and may be a basis for denying a claim for benefits.) **Important: To avoid delay, please sign authorization below.**

Sign here: _____ Date: _____
(Claimant)

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.

Taxpayor 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 in line (2) of Part C is my correct taxpayor 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. I am exempt from FATCA reporting.

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

Sign here _____ Date: _____ ❑ Check here if address is new
(Claimant)

Street Address: _____

City: _____ State: _____ Zip: _____ Telephone No. (_____) _____

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 refer to the fraud notices on the next page for notice specific to your state.

PART D *Please attach copy of Bank Deposit Slip and voided check.*

Please complete the following information if you would prefer the direct deposit of claim proceeds into your personal bank account:

Bank Name: _____ Bank Telephone No.: _____

Bank Address: _____ City and State: _____

Account Number: _____ Routing # _____

ILLINOIS INTEREST STATEMENT: For contracts issued in and residents of Illinois, unless payment is made within fifteen (15) 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 9% 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, ARKANSAS, 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 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 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.