Accidental Dismemberment or Loss of Sight Claim Form

Life Claims Service Center
P.O. Box 105448
Atlanta, GA 30348-5448
Phone: 800-813-5682 Fax: 877-305-3901 Email: lifeanddisabilityclaims@anthem.com

Anthem Life

The furnishing of forms does not constitute an admission of liability on the part of the Company.

INSTRUCTIONS

As soon as you learn that an insured person has suffered any of the losses covered under the policy, this form (completed by the policyholder, claimant and the attending physician) should be sent to the address shown above.
Include the following material:
(a) Group Insurance Application and record card.
(b) All available newspaper clippings pertaining to the injury and loss, and a police or accident report, if available.

Section 1: EMPLOYER STATEMENT

Group no.	Suffix no.	Employee name	
Employee address (No. & Street)	City	State	Zip code
Date of full-time employment	Occupation	Date last worked ____/____/_____	Amount of benefit $
Was coverage continued to date of accident on a premium paying basis? ☐ Yes ☐ No	If no, what was the date of last premium payment? ____/____/_____	Earnings at date last worked? $	Original effective date of employee's insurance ____/____/_____
Date of accident ____/____/_____	Time of accident	Place of accident	Did accident occur on the job? ☐ Yes ☐ No

I hereby certify that the statements contained above are true to the best of my knowledge and belief.

Company name	Company phone no.
Company address (No. & Street, City, State, Zip code)	
Name of authorized company representative (please print)	Title
Signature of authorized company representative X _____	Date ____/____/_____

Section 2: EMPLOYEE STATEMENT

All questions should be fully answered by the insured or his/her legally appointed guardian or committee.

Name (First,Middle,Last)		Social security no.	Date of birth (MM/DD/YYYY) ____/____/_____
Address (No. & Street)	City	State / Zip code	Employee phone no.
Date of injury ___/___/_____	Date of loss ___/___/_____	Date first treated by physician ____/____/_____	Name and address of attending physician
Extent of loss			
Describe in detail how accident occurred			

I certify that the above statements by me are complete, true, and correctly recorded. I hereby authorize any hospital, physician or any other institutions or person who has attended or examined me to disclose to Anthem Life Insurance Company all information acquired by reason of, and records pertaining to, such hospitalization, examination and attendance. I authorize that a photostat of this authorization be accepted with the same authority as the original.

Employee's signature X _____ Date ____/____/_____

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Claim no.	Examiner	Total benefit $	Date approved/denied ____/____/_____

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Proof of Accidental Dismemberment
Attending Physician's Statement

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PATIENT'S NAME AND ADDRESS

	Birth date (MMDDYYYY) ____/____/_____

ATTENDING PHYSICIAN'S STATEMENT

The patient is responsible for completion of this form without expense to the company. Space is available on the reverse side if you wish to amplify your answers.

(a) When did the accident happen?	Date (MMDDYYYY) ____/____/_____
(b) When did the patient first consult you for this condition?	Date (MMDDYYYY) ____/____/_____
(c) Has patient ever had same or similar condition? ☐ Yes ☐ No	If yes, state when and describe:

Was the loss solely the result of an accidental injury? ☐ Yes ☐ No If no, what disease or condition was a contributory cause?

Is the patient competent to endorse checks and direct he proceeds thereof? ☐ Yes ☐ No

TO BE COMPLETED FOR LOSS OF SIGHT

Did the accidental injury result in the total and irrevocable loss of sight of:

Right eye: ☐ Yes ☐ No Date of loss ____/____/_____ Was the eye enucleated? ☐ Yes ☐ No Date ____/____/_____

Left eye: ☐ Yes ☐ No Date of loss ____/____/_____ Was the eye enucleated? ☐ Yes ☐ No Date ____/____/_____

State the date you first determined that central visual acuity was irrecoverably reduced to 20/200 or less with correction:

Date: (MM/DD/YYYY) ____/____/_____

SNELLEN notations on that date:

	Uncorrected	Corrected
O.D.V		
O.S.V.		

Can useful vision likely be restored by medication or surgery? ☐ Yes ☐ No	If yes, what are the prospects?

TO BE COMPLETED FOR LOSS OF LIMB(S)

Did the accidental injury result in a loss of limb(s)? ☐ Yes ☐ No

What limb(s) have been severed?

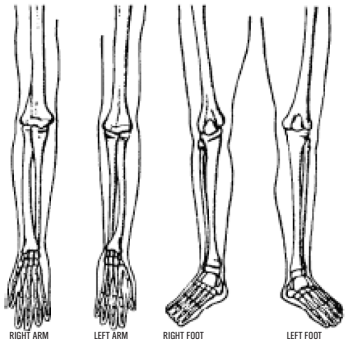
☐ Right Hand Date of severance: ____/____/_____

☐ Left Hand Date of severance: ____/____/_____

☐ Right Foot Date of severance: ____/____/_____

☐ Left Foot Date of severance: ____/____/_____

Please indicate exact point of severance:



Attending physician's name (please print)				Degree
Address (No. & Street)	City	State	Zip code	Phone no.

I certify that the above answers and statements are true and complete according to the best of my knowledge and belief.

Attending physician's signature **X** _____ Date (MMDDYYYY) ____/____/_____

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