Life Waiver of Premium or Continuation of Benefit Claim Form Employer Statement

Clear Form

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

INSTRUCTIONS:
Employer: When an insured person becomes disabled complete and mail this statement, enrollment form, and any beneficiary changes to Anthem Life. Complete the Group no., Suffix no. (if applicable) and the rest of the information in Section 1.

Give *Section 2 – Life Waiver of Premium or Continuation of Benefit Claim Form (Employee Statement)* and *Section 3 – Attending Physician's Statement*, to the insured person with instructions to be mailed to the Group Life Claims Service Center.

Anthem® Life

Anthem Life Insurance Company
Life Claims Service Center
P.O. Box 105448
Atlanta, GA 30348-5448

Phone: 800-813-5682
Fax: 877-305-3901
E-mail: lifeanddisabilityclaims@anthem.com

Notice to Customers Regarding Telephone Service Observance
To ensure our customers receive quality service, we randomly select phone calls for monitoring. These calls, between our customers and employees, are evaluated by supervisors. This is to guarantee that prompt, consistent assistance, and accurate information is delivered in a professional manner. We have been properly licensed by the Georgia Public Service Commission to use such observing equipment.

SECTION 1: EMPLOYER STATEMENT – Please complete ALL items. Any omissions may cause a delay in claim processing.

POLICYHOLDER DATA – EMPLOYER

Group no.	Suffix no.	Company name		
Company street address		City	State	ZIP code
To the attention of		Title	Company phone no.	

EMPLOYEE DATA

Employee last name	First name	MI	Social Security no.	Birthdate (mm/dd/yyyy)	Date employed (mm/dd/yyyy)

Life Insurance	Amount of Insurance	Last Change in Amount of Insurance		
		Increase	Decrease	Date
Basic	$	$	$	
Optional	$	$	$	
Total	$	$	$	

Rate of pay
$ per

Original effective date of individual's life insurance (mm/dd/yyyy)

Occupation (per life insurance schedule)

Date last worked (mm/dd/yyyy)

Date of disability (mm/dd/yyyy)

Has insurance been terminated? ☐ Yes ☐ No
If yes, indicate date (mm/dd/yyyy): _____

Reason for ceasing work
☐ Illness (including disability leave of absence) ☐ Leave of absence (other than disability) ☐ Quit ☐ Dismissed ☐ Temporary layoff ☐ Retired ☐ Vacation

Was insured considered a member/employee at date of disability? ☐ Yes ☐ No

Does your company have a formal pension plan? ☐ Yes ☐ No

Will employee be able to retire under this plan? ☐ Yes ☐ No

Please provide normal retirement date (mm/dd/yy): _____

BENEFICIARY DATA

Beneficiary Name	Relationship	Age	Address	Social Security No.

MODE OF SETTLEMENT OF CLAIM: Do *NOT* complete if the policy provides for waiver of premium only.
If policy provides for election of installments, indicate settlement desired after referring to the paragraph entitled "Modes of Settlement" in the policy:
Installment of $_____ over _____ months, OR; if method of payment is not known, please check ☐ and when determined, please notify us.

THE INFORMATION GIVEN ABOVE IS CORRECT AND COMPLETE ACCORDING TO OUR RECORDS.

Employer (if other than policyholder)	Signature of employer authorized representative X	Title of employer authorized representative	Date (mm/dd/yyyy)
Policyholder	Signature of policyholder authorized representative X	Title of policyholder authorized representative	Date (mm/dd/yyyy)

Si usted necesita ayuda en Español para entender este documento, puede solicitarlo sin ningun costo adicional llamando al número de servicio al cliente que se encuentra en este documento

Save and Print Form

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Life Waiver of Premium or Continuation of Benefit Claim Form Employee Statement

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Policyholder last name	First name	MI	Group no.	Suffix no.

POLICYHOLDER/EMPLOYER: Insert Name and Group Number as requested above. The form should then be given to the insured person for completion by them and their Attending Physician.

EMPLOYEE: (1) Please fill out and sign this portion of your claim form. (**IMPORTANT** – failure to fully answer all questions may cause a delay in the claim processing.)
Should you need assistance in completing this form, contact your Employer.
(2) When completed and signed by you, forward to your Attending Physician.

SECTION 2: EMPLOYEE STATEMENT

1. Last name	First name	MI	Birthdate (mm/dd/yyyy)	Sex ☐ Male ☐ Female	Are you married? ☐ Yes ☐ No

2. Street address	City	State	ZIP code	Social Security no.	No. of children dependent upon you for support:

3. Employer name	Occupation/Job title	Phone no.

4. In your own words, describe the duties of your usual job:

5. Did your usual job involve the following?

a. The use of machines, tools, or equipment ☐ Yes ☐ No
b. Technical knowledge or special skills ☐ Yes ☐ No
c Any supervisory responsibilities ☐ Yes ☐ No
d. Travel ☐ Yes ☐ No

Please explain all yes answers:

6. Please describe the kind and amount of physical activity involved in your job during a typical work day (check the number of hours in a day.)

Walking
0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐

Standing
0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐

Sitting
0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐

Lifting and Carrying: Describe what was lifted, how heavy it was, how often it was lifted and how far it was carried:

7. How does your illness or injury now prevent you from performing your usual duties as described in items 4, 5 and 6?

8a. List any skills you may have as a result of prior employment, training or education, or military service:

8b Level of education *(please check proper box)*

Grade school/High school:
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12 ☐

Degree Earned: ☐ College: _____
☐ Graduate: _____

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Life Waiver of Premium or Continuation of Benefit Claim Form Employee Statement *(continued)*

Anthem® Life

9. Before you stopped working, did your illness or injury cause you to change the following?

		Date changes were made (mm/dd/yyyy)
a. Your job duties	☐ Yes ☐ No	_____
b. Your hours of work	☐ Yes ☐ No	_____
c. Your attendance	☐ Yes ☐ No	_____

Explain how your condition caused these changes:

10. Briefly describe your injury or illness that prevents, or has prevented you from working:

11. If condition due to injury, please indicate the date of the injury and where it occurred:

Date (mm/dd/yyyy): _____ Location:

12. Describe how accident occurred:

13. When did you become unable to work because of your disability?

Are you still disabled? ☐ Yes ☐ No

14. If you are no longer disabled, provide the date you were able to work again (mm/dd/yyyy)

Date of first treatment for this illness or injury: (mm/dd/yyyy)

15. List the name, address and phone number of the doctor who has your latest medical records.
If you have no doctor, check here: ☐

Name			Phone no.	
Street address	City		State	ZIP code

16. How often do you see him?

Date you first saw him (mm/dd/yyyy)

Date you last saw him (mm/dd/yyyy)

17. Reasons for visits

Type of treatment received

18. Have you seen any doctor since your illness or injury began? ☐ Yes ☐ No
If yes, provide the following:

Name			Phone no.	
Street address	City		State	ZIP code

19. How often do you see him?

Date you first saw him (mm/dd/yyyy)

Date you last saw him (mm/dd/yyyy)

20. Reasons for visits

Type of treatment received

21. Has your doctor told you to restrict your activities? ☐ Yes ☐ No
If yes, give name of doctor and state what he told you about restricting your activities:

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Life Waiver of Premium or Continuation of Benefit Claim Form Employee Statement *(continued)*

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22. Check any of the following which apply to you:
- ☐ Confined in a hospital or other medical institution
- ☐ Confined to a house (not able to go outside)
- ☐ Able to go outside without help
- ☐ Confined to a bed or wheelchair at home
- ☐ Able to go outside only with the help of someone else or a device

23. Are your home duties, social activities or ability to care for your personal needs limited in any way? ☐ Yes ☐ No
If yes, describe how and why they are limited:

23. Do you expect to return to work? ☐ Yes ☐ No	Date expected to return (mm/dd/yyyy)	Date returned (mm/dd/yyyy)

25. Have you been seen by other agencies for your injury or illness (VA, Vocational, Rehabilitation, Welfare, etc.)? ☐ Yes ☐ No
If yes, please provide the following:

Agency name			
Agency street address	City	State	ZIP code

Your claim no.	Dates of visits (mm/dd/yyyy)	Type of treatment or examination received

26 Have you filed for or are you entitled to benefits from any of these sources because of this disability?

Sources	Identify Insurance or Agency	Benefit Amount	Payable how? (Lump, Monthly, Weekly, etc.) From To
Workers' Compensation			
Social Security Administration			
Health or Welfare plan			
Retirement or Pension plan			
State, Provincial or Federal agency			
Other:			

27. Are you in the process or have you converted your Group Life Coverage to an Individual policy? ☐ Yes ☐ No

AUTHORIZATION

The above answers are true and complete according to the best of my knowledge and belief. I authorize any employer, insurance company, medical prepayment plan, service organization, physician, practitioner or other person; any hospital, including the Veterans Administration or other institution, to release to or obtain from Anthem Life Insurance Company any medical or benefit payment information that may be required to establish the validity of this claim, and further authorize said company, person or organization, to disclose any personal claim information required for medical case study or review. A photostat of this authorization shall be as valid as the original.

Employee signature	Date (mm/dd/yyyy)
X	

YOU MUST NOTIFY ANTHEM LIFE PROMPTLY IF:

a. Your medical condition improves so that you would be able to work, even though you have not yet returned to work.

b. You go to work whether as an employee or as a self-employed person.

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The laws of some states require us to provide you with the following information:

Alaska: A 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.

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.

Arkansas, Louisiana, and West Virginia: 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.

California: For your protection California 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 guilty of a crime and may be subject to fines and confinement in state prison.

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.

Delaware and Idaho: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

District of Columbia: WARNING: 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.

Florida: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Indiana: A person who knowingly and with intent to defraud an insurer files a statement of claim containing false, incomplete, or misleading information commits a felony.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files a 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.

Maine, Tennessee, Virginia, 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 may include imprisonment, fines or denial of insurance benefits.

Minnesota: A person who files a claim with intent to defraud or helps to commit a fraud against an insurer is guilty of a crime.

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 N.H. Rev. Stat. Ann. §638:20.

New Jersey: A person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New Mexico: A 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 civil fines and criminal penalties.

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 materials 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 violation.

Ohio: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits and application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud, or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

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.

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.

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Attending Physician's Statement

The purpose of this report is to assist us in making a disability determination. In filling out this report please include sufficient details of history, physical and diagnostic findings, clinical course, therapy and response to enable us to make this determination. After signing this form, return it to ANTHEM LIFE.

Printed last name	First name	M.I.	Birthdate (mm/dd/yyyy)

Street address	City	State	ZIP code	Social Security no.

Patient employer	Group policy no.

SECTION 1. HISTORY

Patient age	Date symptoms first appeared or accident happened (mm/dd/yyyy)	Date patient ceased work because of disability (mm/dd/yyyy)

Has patient ever had same or similar condition? ☐ Yes ☐ No If yes, state when and describe:

SECTION 2. DIAGNOSIS

Diagnosis (including complications)

Subjective symptoms

Objective findings (Include results of current X-rays, EKGs or any other special tests or current signs relevant to your judgment of prognosis.)

SECTION 3. TREATMENT

Date of first visit for above condition (mm/dd/yyyy)	Date of last visit (mm/dd/yyyy)	Visit frequency
		☐ Weekly ☐ Monthly ☐ Other: _____

Nature of treatment (Including surgery and medications prescribed, if any.)

SECTION 4. PROGRESS

Patient's present condition	Is patient?
☐ Recovered ☐ Improved ☐ Unchanged ☐ Regressed	☐ Ambulatory ☐ House confined ☐ Bed confined ☐ Hospital confined

If patient is hospital confined please complete the following:

Hospital name: _____ Confined from: _____ through: _____

Hospital address: _____

SECTION 5. CARDIAC

Functional capacity (American Heart Association)	Blood pressure
☐ Class 1 (no limitations) ☐ Class 2 (slight limitations) ☐ Class 3 (marked limitations) ☐ Class 4 (complete limitations)	_____/_____ (systolic/diastolic)

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Anthem® Life

SECTION 6. IMPAIRMENTS (As they relate to employment.)

PHYSICAL IMPAIRMENTS (*As defined in *Federal Dictionary of Occupational Titles*.)

☐ Class 1 – No limitations of functional capacity; capable of heavy work* no restrictions (0-10%)
☐ Class 2 – Medium manual activity* (15-30%)
☐ Class 3 – Slight limitation of functional capacity; capable of light work* (35-55%)
☐ Class 4 – Moderate limitation of functional capacity; capable of clerical/administrative (sedentary*) activity (60-70%)
☐ Class 5 – Severe limitation of functional capacity; incapable of minimum (sedentary*) activity (75-100%)

Remarks:

MENTAL IMPAIRMENTS (if applicable):

☐ Class 1 – Patient is able to function under stress and engage in interpersonal relations (no limitations)
☐ Class 2 – Patient is able to function in most stress situations and engage in most interpersonal relations (slight limitations)
☐ Class 3 – Patient is able to engage in only limited stress situations and engage in only limited interpersonal relations (moderate limitations)
☐ Class 4 – Patient is unable to engage in stress situations or engage in interpersonal relations (marked limitations)
☐ Class 5 – Patient has significant loss of psychological, physiological personal and social adjustment (severe limitations)

Remarks:

SECTION 7. COMPETENCY

Is patient mentally competent to endorse checks and direct the use of proceeds thereof? ☐ Yes ☐ No

SECTION 8. PROGNOSIS

Do you expect a fundamental or marked change in the future? ☐ No ☐ Yes – Improvement ☐ Yes – Deterioration

If improved, will patient recover sufficiently to perform duties of?

Patient's Own Job
☐ Never ☐ 1 month ☐ 1-3 months ☐ 3-6 months ☐ 6-12 months ☐ Over 1 year

Any Other Work
☐ Never ☐ 1 month ☐ 1-3 months ☐ 3-6 months ☐ 6-12 months ☐ Over 1 year

If no improvement expected, please explain:

SECTION 9. REHABILITATION

Is patient a suitable candidate for trial employment or job training?

Patient's own job? ☐ Yes ☐ No Any other work? ☐ Yes ☐ No

If yes, when could trial employment commence?

Patient's Own Job
Date (mm/dd/yyyy): _____ ☐ Full-time ☐ Part-time

Any Other Work
Date (mm/dd/yyyy): _____ ☐ Full-time ☐ Part-time

If no, please explain:

SECTION 10. REMARKS

Printed attending physician name	Degree	Phone no.	
Street address	City	State	ZIP code

Attending physician signature	Date (mm/dd/yyyy)
X	

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