ALLSTATE INSURANCE COMPANY OF CANADA
HOME OFFICE: MARKHAM, ONTARIO
Administrator: Allstate Benefits
PO Box 8100 Stn T
Ottawa, ON K1G 3H6

APPEAL REQUEST FORM

Please use this form to appeal a denial decision.

Insured's Name ________________________________ Certificate No. ______________

Name of representative pursuing appeal, if different from above ______________________________

Number and Street ________________________________ Phone No. ______________

City ______________________ Province ________________ Postal Code ____________

Type of Denial: ☐ Denied Claim ☐ Denied Service ☐ Other

What specific decision are you appealing? ____

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(Explain what you want our company to pay for)

Explain why you believe the claim or service should be covered: ___________________________

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(Attach additional sheets of paper, if needed.)

If you have questions about the appeals process or require assistance to prepare your appeal, you may call Allstate Benefits at 1-844-436-1105.

Please submit this form to:
Group Claims
Allstate Benefits
PO Box 8100 Stn T
Ottawa, ON K1G 3H6

Please make sure to attach everything that shows why you believe Allstate Benefits should cover your claim, including: ☐ **Medical records** ☐ **Supporting documentation** (letter from your doctor, brochures, notes, receipts, etc.). **THANK YOU!**

____ ______________________
Signature of insured or authorized representative Date

PLEASE SEE AUTHORIZATION ON PAGE 2.

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All products are underwritten by Allstate Insurance Company of Canada.

Important: To avoid delay, please sign authorization below.

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medically related facility, insurance company or other organization, institution or person that has any records or knowledge of me (or my dependents) to give such information to Allstate Insurance Company of Canada or its designee. 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 Allstate Insurance Company of Canada in writing of my desire to do so. A photographic copy of this authorization shall be as valid as the original, regardless of date signed. I understand that 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.

Sign here ____ Date:_______________ ❑ Check here if address is new

Claimant

Number and Street:____ City:_____________________ Province:_____________

Postal Code: __________ Telephone No. (_____)________________