Claim Form for Accidental Dismemberment or Loss of Sight
Employer Statement

We need to get some information before we can start processing your employee's benefit claim.

Who needs to fill out each section:

1) You, the employer, need to fill out "Section 1: Employer statement."
2) The employee, or a legally appointed guardian, needs to fill out "Section 2: Employee statement."
3) The attending physician needs to fill out the third page: "Section 1: Patient information" and "Section 2: Attending physician statement."

Also, the following things need to come along with this form:

- Copy of employer's Group Insurance Application and record card.
- Any newspaper clippings/online information about the injury or loss.
- If available, a police/accident report.

Employer is responsible for sending this completed form to:

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

Or send via fax at 877-305-3901

Need help? Call us at 800-552-2137 or email us at lifeclaims@anthem.com.

This claim is for: ☐ An employee ☐ A dependent

Section 1: Employer statement

Group no.			Class no.
Employee last name	First name	M.I.	Occupation
Date when full-time employment started: __/__/____ (MMDDYYYY)			
Date last worked: __/__/____ (MMDDYYYY)			Amount of benefit: $ _____
Was employee paying the premium up until the date of the accident? ☐ Yes ☐ No If no, date of last premium payment __/__/____ (MMDDYYYY)			
Date when coverage started: __/__/____ (MMDDYYYY)			Earnings at last date of employment: $_____ per _____
Date of accident: __/__/____ (MMDDYYYY)			Time of accident: _____
Place of accident: _____			Did accident occur on the job? ☐ Yes ☐ No

Dependent data — Complete this section if this claim is for an insured dependent

Insured dependent full name	Social Security no.	Date of birth (MMDDYYYY)	Gender ☐ Male ☐ Female
Dependent address (no. and street)	City	State	ZIP code
Relationship to insured employee: ☐ Husband ☐ Child ☐ Wife ☐ Domestic Partner	If spouse, was he/she divorced or legally separated? ☐ Yes ☐ No		
If child, was he/she: Married? ☐ Yes ☐ No Employed? ☐ Yes ☐ No Full-time student? ☐ Yes ☐ No			
If employed, was employment: ☐ Full time ☐ Part time Date employed: __/__/____ (MMDDYYYY)			
Date dependent insured under the group policy: __/__/____ (MMDDYYYY)			
Was insurance terminated? ☐ Yes ☐ No If yes, date: __/__/____ (MMDDYYYY)			
Amount of dependent's insurance claimed: $ _____	Date of dependent's death: __/__/____ (MMDDYYYY)		

My signature below means that as far as I know, everything I've written/chosen above is correct.

Company name			Company phone no.
Company address (no. and street)	City	State	ZIP code
Name of authorized company representative	Title		
Signature of authorized company representative **X**			Date (MMDDYYYY)

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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Claim Form for Accidental Dismemberment or Loss of Sight
Employee Statement

Section 2: Employee statement

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

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

Claim is for: ☐ Myself ☐ My dependent – Name: _____ Relationship: ☐ Spouse ☐ Domestic Partner ☐ Child

Date of injury: (MMDDYYYY)

Date of loss: (MMDDYYYY)

Date first treated by physician: (MMDDYYYY)

Name of attending physician

Extent of loss

Describe how accident happened

As far as I know, everything I've written above is correct. I understand that my signature below allows 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 to get information about the accident from any hospital, physician or any other institutions or person who provided care. I also understand that a copy of my authorization can be used instead of 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.

Signature of employee **X**	Date (MMDDYYYY)

For Anthem use only

Claim no.	Examiner	Total benefit $	Date approved/denied

Notice about telephone service reviews: To make sure our customers get quality service, we randomly select phone calls for monitoring. These calls, between our customers and employees, are evaluated by supervisors. This is to guarantee our members get quick and reliable help in a professional way. We are licensed by the Georgia Public Service Commission to use this type of reviewing tools.

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Attending Physician Statement About Accidental Dismemberment or Loss of Sight

Life Claims Service Center
P.O. Box 105448
Atlanta, GA 30348-5448
Or send via fax at 877-305-3901

The employee seeking benefits is responsible for getting this information at his/her own expense.

Need help? Call us at 800-552-2137 or email us at lifeclaims@anthem.com.

Section 1: Patient information

Last name	First name	M.I.	Date of birth (MMDDYYYY)

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

When did the accident happen? (MMDDYYYY)

When did the patient first see you for this condition? (MMDDYYYY)

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

Did the loss/injury happen as a result of an accident? ☐ Yes ☐ No
If no, what disease/condition contributed to the loss/injury? _____

Is the patient able to endorse checks and be responsible to manage funds? ☐ Yes ☐ No

Complete this part for loss of sight

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

	Date of loss (MMDDYYYY)	Was the eye enucleated?	Date (MMDDYYYY)
Right eye: ☐ Yes ☐ No		☐ Yes ☐ No	
Left eye: ☐ Yes ☐ No		☐ Yes ☐ No	

Write in the date you first determined that central visual acuity was irrecoverably reduced to 20/200 or less with correction: (MMDDYYYY)

SNELLEN notes on that date:	Uncorrected	Corrected
O.D.V		
O.S.V.		

Complete this part for loss of limb(s)

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

What limb(s) have been severed?

Date of severance (MMDDYYYY)

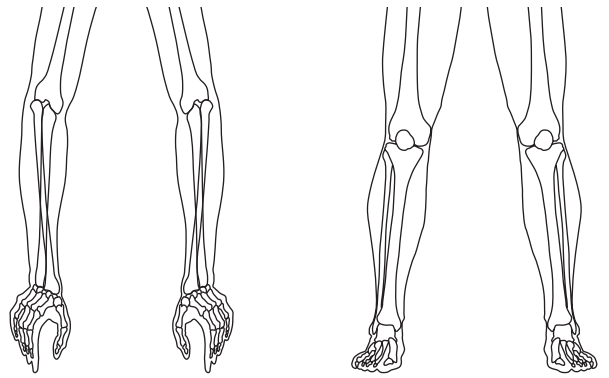
Right hand:

Left hand:

Right foot:

Left foot:

Please indicate the exact point of the loss of limb(s):



Right arm Left arm Right leg Left leg

Attending physician last name	First name	M.I.	Degree

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

My signature below means that as far as I know, everything I've written/chosen above is correct.

Signature of attending physician	Date (MMDDYYYY)
X	

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Use this space for any additional information