



Allstate

Workplace Division

WELLNESS CLAIM FORM

If you have any questions regarding our determination of 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.

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.

POLICYHOLDER / CERTIFICATEHOLDER

Insured's Name: _____		Patient: _____	
Policy Number(s): 1) _____		2) _____	
Social Security Number: _____	Date of Birth: ____/____/____	<input type="checkbox"/> Male	<input type="checkbox"/> Female
		<small>MO/DAY/YR</small>	
Home Number: (____) _____		E-mail: _____	

Filing a claim for your calendar year Wellness Benefit is easy! If you have had one of the listed preventative tests or HPV Vaccination shown below, please check the appropriate boxes and attach any documentation you may have showing the provider, patient's name, the date of the test, and exam performed. If your policy was issued in Pennsylvania or California, please send us the actual bill and the Explanation of Benefits from your Major Medical Carrier.

Thank you for selecting Allstate Workplace Division and for having your annual wellness exam!

WELLNESS SCREENINGS	
<input type="checkbox"/> Biopsy for skin cancer	<input type="checkbox"/> Flexible sigmoidoscopy
<input type="checkbox"/> Blood test for triglycerides	<input type="checkbox"/> Hemocult stool analysis
<input type="checkbox"/> Bone Marrow Testing	<input type="checkbox"/> HPV (Human Papillomavirus) Vaccination
<input type="checkbox"/> CA15-3 (cancer antigen 15-3 - blood test for breast cancer)	<input type="checkbox"/> Lipid Panel (total cholesterol count)
<input type="checkbox"/> CA125 (cancer antigen 125 - blood test for breast cancer)	<input type="checkbox"/> Mammography, including Breast Ultrasound
<input type="checkbox"/> CEA (carcinoembryonic antigen – blood test for colon cancer)	<input type="checkbox"/> Pap Smear, including ThinPrep Pap Test
<input type="checkbox"/> Chest X-ray	<input type="checkbox"/> PSA (prostate specific antigen – blood test for prostate cancer)
<input type="checkbox"/> Colonoscopy	<input type="checkbox"/> Serum Protein Electrophoresis (test for myeloma)
<input type="checkbox"/> Doppler screening for carotids	<input type="checkbox"/> Stress test on bike or treadmill
<input type="checkbox"/> Doppler screening for peripheral vascular disease	<input type="checkbox"/> Thermography
<input type="checkbox"/> Echocardiogram	<input type="checkbox"/> Ultrasound screening of the abdominal aorta for abdominal aortic aneurysms
<input type="checkbox"/> EKG (Electrocardiogram)	

ASSIGNMENT OF BENEFITS FOR WELLNESS COVERAGE (n/a in New Hampshire)

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

Address

Provider's Tax Identification Number

City State Zip

Relationship

Signature of Policy Owner

Date

You may mail or fax your claim to:
American Heritage Life Insurance Company
1776 American Heritage Life Drive, Jacksonville, FL 32224
Phone 1-800-521-3535 Fax 1-800-430-4188

