aetna℠

Group Accident Plan Claim Form

Insured by American Heritage Life Insurance Company (the Company), a subsidiary of The Allstate Corporation*

Category Code: VPCF

Please contact our Customer Care Center at 1-877-750-5434, 8:00 A.M. to 8:00 P.M. Eastern Standard Time if you have any questions regarding benefits available, or how to file your claim, or if you wish to file an appeal regarding any determination. You may also contact us at www.AetnaVoluntaryBenefits.com.

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 Your Accident Claim

- Please check the box or boxes that best describe your current claim:
  - ☐ Outpatient Physicians Treatment Benefit
  - ☐ Medical Expenses
  - ☐ Dislocation/Fracture
  - ☐ Initial Hospitalization Confinement
  - ☐ Hospitalization Confinement
  - ☐ ICU
  - ☐ Ground Ambulance
  - ☐ Air Ambulance
  - ☐ Accidental Death
  - ☐ Common Carrier Accidental Death
  - ☐ Dismemberment

  * If filing for benefit under your Disability Rider please download and complete the disability claim form.
- Itemized bills including the Patient's name, services provided and the diagnosis treated are required. Claims for the fracture benefit should also include a radiology report.
- To expedite the processing of your claim, please include your policy number. If not known, you may contact our Customer Care Center at 1-877-750-5434.
- **If you wish to have your claim proceeds directly deposited electronically into your bank account, please complete the ACH Form available on our website at www.AetnaVoluntaryBenefits.com.**

How to Submit Your Claim

- You may fax your claim to us at 1-866-398-9210 or scan and **electronically submit** your claim through: www.AetnaVoluntaryBenefits.com.
- Or you may mail your claim to:
  Aetna Voluntary Plans
  PO Box 40869
  Jacksonville, FL 32203

* Additional claim forms are available on our website at www.AetnaVoluntaryBenefits.com.

Certificateholder Information

1. Employer Name		2. Occupation
3. Certificateholder Name/First	Middle	Last
4. Accident Policy Number(s) 1)	2)	
5. Social Security Number	6. Date of Birth / /	7. ☐ Male ☐ Female
8. Home Number: ( )	9. Email	

Patient's Information

1. Patient's Name/First	Middle	Last
2. Social Security Number	3. Date of Birth / /	4. ☐ Male ☐ Female
5. This person is your (self, wife, son, daughter, other):		

Accident Details

1. Date of Accident / /	2. Time of Accident ☐ a.m. ☐ p.m.	3. Where did it happen?
4. Tell us exactly how your accident/injury happened		

Attending Physician's Statement

1. Patient's Name	2. Policy Number
3. Diagnosis	
4. When did symptoms first appear or accident happen? (MM/DD/YYYY) / /	
5. When did patient first consult you for this condition? (MM/DD/YYYY) / /	
6. Has patient ever had same or similar condition? ☐ Yes ☐ No If Yes, state when and describe:	
7. Describe any other diseases or infirmity affecting present condition.	
8. Nature of surgical procedure, if any (describe fully).	
9. If patient is hospitalized, give name and address of hospital. Hospital: City: State:	
10. Date admitted (MM/DD/YYYY) / /	11. Date discharged (MM/DD/YYYY) / /
12. Referring Physician	13. Phone ( )
14. Mailing Address	

Physician Verification

1. Signed ,MD	2. Date (MM/DD/YYYY)	3. Phone ( )
4. Street Address		
5. City/Town	6. State/Province	7. Zip Code

Assignment of Benefits (n/a in New Hampshire) - Please complete this section ONLY if you wish for us to send your benefit to your medical provider instead of to you.

I request your company send benefits to someone other than me. Please send benefits available to the name and address shown below:

1. Name	2. Address	
3. Provider's Tax Identification Number	4. City	5. State
6. Relationship	7. Zip Code	
8. Signature of Policy Owner		

Important: To avoid delay, please sign authorization below.

I authorize any physician, medical practitioner, hospital, clinic or other medical facility, insurance company, the Medical Information Bureau or other organization, institution or person, that has records or knowledge of me or my health to give to American Heritage Life Insurance Company (AHL), its subsidiaries or its reinsurers any information relating to my claim. A copy of this authorization is as valid as the original. This authorization applies to any dependent on whom a claim is filed. This authorization is valid for a period of 24 months from the date signed. I understand that I may revoke this authorization at any time by notifying AHL in writing of my desire to do so. 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. (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.)

Claimant Signature			Date
Mailing Address ☐ Check here if address is new			
City	State	Zip	Telephone Number

*The Group Accident Plan is a limited benefit insurance policy and is underwritten by American Heritage Life Insurance Company (headquarters: Jacksonville, Florida). Eligible claims for this plan are the sole financial responsibility of American Heritage Life Insurance Company.

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, 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 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 my be subject to fines and confinement in prison.