Short Term Disability Claim Form

Clear Form

Anthem® Life

IMPORTANT NOTICE TO EMPLOYEE – PLEASE READ CAREFULLY

You or someone acting on your behalf should complete Section I and then have your employer complete Section II. Have your physician complete Section III within ten days. After all three sections are completed, submit the form to us at the address or fax number listed below. Your cooperation will facilitate payments promptly when they are due.

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.

SECTION I: TO BE COMPLETED BY THE EMPLOYEE

1a Employee last name	1b Employee first name	MI	2 Marital status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	3 Gender ☐ Male ☐ Female	4 Birthdate (mm/dd/yyyy)

5a Employee street address	5b City	5c State	5d ZIP code

6 Phone no.	7 Cell no.	8 Fax no.	9 E-mail address	10 Social Security no.

11 Date you last worked due to your disability (mm/dd/yyyy)	12 Date you returned to work (mm/dd/yyyy)	13 If not yet returned, date you expect to return (mm/dd/yyyy)

14 Disability due to:
☐ Illness
☐ Injury – Type: ☐ Auto ☐ Workers' Compensation ☐ Home ☐ Other If due to injury, please provide complete details to accident, date and time (attach a separate sheet if necessary):

15 Employer name

I authorize the release to or by Anthem Life Insurance Company (Anthem Life) any medical or insurance information required to process my claim. I understand that any information obtained pursuant to this authorization will be used only to evaluate my claim and may be transferred to any organization or person employed by or representing Anthem Life to assist with this purpose. This authorization is valid for the duration of my claim. I understand I have a right to request and receive a copy of this authorization. A photocopy of this authorization is as valid as the original.

The above statements are true and complete to the best of my knowledge and belief. (Your signature is required for benefit consideration.)

Employee Signature	Date (mm/dd/yyyy)
X	

SECTION II: TO BE COMPLETED BY THE EMPLOYER

17 Group policy no.	18 Date employed (mm/dd/yyyy)	19 Effective date of insurance (mm/dd/yyyy)	20 Occupation/Job title	21 Standard no. of hours worked per week

22 Social Security no.	23 Employee no. (if applicable)	24 Employee benefit class	25 Amount of weekly benefits

26a Date employee last worked: ____/____/____ No. of hours: _____ ☐ AM ☐ PM
26b Date employee scheduled to return to work: ____/____/____ ☐ AM ☐ PM
26c Date employee returned to work: ____/____/____ ☐ AM ☐ PM

27 Employee's wage: $_____
per ☐ hour ☐ week ☐ year
☐ Hourly ☐ Salaried

28 Did injury or illness arise out of or in course of employment for wages or profit? ☐ Yes ☐ No

29 Is claim being made for Workers' Compensation? ☐ Yes ☐ No

30 What percentage of the Short Term Disability premium does the employer pay? _____%

31 If the employee contributes to the premium, contributions are made: ☐ Pre-Tax ☐ Post-Tax

32 Comments

33 Employee status on the last day worked or current employee status

34 Insured group name	35 Branch or division address	36 Phone no.

37 Printed name of employer representative	38 Title

39 Signature of employer representative	40 Date (mm/dd/yyyy)
X	

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

Save and Print Form

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.

SECTION III: TO BE COMPLETED BY PHYSICIAN

Note to Physician:

Completion of this form will assist your patient in presenting claim for group and/or individual disability benefits. Please complete all areas of the form; if a section is non-applicable, please enter N/A in the response area.

1a Patient's last name	1b Patient's first name	1c M.I.	2 Birthdate (mm/dd/yyyy)

3 Current diagnosis	4 ICD-9 code/DSM IV

5 Subjective findings	6 Objective findings

7 Has patient ever had same or similar condition? ☐ Yes ☐ No If yes, please specify dates of treatment:	8 Did injury or illness arise out of or in course of employment for wages or profit? ☐ Yes ☐ No ☐ Unknown If yes, please explain:

9 Is Disability due to pregnancy? ☐ Yes ☐ No

If yes, LMP (mm/dd/yyyy): ____/____/_____ EDU (mm/dd/yyyy): ____/____/_____ Type of delivery: ☐ Vaginal ☐ C-section

10 Was patient hospitalized? ☐ Yes ☐ No If yes, please provide dates of confinement and name of hospital/facility:	11 Nature of surgical procedure, if any. (Describe in full.) Date performed (mm/dd/yyyy): ____/____/_____

TREATMENT

12 Date patient first unable to perform job duties (mm/dd/yyyy)	13 Date of first visit (mm/dd/yyyy)	14 Date of last visit (mm/dd/yyyy)

15 Patient's present condition ☐ Recovered ☐ Improved ☐ Unchanged ☐ Regressed	16 Frequency of visits ☐ Weekly ☐ Monthly Other: _____

17 Treatment plan

18 Functional impairments	19 Current medications and dosages

EXTENT OF DISABILITY

20 Patient released to return to work? ☐ Yes ☐ No

If yes: ☐ Full-time, no restrictions Date return to full duty:

☐ Light duty (Please specify restrictions, limitations, hours, graduated return to work schedule, etc.):

Date return to light duty (mm/dd/yyyy): ____/____/_____

21 Is patient a suitable candidate for a rehabilitation program? ☐ Yes ☐ No

PSYCHIATRIC CONDITION

22 Is this patient competent to endorse checks and direct the proceeds thereof? ☐ Yes ☐ No If no, please attach supporting documentation.

23a Physician printed last name	23b Physician first name	23c M.I.	24 Physician specialty

25a Physician street address	25b City	25c State	25d ZIP code

26 Physician phone no.	27 Physician fax no.	28 Physician e-mail address

Signature of physician X	Date (mm/dd/yyyy)

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.