WALMART GROUP CRITICAL ILLNESS
CLAIM FORM AND INSTRUCTIONS

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 the Walmart Claim Department at 1-800-514-9525, 8:00 A.M. to 8:00 P.M. Eastern Standard Time or visit our website at www.AllstateBenefits.com/walmart

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.

- To avoid delays in processing, please fill out all sections that apply to your claim.
- Include your certificate number. To obtain your certificate number, you may call **1-800-514-9525** or visit our website at www.AllstateBenefits.com/walmart**.**
- You may **fax** your claim to us at **1-877-423-8804** or scan and **electronically submit** your claim through: www.AllstateBenefits.com/mybenefits.
- You may also **mail** your claim to: **American Heritage Life Insurance Company**
  P.O. Box 41488
  Jacksonville, Florida 32203-1488
- Please be assured that your claim will receive our prompt attention. If you would like to receive your claim proceeds even faster, Allstate Benefits can automatically deposit them into your bank account or on your Money Network Card by completing and returning our ACH form (ABJ16661WMT). This form can be found on our website at www.AllstateBenefits.com/walmart.
- Additional claim forms are available on our website at www.AllstateBenefits.com/walmart.

INSURED AND PATIENT INFORMATION

1. Insured's Name: First:_____ Middle: _____ Last: _____

   E-mail: _____ Certificate Number: _____

   Social Security Number: _____ Date of Birth: ____/____/____ ❑ Male ❑ Female

   Mailing Address: _____ Apt #: _____

   City: _____ State: _____ Zip: _____ ❑ Check here if address is new
2. Daytime Phone Number: (____) _____ Evening/Cell Phone Number: (____) _____
3. Occupation: _____

PATIENT'S INFORMATION

4. Name: First: _____ Middle: _____ Last: _____
5. Social Security Number: _____ Date of Birth: ____/____/____ Age: _____ ❑ Male ❑ Female
6. Relation to Insured: ❑ Self ❑ Spouse ❑Child ❑ Other _____

INSTRUCTIONS FOR FILING YOUR CRITICAL ILLNESS CLAIM

Following are the benefits available under your Wal-Mart Group Critical Illness Policy. Please check the benefit(s) you believe may be due based upon your condition. To avoid delay, the **patient must sign and submit the Authorization to Release Information to AHL (form ABJ21476)**. You must also submit:

- ❑ The results of a tissue specimen, culture(s) and/or titer(s) or other diagnostic studies, which initially diagnosed the specified disease, must accompany your claim.
- ❑ A copy of your itemized hospital billing and completed Attending Physician's Statement.

*Additional information may be required as shown below.

Critical Illness Benefit		Please attach the medical record documentation of your condition
Alzheimer's Disease	❑	Medical record documentation by psychiatrist or neurologist to include proof of inability to perform 3 or more activities of daily living
Benign Brain Tumor	❑	Pathology report
Carcinoma in situ	❑	Pathology report
Coma	❑	Medical documentation showing state of unconsciousness for 7 or more consecutive days
Complete Loss of Hearing	❑	Medical documentation showing diagnosis of total hearing loss in both ears for at least 6 months
Complete Loss of Sight	❑	Medical documentation by ophthalmologist showing permanent loss of sight to 20 degrees or less in both eyes
Coronary Artery By-Pass Surgery	❑	Medical record or billing proof of procedure
Dismemberment	❑	Medical documentation showing permanent loss of one or more limbs
End Stage Renal Failure	❑	Medical record documentation showing proof of failure to both kidneys and proof of dialysis or transplant
Heart Attack	❑	Electrocardiograph proof and lab reports showing elevated cardiac enzymes or biochemical markers
Invasive Cancer	❑	Pathology report
Paralysis	❑	Medical documentation showing diagnosis of the loss of the use of a limb without severance
Parkinson's Disease	❑	Medical documentation by a neurologist showing inability to perform 3 or more daily living activities
Ruptured or Dissecting Aneurysm	❑	Medical records documentation of Ruptured or Dissecting Aneurysm
Skin Cancer	❑	Pathology report
Stroke	❑	Medical record documentation of permanent neurological deficit
Transient Ischemic Attack (TIA)	❑	Medical record documentation of a TIA

SPECIFIED DISEASES: (Please check the illness for which you are requesting benefits)

Addison's Disease	❑	
Amyotrophic Lateral Sclerosis (Lou Gehrig's Disease)	❑	
Cerebrospinal Meningitis (bacterial)	❑	
Cerebral Palsy	❑	
Cystic Fibrosis	❑	
Diphtheria	❑	
Encephalitis	❑	
Huntington's Chorea	❑	
Legionnaire's Disease	❑	*Confirmation by culture or sputum
Malaria	❑	
Multiple Sclerosis	❑	
Muscular Dystrophy	❑	
Myasthenia Gravis	❑	
Necrotizing fasciitis	❑	
Osteomyelitis	❑	
Poliomyelitis	❑	
Rabies	❑	*Also eligible for Recurrence Benefit
Sickle Cell	❑	
Systemic Lupus	❑	
Systemic Sclerosis	❑	
Tetanus	❑	
Tuberculosis	❑	

❑ **RECURRENCE BENEFIT** ❑ **MAJOR ORGAN TRANSPLANT OPTIONAL BENEFIT RIDER** ❑ **LODGING BENEFIT**

❑ **NATIONAL CANCER INSTITUTE (NCI) EVALUATION** ❑ **POST TRAUMATIC STRESS DISORDER** ❑ **AMBULANCE BENEFIT**

SIGN THIS PART ONLY IF YOU WISH TO ASSIGN YOUR BENEFITS TO A PROVIDER OR A FACILITY

I request that American Heritage Life Insurance Company send benefits to someone other than me. Please send benefits available to the name and address shown below:

Name _____ Relationship _____

Provider or Facility Tax Identification Number _____ Address _____

City _____ State _____ Zip _____

Signature of Insured _____ Date _____

ATTENDING PHYSICIAN'S STATEMENT

Patient's Name: _____ Age: _____

1. Diagnosis: _____
2. If condition is due to pregnancy, what is expected delivery date? Date ____/____/____ MO/DAY/YR
3. When did symptoms first appear or accident happen? Date ____/____/____ MO/DAY/YR
4. When did patient first consult you for this condition? Date ____/____/____ MO/DAY/YR
5. Has patient ever had same or similar condition? (If "yes," state when and describe.) ❑ Yes ❑ No _____
6. Describe any other diseases or infirmity affecting present condition. _____
7. Nature of surgical or obstetrical procedure, if any (describe fully). _____
8. Is patient unable to perform job duties? ❑ Yes ❑ No If yes, from _____ through _____
9a. What specific job duties is patient unable to perform? _____
9b. Specific RESTRICTIONS (What the patient should not do and why). Please quantify in hours, weight, etc. _____
9c. Specific LIMITATIONS (What the patient cannot do and why). _____
10. If retired or unemployed which activities of daily living (ADLs) is patient unable to perform? _____
11. Date patient last examined by you: _____ Frequency of visits: ❑ weekly ❑ monthly ❑ other _____
12. Is patient: ❑ ambulatory ❑ bed confined ❑ house confined ❑ other _____
13. If patient is hospitalized, give name and address of hospital.
    Hospital: _____ City: _____ State: _____

14a. Date admitted: ____/____/____ MO/DAY/YR Date discharged: ____/____/____ MO/DAY/YR

14b. When do you expect patient to resume partial duties? ____/____/____ MO/DAY/YR Full duties? ____/____/____ MO/DAY/YR

14c. If patient is unemployed or retired, on what date would you expect a person of like age, gender and good health to resume his/her normal and necessary activities? ____/____/____ MO/DAY/YR

15. Have you completed paperwork for any other insurance company? ❑ Yes ❑ No Social Security Disability? ❑ Yes ❑ 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. Check to be sure that all information is correct before signing. Please refer to page 4 for notice specific to your state.

PHYSICIAN VERIFICATION

Signed: _____ , MD Date: ____/____/____ MO/DAY/YR Phone: (____) _____

Street Address: _____

City/Town: _____

State/Province: _____ Zip Code: _____

CERTIFICATION

I acknowledge receipt of the Fraud Warnings By State 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.

Signature: _____ Date: _____

Print Name: _____

ILLINOIS INTEREST STATEMENT: For contracts issued in and residents of Illinois, unless payment is made within thirty-one (31) 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 10% 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, 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 ARKANSAS: 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.

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.

AMERICAN HERITAGE LIFE INSURANCE COMPANY

HOME OFFICE:
1776 AMERICAN HERITAGE LIFE DRIVE
JACKSONVILLE, FLORIDA 32224-6687

AUTHORIZATION TO RELEASE INFORMATION TO AHL

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.

_____ _____
Claimant/Applicant's Signature Date Signed (mm/dd/yyyy)

_____ _____
Claimant/Applicant's Printed Name 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)