Accelerated Death Benefit/Living Benefit Claim Form
Employer Statement

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

Employer instructions:

1. Check that the employee has completed, dated and signed the *Employee Statement*. Verify that all required information has been provided.
2. Be sure that the employee has retained a copy of this claim form and all required documentation for their records.
3. Complete all sections of this *Employer Statement*.
4. Include a copy of the employee's signed application.
5. Send this claim form and all required documents to the address shown to the right.

Life Claims Service Center
P.O. Box 105448
Atlanta, GA 30348-5448
Phone: 800-552-2137
Fax: 877-305-3901
Email: lifeclaims@anthem.com

Section 1: Employer information

Company name		Group policy no.	Class no.	
Company address (no. and street)	City		State	ZIP code

Section 2: Employee information

Employee last name	First name	M.I.	Social Security no.	Date of birth (MMDDYYYY)	
Employee address (no. and street)	City			State	ZIP code
Gender ☐ Male ☐ Female	Marital status ☐ Married ☐ Single ☐ Divorced ☐ Widowed	Rate of pay $_____ per: _____		Amount of insurance $	
Occupation	Date when full-time employment started (MMDDYYYY)	Date last physically at work full-time (MMDDYYYY)			
Reason for leaving work					
Is coverage continuing on a premium paying basis? ☐ Yes ☐ No If no, date of last premium (MMDDYYYY)					

Section 3: Beneficiary information

Beneficiary last name	First name	M.I.	Relationship to employee	Age
Beneficiary address (no. and street)	City		State	ZIP code

Section 4: Employer representative information and signature

Employer representative last name	First name	M.I.	Title
Phone no.	Employer email address		
Employer representative signature **X**			Date (MMDDYYYY)

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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.

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.

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Accelerated Death Benefit/Living Benefit Claim Form
Employee Statement

Employee instructions:

1. Complete sections 1 and 2 of this *Employee Statement*.
2. Have your doctor complete the *Attending Physician Statement*.
3. If applicable, provide the following documentation:
   - If you are divorced, a copy of the court approved divorce settlement agreement.
   - If you have assigned your rights under the group policy to an assignee or an irrevocable beneficiary, written consent from that assignee or irrevocable beneficiary, for payment of a living benefit claim.
4. Be sure to keep a copy of this claim form and all additional documentation for your records. Give the employer this claim form and all additional documentation.

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Section 1: Employee information

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

Last name	First name	M.I.	Social Security no./Tax ID no.	Date of birth (MMDDYYYY)

Address (no. and street)	City	State	ZIP code	Phone no.	Email address

Reason for this claim. What is the qualifying medical condition?	Amount of benefit you are claiming $

Date last physically at work full-time _____ (MMDDYYYY)

Are you now in the process or have you converted your Group Life coverage to an Individual policy? ☐ Yes ☐ No

One or more of the following, herein referred to as 'Insurance Company': Anthem Life Insurance Company, Anthem Life & Disability Insurance Company, Anthem Blue Cross Life and Health Insurance Company, Greater Georgia Life Insurance Company , UniCare Life & Health Insurance Company, reserves the right to request an Independent Medical Examination at the Company's expense.

Have divorce proceedings ever been instituted by or against you? ☐ Yes ☐ No If yes, when and where? _____
(If you answer yes to this question, please refer to no. 3 in the Employee instructions at the top of this form.)

Have you assigned your rights under the group policy to an assignee or irrevocable beneficiary? ☐ Yes ☐ No

Section 2: Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct Taxpayer Identification Number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding either because I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of failure to report all interest and dividends, or the IRS has notified me that I am no longer subject to backup withholding.

Certification instructions: You must cross out item (2) above if you have been notified by the IRS that you are subject to backup withholding because of underreporting interest or dividends on your tax return. However, if after being notified by the IRS that you were subject to backup withholding you received another notification from the IRS that you are no longer subject to backup withholding, do not cross out item (2).

Claimant address (no. and street)	City	State	ZIP code

Claimant signature	Relationship to insured	Date (MMDDYYYY)
X		

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

For New York residents, the following statement applies: 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation.

Employee signature	Date (MMDDYYYY)	Witness signature	Date (MMDDYYYY)
X		**X**	

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.

For use by Insurance Company only

Examiner	Claim no.	Total – Benefit and interest	Date approved/denied

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Accelerated Death Benefit/Living Benefit Claim Form Disclosure Statement

Any Accelerated Death Benefit/Living Benefit paid to you may be taxable. If so, you may incur a tax obligation. You should seek assistance from a qualified tax advisor prior to your receipt of this benefit.

Receipt of any Accelerated Death Benefit/Living Benefit may affect your eligibility for public assistance programs such as medical assistance (Medicaid), aid to families with dependent children, and supplemental security income. Prior to your receipt of any Accelerated Death Benefit/Living Benefit you should consult with the appropriate social services agency concerning how receipt of this benefit will affect your and/or your family's eligibility for these programs.

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Section 1: Effect of payment of personal Accelerated Death Benefit/Living Benefit on your remaining personal life insurance and supplemental life insurance benefits

$ _____ Your (combined amount of personal life insurance and supplemental life insurance) Benefit prior to payment of your Accelerated Death Benefit/Living Benefit

– $ _____ Minus your Accelerated Death Benefit/Living Benefit

$ _____ Your (combined amount of personal life insurance and supplemental life insurance) Benefit remaining after payment of your Accelerated Death Benefit/Living Benefit

This Accelerated Death Benefit/Living Benefit is not a long-term care policy or a nursing home insurance policy. The amount this benefit pays you may not be enough to cover your medical, nursing home, or other bills. You may use your Accelerated Death Benefit/Living Benefit for any purpose.

For New York residents, the following statement applies: 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation.

Section 2: Applicant information and signature

Applicant last name	First name	M.I.
I acknowledge that I have made application for this benefit of my own free will, and without coercion of a third party.		
Applicant signature **X**		Date (MMDDYYYY)

Section 3: Spouse information and signature

Spouse last name	First name	M.I.
I acknowledge that I have made application for this benefit of my own free will, and without coercion of a third party.		
Spouse signature **X**		Date (MMDDYYYY)

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.

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Accelerated Death Benefit/Living Benefit Claim Form
Attending Physician Statement

Attending physician instructions:
Please mail or fax this report directly to the address shown to the right.

Life Claims Service Center
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Atlanta, GA 30348-5448
Phone: 800-552-2137
Fax: 877-305-3901
Email: lifeclaims@anthem.com

Section 1: Patient information

Patient last name	First name	M.I.	Social Security no.	Date of birth (MMDDYYYY)

Address (no. and street)	City	State	ZIP code

Employer

Section 2: Attending physician's statement — Space is available on the reverse side if you wish to amplify your answers.

The employee seeking benefits is responsible for getting this information at his/her own expense. If number 4 is not completed in full, claim processing will be delayed.

1	Diagnosis	
2	a. Subjective symptoms	
	b. Objective findings: Include results of current x-rays, EKGs, or any other special tests relevant to your judgment of prognosis	
	c. Is patient: ☐ Ambulatory ☐ Bed confined ☐ House confined ☐ Hospital confined	
3	Treatment	
	Date of first visit for above condition (MMDDYYYY)	Date of most recent visit (MMDDYYYY)
4	**Prognosis:** "In my best medical judgment, the above patient's life expectancy is _____ months or less, or not more than _____ months."	
5	**Mental condition:** Is the patient competent to endorse checks and direct the proceeds thereof? ☐ Yes ☐ No	

Remarks

Section 3: Attending physician's information and signature

Attending physician last name	First name	M.I.	Degree

Address (no. and street)	City	State	ZIP code

Attending physician signature X	Date (MMDDYYYY)

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Use this space for any additional information