

I'm not robot!

ADDENDUM TO PURCHASE AGREEMENT

In reference to the Purchase Agreement that was executed on the _____ day of _____, 20____,
by _____
(hereinafter known as "Seller"), and _____
(hereinafter known as "Buyer"), (if real property, Street Address, City, County, State and Zip) _____

that for good consideration the parties made the following modifications, extensions, additions or changes a part of the said Purchase Agreement as if contained therein; and where the context so admits the remainder of said Purchase Agreement shall remain in full force and effect.

This agreement, upon its execution by both parties, is herewith made an integral part of the aforementioned Purchase Agreement.

The undersigned Buyer, having inspected the above described property and its appurtenances, offers and agrees to purchase said property on the terms and conditions herein stated and acknowledged receipt of a copy of this agreement from the Agent named above.

ACCEPTANCE OF BUYER

Signature of Buyer _____ Date: ____/____/____
Time: _____ m

Signature of Buyer _____ Date: ____/____/____
Time: _____ m

ACCEPTANCE OF SELLER

The undersigned Seller accepts the foregoing offer to purchase and agree to sell the above described property on the terms and conditions as stated herein and acknowledges receipt of a copy of this agreement.

Signature of Seller _____ Date: ____/____/____
Time: _____ m

Signature of Seller _____ Date: ____/____/____
Time: _____ m

ADD102
Nevada Legal Forms & Tax Services, Inc.
www.nvadeforms.com

© Consult an attorney if you doubt the forms fitness for your purpose.

WELLNESS CLAIM FORM

Allstate Benefits

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 1-800-338-3433 (9:00 A.M. to 6:00 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: _____ Father _____ Male _____ Female _____
Policy Number(s): 1) _____ 2) _____
Insured's Social Security Number: _____ Insured's Date of Birth: _____
Home Address: _____ Contact: _____

Filing a claim for your calendar year Wellness Benefits 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 positive health status, the date of the test, and exact date/year. 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"/> Hemocelluloferritin
<input type="checkbox"/> Bone Massow Screening	<input type="checkbox"/> HPV (Human Papillomavirus) Vaccination
<input type="checkbox"/> CA15-3 (cancer antigen 15-3 - blood test for certain 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 certain cancers)	<input type="checkbox"/> Pap Smear, including ThinPrep Pap Test
<input type="checkbox"/> Cholesterol 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 site or treadmill
<input type="checkbox"/> Doppler screening for peripheral vascular disease	<input type="checkbox"/> Thyroidopathy
<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)

The undersigned American Heritage Life Insurance Company agent hereby assigns all benefits to whom they are due. Please send benefits available to the name and address of your policy.

Name: _____ Address: _____
Insured's Tax Identification Number: _____ City: _____ State: _____ Zip: _____
Residence: _____
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: 1-800-338-3433 Fax: 1-800-433-4138

ALLSTATE 0811



APPEAL REQUEST FORM

Allstate Benefits

PLEASE USE THIS FORM TO APPEAL A DENIAL DECISION.

Insured's Name (Last, First, MI): _____
Name of representative providing appeal: I appeal from above
Home and mailing address: _____
City, Province, Postal Code: _____
Your phone: () _____ Cell: () _____
What specific action are you appealing? _____

Reason why you need to complete a form: _____
Explain why you believe the claim is/was/would be covered: _____

(Check additional sheets of paper if needed)

If you have questions about the appeal process or need assistance in preparing an appeal, please contact our Member Assistance Administration at 1-800-338-3433 (9:00 A.M. to 6:00 P.M. Eastern Standard Time).

Please attach this form to:
Member Assistance Administration
Allstate Canada
One King Street West
Toronto, Ontario M5X 1C5

Please refer to all appeal requests that involve any other Allstate benefits should cover your claim, including Accident Sickness. Reporting requirements/conditions from your other insurance, such as: Medicare, etc. (Include ICD)

Signature of insured or authorized representative: _____

PLEASE SEE INSTRUCTIONS ON PAGE 1

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