$50 2x/yr if employee only coverage and 4x/yr if any dependents are covered

Can be used for any dentist, doctor, eye doctor, or chiropractor visit for any reason (does not have to be due to Accident)

OUTPATIENT PHYSICIAN'S TREATMENT 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 Care Center at 1-800-348-4489, 8:00 A.M. to 8:00 P.M. Eastern Standard Time or visit our website at www.allstatebenefits.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.

Mail or Fax Your Claim to: **American Heritage Life Insurance Company**
1776 American Heritage Life Drive, Jacksonville, FL 32224
Fax 1-866-427-3730

If you would like to have claim benefits automatically deposited into your bank account, please complete and send our ACH form (ABJ16661). This form can be found on our website at www.allstatebenefits.com or www.allstatebenefits.com/mybenefits.

POLICYHOLDER / CERTIFICATE HOLDER:

POLICY / CERTIFICATE NUMBER(s): _____ ; _____ ; _____

POLICYHOLDER / CERTIFICATE HOLDER:

First Name: _____ MI: _____ Last Name: _____

Social Security Number: _____ Date of Birth: _____ Age: _____ ☐ Male ☐ Female

Mailing Address: _____ Apt#: _____

City: _____ State: _____ Zip: _____ ☐ **Check here if address is new**

Phone #: _____ E-mail: _____

PATIENT'S INFORMATION:

First Name: _____ MI: _____ Last Name: _____

Social Security Number: _____ Date of Birth: _____ Age: _____ ☐ Male ☐ Female

Relation to Policyholder / Certificate Holder: ☐ Self ☐ Spouse ☐ Child ☐ Other

OUTPATIENT PHYSICIAN'S TREATMENT BENEFIT

Your coverage includes an Outpatient Physician's Treatment Benefit that pays a benefit when a covered person receives treatment by a physician outside of a hospital. Please refer to your policy / certificate for limitations that may apply.

Reason for the physician treatment / examination:

- ☐ Accident
- ☐ Illness
- ☐ Well/Preventative Exam

Please provide the following:

Provider Name: _____

Provider Address: _____

_____

Date(s) of service: _____

Please attach a copy of a bill or documentation of treatment provided by a physician, outside of the hospital.

IF ELIGIBLE FOR 4X PER YEAR REIMBURSEMENT OF $50, CANNOT BE USED MORE THAN 2X ON ANY ONE FAMILY MEMBER