Long Term Disability
Notice of Claim Package

Anthem® Life

EMPLOYER NOTICE OF CLAIM – INSTRUCTIONS

At approximately 45 days before end of benefit waiting period:

A. Complete the Employer's Report of Claim in full.

   Include:

   - Job description *(detailed duties, including physical requirements)*
   - Documentation of earnings in accordance with your plan description
   - Workers' Compensation information *(copy of first report of accident and the decision if any has been determined at this time)*

B. Give remaining part form to claimant for completion. These forms should be forwarded to the address shown below.

   Request:

   - Copy of awards from other source of benefits: Social Security, Workers' Compensation, Retirement, State Disability, No-fault auto insurance and any other disability income
   - That the employee forward proof of his/her age

C. If claimant has more than one treating physician, give claimant additional forms for completion.

D. All portions of this form package must be completed to avoid undue delay in processing claimant's request for benefits.

E. Any questions about these claim filing procedures should be referred to:

   Anthem Life Insurance Company
   Disability Claims Service Center
   P.O. Box 105426
   Atlanta, GA 30348-5426
   Phone: 800-232-0113 Fax: 800-850-0017
   E-mail: lifeanddisabilityclaims@anthem.com

Long Term Disability Claim Form
Employer Statement

Clear Form

Anthem Life

EMPLOYER STATEMENT

1a Employee last name	1b Employee first name	MI	2 Social Security no.	3 Birthdate (mm/dd/yyyy)

4a Street address	4b City	4c State	4d ZIP code	5 Phone no

6 Policy no.	7 Certificate no.	8 Billing unit	9 Class

10 Employee date of hire (mm/dd/yyyy)	11 Effective date of LTD coverage (mm/dd/yyyy)	12 Date employee last worked full-time (mm/dd/yyyy)

EMPLOYMENT

13 Occupation at time last worked (Attach job description.)

14 Work schedule at time last worked

No. of days per week: _____ No. of hours per day: _____

15 Reason for leaving work:

☐ Sickness ☐ Granted LOA ☐ Laid off ☐ Retired
☐ Dismissed ☐ Resigned ☐ Vacation ☐ Other

16 Has employee returned to work? ☐ Yes ☐ No

☐ Part-time – Date: ____/____/____ ☐ Full-time – Date: ____/____/____

INCOME

17 How is employee paid?

☐ Straight salary ☐ Hourly ☐ Salary and commission
☐ Commissions only ☐ Salary and bonus

18 Employee's basic monthly earnings:

$ _____

LTD benefit _____

If salary is based on less than 12 months: No. of months: _____

19 Employee's percentage of LTD premium contribution:

Employee pays: _____% Employer pays: _____%

OTHER BENEFITS

20 Has insured received other disability payments since time last worked?

Salary Continuance: ☐ Yes ☐ No
If yes, weekly amount: _____
Date benefits cease (mm/dd/yy): ____/____/____

Insured Short Term: ☐ Yes ☐ No
If yes, weekly amount: _____
Date benefits cease (mm/dd/yy): ____/____/____

Other Type: _____ ☐ Yes ☐ No
If yes, weekly amount: _____
Date benefits cease (mm/dd/yy): ____/____/____

21 Did claim result from job activity? ☐ Yes ☐ No
If yes, explain:

22 Has Workers' Compensation claim been filed?

☐ Yes ☐ No
☐ Pending ☐ Denied (enclose copy)

23 Workers' Compensation weekly amount

$ _____

Include a copy of first report of accident.

RETIREMENT

24 Is employee covered by sponsored retirement plan? ☐ Yes ☐ No

25 Does retirement plan contain a disability provision? ☐ Yes ☐ No

26 Is employee or will this employee be eligible for a disability or retirement pension? ☐ Yes ☐ No

If yes, type: ☐ Disability ☐ Retirement ☐ Other: _____

Monthly amount: $ _____ Date benefits commence (mm/dd/yy): ____/____/____

Note: If any portion of this pension benefit is attributable to the employee's contribution, please provide details including the percentage of his/her contribution to the total contribution.

CERTIFICATION

27 Employer name	28 Employer phone no.	29 Certificate no.

30a Employer street address	30b City	State	ZIP code

31 Employer (taxpayer) ID no. (EIN)	OR	32 Public employer Social Security no.

33 Printed name of authorized company representative	34 Title

35 Signature of authorized company representative	36 Date (mm/dd/yyyy)
X	

Separate and send this form (with other enclosures) to the address shown on the front page. Give the remaining forms to the claimant.

Save and Print Form

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.

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.

Long Term Disability Claim Form
Employee Statement

Anthem® Life

EMPLOYEE STATEMENT

1a Last name	1b First name	MI	2 Social Security no.	3 Phone no.

4a Street address	4b City	4c State	4d ZIP code

5 Birthdate (mm/dd/yyyy)	6 Height	7 Weight	8 Sex	9 Marital status	10 Spouse birthdate (mm/dd/yyyy)	11 Is spouse employed?
			☐ Male ☐ Female	☐ Single ☐ Married ☐ Widowed ☐ Divorced	___/___/_____ First name: _____	☐ Yes ☐ No

12 No. of children under age 19

13 List unmarried children who have not yet finished high school

Name	Birthdate (mm/dd/yyyy)	Name	Birthdate (mm/dd/yyyy)	Name	Birthdate (mm/dd/yyyy)
_____	___/___/_____	_____	___/___/_____	_____	___/___/_____
_____	___/___/_____	_____	___/___/_____	_____	___/___/_____

14 Employer name	15 Group policy no.	16 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: _____

EMPLOYMENT

17 Occupation (List the duties of your occupation at the time of disability.)

18 Date of accident or date first noticed symptoms of illness (mm/dd/yyyy)	19 I have been unable to work because of the disability since (mm/dd/yyyy)	20 I returned to work on a part-time basis on (mm/dd/yyyy)	21 I returned to work on a full-time basis on (mm/dd/yyyy)

22 Is your accident or illness related to your occupation? ☐ Yes ☐ No

23 If yes, explain:

Have you, or do you intend to file a Workers' Compensation claim? ☐ Yes ☐ No

CLAIMS HISTORY

24 Describe how and where accident occurred or describe the onset and nature of your illness:

☐ Auto ☐ Work ☐ Home ☐ Other

25 Date you were first treated for this illness or injury (mm/dd/yyyy): ___/___/_____

26 Treated by				
	Hospital name			
	Street address	City	State	ZIP code
	Doctor name			
	Street address	City	State	ZIP code

27 Have you ever had the same or similar condition in the past? ☐ Yes ☐ No If yes, complete no. 28.

28 Treated by				
	Hospital name			
	Street address	City	State	ZIP code
	Doctor name			
	Street address	City	State	ZIP code

Long Term Disability Claim Form
Employee Statement (continued)

Anthem® Life

INCOME

29 Describe other income you are receiving:

Yes	No		Amount	Date Began (mm/dd/yyyy)	Date Terminated (mm/dd/yyyy)
☐	☐	Social Security (disability or retirement)	$ _____	___/___/_____	___/___/_____
☐	☐	State disability	$ _____	___/___/_____	___/___/_____
☐	☐	Retirement (normal, early or disability)	$ _____	___/___/_____	___/___/_____
☐	☐	Workers' Compensation	$ _____	___/___/_____	___/___/_____
☐	☐	Group disability benefits	$ _____	___/___/_____	___/___/_____
☐	☐	Other (describe): _____	$ _____	___/___/_____	___/___/_____

BENEFITS

30 Have you, or do you plan to apply for any benefits described above? ☐ Yes ☐ No

Type	Date Application Filed (mm/dd/yyyy)
_____	___/___/_____
_____	___/___/_____

31 If your request for benefits is approved do you want us to withhold amounts from each benefit check for federal income tax purposes? ☐ Yes ☐ No

If yes, what amount? $ _____ (Indicate amount per month, $88.00 minimum.)

32 If your request for benefits is approved do you want us to withhold amount from each benefit check for state tax purposes? ☐ Yes ☐ No

If yes, what amount? $ _____ (Indicate amount per month, $88.00 minimum.)

Any person who knowingly and with intent to defraud or deceive any insurance company files a statement of claim containing any false or misleading information may be subject to criminal penalties.

The above statements are true and complete to the best of my knowledge and belief.

Employee signature	Date (mm/dd/yyyy)
X	

Long Term Disability
Employee Authorization for Release of Information

Anthem® Life

AUTHORIZATION TO BE COMPLETED BY CLAIMANT

AUTHORIZATION FOR RELEASE OF INFORMATION
(HIPAA COMPLIANT)
(to be signed and dated by the insured/claimant)

I authorize any licensed physician, any other medical practitioner or provider, pharmacist, hospital, clinic, other medical or medically related facility, federal, state or local government agency, insurance or reinsuring company, consumer reporting agency or employer having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me, and any non-medical information about me, to give any and all such information to authorized representatives of Anthem Life Insurance Company (Anthem Life) and including, but not limited to any other mental or psychiatric records, medical, dental and hospital records (including psychiatric, alcohol, and drug abuse, and HIV/AIDS information) which may have been acquired in the course of examination or treatment. I understand that the information obtained by use of this authorization will be used by Anthem Life representatives to evaluate and adjudicate my current disability claim, and may be re-disclosed to (a) any medical, investigative, financial or vocational specialist or entity, or (b) any other organization or person, employed by or representing Anthem Life solely to assist with the evaluation and adjudication of my current disability claim. Each such person or entity to whom this re-disclosure is made shall comply with the HIPAA Privacy Rule as regards any re-disclosed protected health information.

This authorization is valid during the pendency of my claim and shall expire on the date my claim finally ends. A photocopy of this authorization is as valid as the original. I understand that my authorized representative or I have the right to request and receive a copy of this authorization and the information to which it pertains.

I understand that I have the right to revoke this authorization by notifying Anthem Life in writing, of my revocation. However, such revocation is not effective to the extent that Anthem Life have relied previously upon this authorization for the use or disclosure of my protected health information. In addition, I understand that my revocation of, or my failure to sign this authorization may impair Anthem Life's ability to evaluate my current disability claim and as a result may be a basis for denying that current disability claim for benefits.

If you reside in California, Connecticut or North Dakota: This authorization excludes the release of information about Human Immunodeficiency Virus (HIV).

If you reside in Minnesota: This authorization excludes the release of information about HIV (AIDS VIRUS) tests.

If you reside in Maine: This authorization excludes disclosure of the result of a test for HIV if the applicant has tested positive but has not developed symptoms of the disease AIDS. Such test results shall not be discovered or published. Nothing in this caveat will prohibit this authorization from including the fact that the applicant has AIDS.

If you reside in Vermont: This authorization EXCLUDES the release of any information about previously administered HIV-related tests, including but not limited to tests for HIV antibodies, T-Cell counts, AIDS or ARC. The proposed insured is NOT AUTHORIZING ANTHEM LIFE to forward the results from any new test, requested by us, to any outside, non-affiliated company or entity not under specific contract with us to perform underwriting services, and ANTHEM LIFE shall comply, as applicable with the provisions of Title 8, Section 4724 (20) of the Vermont Statutes.

Claimant printed name	Birthdate (mm/dd/yyyy)
Claimant signature **X**	Date (mm/dd/yyyy)

Relationship of authorized person	Description of personal representative's authority, if applicable (If signed by authorized representative, attach verification of identity.)

Send completed form to:

Anthem Life Insurance Company
Disability Claim Service Center – LTD Unit
P.O. Box 105426
Atlanta, GA 30348-5426

For customer service:

Call: 800-232-0113
Fax: 800-850-0017

Long Term Disability Claim Form
Attending Physician's Statement

Anthem® Life

HISTORY

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

Date symptoms first appeared or accident happened (mm/dd/yyyy)	Date patient ceased work because of disability (mm/dd/yy)	Has patient ever had same or similar condition? ☐ Yes ☐ No If yes, state when and describe:

Is condition due to injury or sickness arising out of patient's employment?	Names and addresses of other treating physicians
☐ Yes ☐ No ☐ Unknown	

DIAGNOSIS (If disabling condition is due to a mental or nervous disorder, the attached *Functional Capabilities Evaluation* and *Mental Status Questionnaire* sections must also be completed.)

Diagnosis (including complications)	Subjective symptoms	If pregnancy, estimated date of delivery

Objective findings (including current X-rays, EKGs, laboratory data and any clinical findings

TREATMENT

Date of first visit (mm/dd/yyyy)	Date of last visit (mm/dd/yyyy)	Frequency ☐ Weekly ☐ Monthly ☐ Other: _____

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

PROGRESS

Patient's present condition	Is patient?	Is patient mentally competent to endorse checks and direct proceeds thereof?
☐ Recovered ☐ Improved ☐ Unchanged ☐ Regressed	☐ Ambulatory ☐ House confined ☐ Bed confined ☐ Hospital confined	☐ Yes ☐ No

Has patient been hospital confined? ☐ Yes ☐ No If yes, please complete the following: (mm/dd/yyyy (mm/dd/yyyy

Hospital name: _____ Confined from: ____/____/_____ through: ____/____/_____

Hospital address: _____

CARDIAC

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

IMPAIRMENTS

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:

Long Term Disability Claim Form
Attending Physician's Statement (continued)

Anthem® Life

IMPAIRMENTS (continued)

Mental Impairments (if any):

(a) Please define "stress" as it applies to this claimant and in light of his/her job requirements.

(b) What stress and problems in interpersonal relations has claimant had on job?

- ☐ 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)

PROGNOSIS

Is patient now totally disabled? (unable to be gainfully employed)	Date patient became disabled due to present illness (mm/dd/yyyy)
Patient's Job: ☐ Yes ☐ No Any other work: ☐ Yes ☐ No	

When do you expect a fundamental or marked change in the future?

☐ 1 month ☐ 1-3 months ☐ 3-6 months ☐ Never Applies to: ☐ Patient's job ☐ Other work

REHAB

Is patient a suitable candidate for occupational rehabilitation?	Can present job be modified to allow for handling with impairment?
Patient's own job? ☐ Yes ☐ No Any other work? ☐ Yes ☐ No	☐ Yes ☐ No

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

REMARKS

Limitations, therapy, etc.

Printed attending physician name	Degree		Phone no.
Street address	City	State	ZIP code
Signature X			Date (mm/dd/yyyy)

Long Term Disability Claim Form
Supplemental Attending Physician's Statement

Anthem® Life

MENTAL STATUS QUESTIONNAIRE (Needs to be completed only if condition is due to mental or nervous disorder.)

Patient last name	First name	M.I.

Date treatment began (mm/dd/yyyy)	Continuing? ☐ Yes ☐ No	Date treatment terminated (mm/dd/yyyy)

Diagnosis (Use DSM III Multi-axial evaluation nomenclature and code numbers.)

I

II

III

IV

V

PLEASE RESPOND TO ALL ITEMS. USE ADDITIONAL PAGES AS NECESSARY.

State patient's initial reason for seeking treatment. Describe how and when the condition was first manifested. Summarize previous treatment testing, if any.

Describe patient's current condition and mental status. Include the duration and severity impairments and stress factors.

Medications: Please list current medications, dosage and dates begun, as well as existing or possible side effects.

Duration and Treatments: Please summarize current treatment goals and estimated duration of treatment to achieve stated goals.

Comments

Long Term Disability Claim Form
Supplemental Attending Physician's Statement (continued)

Anthem® Life

FUNCTIONAL CAPACITIES EVALUATION

Based on your evaluation of the claimant's psychiatric status, please give your opinion as to the extent of the claimant's ability to do the following on a **sustained** basis.

None: No impairment in this area.
Mild: Suspected impairment of slight importance which does not affect functionality ability.
Moderate: Impairment affects but does not preclude ability to function.
Moderately Severe: Impairment significantly affects ability to function.
Severe: Extreme impairment of ability to function.

1	Ability to relate to other people.	☐ None	☐ Mild	☐ Moderate	☐ Moderately Severe	☐ Severe
2	Restriction of daily activities, e.g. ability to attend meetings, socialize with others, attend to personal needs, etc.	☐ None	☐ Mild	☐ Moderate	☐ Moderately Severe	☐ Severe
3	Deterioration of personal habits.	☐ None	☐ Mild	☐ Moderate	☐ Moderately Severe	☐ Severe
4	Constriction of interests.	☐ None	☐ Mild	☐ Moderate	☐ Moderately Severe	☐ Severe
5	Understand, carry out, and remember instructions.	☐ None	☐ Mild	☐ Moderate	☐ Moderately Severe	☐ Severe
6	Respond appropriately to supervision.	☐ None	☐ Mild	☐ Moderate	☐ Moderately Severe	☐ Severe
7	Perform work requiring regular contact with others.	☐ None	☐ Mild	☐ Moderate	☐ Moderately Severe	☐ Severe
8	Perform work where contact with others will be minimal.	☐ None	☐ Mild	☐ Moderate	☐ Moderately Severe	☐ Severe
9	Perform tasks involving minimal intellectual effort.	☐ None	☐ Mild	☐ Moderate	☐ Moderately Severe	☐ Severe
10	Perform intellectually complex tasks requiring higher levels of reasoning, math and language skills.	☐ None	☐ Mild	☐ Moderate	☐ Moderately Severe	☐ Severe
11	Perform repetitive tasks.	☐ None	☐ Mild	☐ Moderate	☐ Moderately Severe	☐ Severe
12	Perform varied tasks.	☐ None	☐ Mild	☐ Moderate	☐ Moderately Severe	☐ Severe
13	Makes independent judgments.	☐ None	☐ Mild	☐ Moderate	☐ Moderately Severe	☐ Severe
14	Supervise or manage others.	☐ None	☐ Mild	☐ Moderate	☐ Moderately Severe	☐ Severe
15	Perform under stress when confronted with emergency, critical, unusual or dangerous situations; or situations in which working speed and sustained attention are make or break aspects of the job.	☐ None	☐ Mild	☐ Moderate	☐ Moderately Severe	☐ Severe

Physician signature	Date (mm/dd/yyyy)
X	

Anthem Life Insurance Company
Disability Claim Service Center
P.O. Box 105426
Atlanta, GA 30348-5426

Phone: 800-232-0113
Fax: 800-850-0017
E-mail: lifeanddisabilityclaims@anthem.com