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

We need to get some information before we can start processing your employee's claim.
All information needs to be included to make sure there isn't any delay during processing.

Please make sure to:

1) Send us a copy of your employee's enrollment and beneficiary designation form along with your statement.
2) Complete the first section of the employee and attending physician statements by including your policy's group number and your employee's information.
3) After filling out the first section of each statement, give the employee and attending physician statement pages to the covered employee so he/she can take the steps to complete them and send them back to us.

Employer needs to send this statement to:

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 contact information

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

Section 2: Employee information

Last name	First name	M.I.	Social Security no.	Date of birth (MMDDYYYY)
Occupation (per life coverage schedule)	Date employed (MMDDYYYY)	Rate of pay $_____ per _____	Original effective date of individual's life coverage (MMDDYYYY)	
Date last worked (MMDDYYYY)	Date of disability (MMDDYYYY)	Has coverage been terminated? ☐ Yes ☐ No If yes, indicate date (MMDDYYYY)		

Life coverage	Amount of coverage	Last change in amount of coverage		
		Increase	Decrease	Date
Basic	$	$	$	
Optional	$	$	$	
Total	$ 0	$ 0	$ 0	

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

Was the covered employee 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 (MMDDYYYY)

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.

Section 3: Signatures required

As far as I know, everything I've written above is correct and matches our records.
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.

Employer (if other than policyholder)	Employer's authorized representative's signature X	Employer's authorized representative's title	Date (MMDDYYYY)
Covered employee	Covered employee's or legally appointed guardian's signature X	Covered employee's or legally appointed guardian's title	Date (MMDDYYYY)

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.

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

We need to get some information before we can start processing your claim.
All information needs to be included to make sure there isn't any delay during processing.

What you need to do:

1) Make sure your employer has filled out the first section of the employee and attending physician statements.
2) Fill out this statement and send back to us.
3) Give the attending physician statement to your attending physician so he/she can fill out and send back to us.

Employee needs to send this statement to:

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

Phone: 800-552-2137
Fax: 877-305-3901
Email: lifeclaims@anthem.com

Please talk to your employer if you need help completing this form.

Section 1: To be completed by the employer

Covered employee's last name	First name	M.I.	Group no.	Suffix no.

Section 2: To be completed by the covered employee

1.	Last name	First name		M.I.	Date of birth (MMDDYYYY)	Sex ☐ Male ☐ Female	Are you married? ☐ Yes ☐ No
2.	Street address	City	State	ZIP code	Social Security no.	Phone no. May we contact you at this number? ☐ Yes ☐ No	
3.	Employer name				Occupation/Job title		
4.	In your own words, tell us about your duties at your 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: 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12 ☐ Degree earned: ☐ College: _____ ☐ Graduate: _____						

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

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

Date changes were made (MMDDYYYY)

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: (MMDDYYYY) Location: _____

12. Describe how accident happened:

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: (MMDDYYYY)

Date of first treatment for this illness or injury: (MMDDYYYY)

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

Doctor's name		Phone no.	
Street address	City	State	ZIP code

16. How often do you see the doctor?

Date you first saw this doctor (MMDDYYYY)

Date you last saw this doctor

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:

Doctor's name		Phone no.	
Street address	City	State	ZIP code

19. How often do you see the doctor?

Date you first saw this doctor (MMDDYYYY)

Date you last saw this doctor

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/she told you about restricting your activities:

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

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:			
24.	Do you expect to return to work? ☐ Yes ☐ No	Date expected to return (MMDDYYYY)	Date returned (MMDDYYYY)	
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 (MMDDYYYY)	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			

Section 3: Signatures required

As far as I know, everything I've written above is correct. I understand that my signature below allows the Insurance Company to get any type of information about this claim from any employer, insurance company, medical prepayment plan, service organization, practitioner, doctor, hospital, including the Veterans Administration or any other institutions or person who provided care. I understand that a copy of my authorization can be used instead of the original. I also agree to let the Insurance Company know right away if my medical condition improves so that I am able to work, even though I have not yet returned to work. And if I go to work whether as an employee or as a self-employed person.

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)
X	

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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The laws of some states require us to give you the following information

Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

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 to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the 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.

Kansas: 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 may be guilty of insurance fraud as determined by a court of law and may be subject to fines and confinement in prison.

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.

Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

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: 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 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.

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

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Attending Physician Statement – Life Waiver of Premium or Continuation of Benefit Claim Form

We need to get some information before we can start processing your patient's claim for disability. All information needs to be included to make sure there isn't any delay during processing.

Attending physician needs to send this statement to:

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: Employee information

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

Street address	City	State	ZIP code

Patient employer	Group policy no.

Section 2: Details about the patient

Patient age	Date symptoms first appeared or accident happened (MMDDYYYY)	Date patient ceased work because of disability (MMDDYYYY)

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

Section 3: Your diagnosis

Diagnosis (including complications)

ICD-10 code: _____

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 4: Treatment history

Date of first visit for above condition (MMDDYYYY)	Date of last visit (MMDDYYYY)	Visit frequency
		☐ Weekly ☐ Monthly ☐ Other: _____

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

Section 5: Patient 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 6: Cardiac information

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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Attending Physician Statement – Life Waiver of Premium or Continuation of Benefit Claim Form (continued)

Section 7: Impairments related to work

Body impairments

☐ 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:

*As defined in *Federal Dictionary of Occupational Titles.*

Mental impairments (if any):

☐ 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 8: Work limitations

Restricted: ☐ Lifting ☐ Pushing ☐ Pulling ☐ Carrying
Restricted: ☐ Bending

Maximum weight in pounds: ☐ 10 ☐ 11-24 ☐ 25-34 ☐ 35-50 ☐ 51-74 ☐ 75-100
Maximum no. times per hour: ☐ 0-2 ☐ 2-6 ☐ 6-10 ☐ 10-20 ☐ 20-45

☐ Keep wound clean and dry ☐ Right hand work only ☐ Left hand work only ☐ No repetitive motions ☐ No climbing or overhead work ☐ Hand grasp
☐ Elbow flexition ☐ No operation moving equipment ☐ Wrist motion ☐ Foot control ☐ Sitting job only ☐ Other (Specify) _____

Section 9: Patient ability

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

Section 10: Your 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 11: Rehabilitation information

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: (MMDDYYYY) ☐ Full-time ☐ Part-time
Any other work: Date: (MMDDYYYY) ☐ Full-time ☐ Part-time
If "No," please explain:

Section 12: Any other remarks

Section 13: Attending physician information and signature

Printed attending physician name	Degree	Phone no.	
Street address	City	State	ZIP code
Attending physician signature X		Date (MMDDYYYY)	

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