

# AMERICAN HERITAGE LIFE INSURANCE COMPANY (AHL)

## LIFE COVERAGE CLAIM FORM

Submit Claims: Online at: <https://www.standard.com/ahl>; or Fax to: 1-866-424-8482; or

Mail to: American Heritage Life Insurance Company 4920 San Pablo Road S, Suite 200C, Jacksonville, FL 32224-6687

For questions regarding the policy benefits, supporting documentation, or for claim assistance, instructions can be found on our website or contact our Customer Care Center at 1-800-521-3535.

Please refer to the Coverage Documents for benefits available as well as applicable terms, conditions, exclusions, and limitations.

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

### Section 1 – Please provide the following information regarding the Policy/Certificate Holder and the Deceased.

COVERAGE NUMBER(S): \_\_\_\_\_

#### POLICY/CERTIFICATE HOLDER INFORMATION:

First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Last Name: \_\_\_\_\_ SS #: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_ Phone #: \_\_\_\_\_ Email: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

#### DECEASED INFORMATION: (If different than Policy/Certificate Holder)

First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Last Name: \_\_\_\_\_ SS #: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_ Relation to Insured: ☐ Self ☐ Spouse ☐ Domestic Partner ☐ Child ☐ Other: \_\_\_\_\_

Resident State: \_\_\_\_\_ Marital status at time of death: ☐ Single ☐ Married ☐ Widowed ☐ Divorced (If divorced, provide dissolution paperwork)

### Section 2 – Please provide the following information regarding the person filing this claim.

Please be aware, each beneficiary needs to complete a claim form.

In addition, we will need one copy of the death certificate, including the cause of death. A certified copy of the death certificate may be required. We will notify you if any additional supporting documentation is needed for review.

First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Last Name: \_\_\_\_\_ SS #: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_ Phone #: \_\_\_\_\_ Email: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Physical Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Your relationship to the deceased: ☐ Self ☐ Spouse ☐ Domestic Partner ☐ Child ☐ Other: \_\_\_\_\_

Are you the beneficiary named in the Coverage? ☐ Yes ☐ No ☐ Unknown (Please provide documentation showing beneficiary designation)

### Section 3 – Please provide the applicable claim details.

1. Is this a death claim? ☐ Yes ☐ No Date of Death: \_\_\_\_\_

2. What was the cause(s) of death? (List all): \_\_\_\_\_  
When did symptoms of this condition first occur? \_\_\_\_\_

3. Was the cause of death accidental? ☐ Yes ☐ No If no, move to question 4. If yes, please provide: Accident Date: \_\_\_\_\_ Time: \_\_\_\_\_ AM/PM  
Describe how the accident happened: \_\_\_\_\_

Was the accident work-related? ☐ Yes ☐ No

Was a police or traffic report filed? ☐ Yes ☐ No (If yes, please provide a copy of the report)

Was this an auto accident? ☐ Yes ☐ No (If yes, the claimant was the: ☐ Driver ☐ Passenger)

4. When did the deceased last work? \_\_\_\_\_ Where did the deceased last work? \_\_\_\_\_  
Unknown: ☐

5. Provide the Attending Physician and Facility information:

Physician Name: \_\_\_\_\_

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

Phone#: \_\_\_\_\_

First Visit: \_\_\_\_\_ Next Visit: \_\_\_\_\_

Follow Up Visits: \_\_\_\_\_

Facility Name: \_\_\_\_\_

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

Phone#: \_\_\_\_\_

Dates of Service: \_\_\_\_\_

Admission Date: \_\_\_\_\_ Discharge Date: \_\_\_\_\_

**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.**

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INSURED'S NAME: \_\_\_\_\_ CLAIMANT'S NAME: \_\_\_\_\_  
COVERAGE NUMBER(S): \_\_\_\_\_ CLAIM NUMBER: \_\_\_\_\_

### Section 4 – If benefits have been assigned to the Funeral Home or Funding Company, please complete this section, and provide a fully executed benefit assignment.

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

Name: \_\_\_\_\_ Telephone #: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

### Section 5 – If you would like Benefits Direct Deposited, please complete this section. You will also need to provide a copy of a voided, pre-printed check with the claim submission.

Account Holder's Name: \_\_\_\_\_

Bank Name: \_\_\_\_\_ Bank Phone Number: \_\_\_\_\_

Bank Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Account Number: \_\_\_\_\_ Routing Number: \_\_\_\_\_

The financial institution information provided above is complete and accurate. By signing this authorization, I consent for AHL to deposit this claim payment into my bank account.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Print Name: \_\_\_\_\_

**Note: Please do not forget to provide a copy of a Voided, Pre-Printed Check.**

### Section 6 – Please complete this section as required by the Internal Revenue Service.

#### 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 #: \_\_\_\_\_

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COVERAGE NUMBER(S): \_\_\_\_\_ CLAIM NUMBER: \_\_\_\_\_

### Section 7 - 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: \_\_\_\_\_

### 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 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 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 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 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 imprisonment.

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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, 4920 San Pablo Road S, Suite 200C, Jacksonville, FL 32224-6687.**

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.

***Your provider may require you to complete an additional authorization form. If asked to complete this authorization, your prompt response will help expedite the process.***

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

\_\_\_\_\_  
Claimant/Applicant's Signature

\_\_\_\_\_  
Date Signed (mm/dd/yyyy)

\_\_\_\_\_  
Claimant/Applicant's Printed Name

\_\_\_\_\_  
XXX-XX-  
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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### 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.
- 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  
4920 San Pablo Road S, Suite 200C  
Jacksonville, FL 32224-6687

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