AnthemLife
Anthem Life Insurance Company

Administered By:
Bay Bridge Administrators, LLC.
P.O.Box 161690
Austin, TX 78716
(512) 329-5069
(800) 845-7519

BAY BRIDGE ADMINISTRATORS

To file an application for Total Disability benefits, please follow the instructions below to avoid unnecessary delays.

This claim form requests information that is necessary for the speedy and accurate administration of your claim. If it is not completed in full, determination of benefits will be delayed until all required information has been received. If a question does not apply, or information is not available, please write "NA" (not applicable) in those spaces.

Note: We cannot accept claim forms which are completed prior to date of Total Disability.

There are four (4) primary sections to be completed in this form:

Section 1: Authorization and Disclosures

You (the employee) must fully complete the "Authorization," page 2. This will allow us to secure additional information (if necessary) to make a decision on your claim.

Section 2: Employee's Statement

You (the employee) must fully complete the section "To Be Completed By the Employee," page 3.

Section 3: Employer's Statement

Please have the section "To Be Completed By Employer," page 4, completed by an administrator in the Benefits or Payroll office at your district.

Section 4: Physician's Statement

Have your attending physician complete and sign the section "To Be Completed By Physician," page 5 & 6. Please include any additional medical records (i.e. office notes, test results, x-rays) which may support your total disability.

Please note: If filing due to pregnancy, this section cannot be completed prior to delivery, unless your physician is stating you are totally disabled due to medical complications related to your pregnancy.

ALL FOUR SECTIONS MUST BE COMPLETED BEFORE YOUR CLAIM CAN BE PROCESSED. When all sections have been completed and signed, please send all original copies to Bay Bridge Administrators, LLC., at the above address. Faxed copies cannot be accepted.

NOTE: It may be necessary for us to obtain additional medical records before your claim can be processed.

It is the responsibility of you and your employer to inform us of any scheduled or actual return to work date as soon as possible. If an overpayment should occur on your claim, the amount of the overpayment must be returned to us.

Authorization and Disclosures

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Section 1: To Be Completed By Employee

The following authorization will be used to obtain additional information (if necessary) concerning this claim.

Authorization for Release of Information

Persons or Institutions: This authorizes you to give Anthem Life Insurance Company, its representatives, or persons performing business or legal services on behalf on Anthem Life any information, data or records you have regarding my medical history and treatment (including records pertaining to psychiatric, drug or alcohol use, and any medical condition I may now have or have had), and any information, data or records regarding my Social Security, FICA earnings history, Worker's Compensation, state disability, pension, credit, financial, earnings and employement history needed to evaluate my claim for disability benefits.

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 during the pendency of my claim. I understand that I have the right to request and receive a copy of this authorization. A photocopy of this authorization is as valid as the original.

Name (Please Print)

X _____ _____

Signature Date

Address

The law of some states requires us to provide you with the following information:

Any person who knowingly, and with intent to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information, is guilty of a felony, and may be subject to imprisonment, fines, and civil damages.

California: For your protection California law requires the following to appear on this form: Any person who knowingly presents 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.

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 a 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.**

Florida: Any person who knowingly, and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

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 act, which is a crime.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New York: Any person who knowingly and with intent to defraud any insurance company of 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.

In addition, submission of false information in connection with this claim form may also constitute a crime under federal laws. Anthem Life will pursue any appropriate legal remedies in the event of insurance fraud, including prosecuting under federal mail fraud, and/or the Federal Racketeer Influenced and Corrupt Organization Act statues. Any false statements made herein may be reported to state and federal tax and regulatory authorities as is appropriate.

Please return original claim forms to: Bay Bridge Administrators, LLC
-Bay Bridge Administrators cannot accept faxed copies-

Claim For Total Disability Benefits

Statement of Insured

Note: This statement must be made by the insured. Every question must fully answered. The Company reserves the right to ask for additional statements if deemed necessary for proper disposition of the claim.

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Section 2: To Be Completed By Employee (Please Print)

If claim form is not completed in full, determination of benefits will be delayed until all required information has been received. Write "NA" in non-applicable sections.

1. a. Your Full Name | Date of Birth | All Carrier Life Policy Numbers:

b. Your Present Address | Social Security Number

Phone No. ( )

Height | Weight | ☐ Male ☐ Female | Job Title/Occupation

2. Employer's Name and Address | Employer's Phone No. ( )

3. Job Title and Specific Duties: | Length of Time with Employer

Date you last worked | Length of Time in Position | Earnings $_____per_____

4. Date of accident or date of first symptoms | Have you ever had same or similar condition ☐ Yes ☐ No | If returned to work, give date | If you have not returned to work;approximate return to work date:

Describe fully your present disability and its cause, with complete history to date | Is the condition work related? ☐ Yes ☐ No

If your condition is work related, explain what happened:

If your condition is work related, have you filed a Workers' Compensation Claim? ☐ Yes ☐ No If no, Do you intend to? ☐ No ☐ Yes

If no, explain why not:

5. List all Physicians Consulted or Hospital Confinements in the Last Three Years. (List on separate paper if needed)

Name of Doctors	Specialty	Mailing Address and Phone Numbers	Date of 1st Treatment

Name of Hospitals	Mailing Address	Confinement Dates (From-To)

6. Describe other income you are receiving (If you answer 'Yes' to any of the following, please enclose documentation regarding the amount of other income)

Yes	No	Type	Amount	Date Began	Date Terminated
☐	☐	Social Security (disability or retirement)*	$_____	_____	_____
☐	☐	State Disability*	$_____	_____	_____
☐	☐	Retirement (normal, early, or disability)*	$_____	_____	_____
☐	☐	Workers' Compensation*	$_____	_____	_____
☐	☐	Short Term Disability*	$_____	_____	_____
☐	☐	Unemployment*	$_____	_____	_____
☐	☐	Other (describe) _____	$_____	_____	_____

*If yes, give name and address of Insurer(s)

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

Signed _____ Dated _____

EMPLOYER'S STATEMENT

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Section 3: To Be Completed By Employer (Please Print)

If claim form is not completed in full, determination of benefits will be delayed until all required information has been received. Write "NA" in non-applicable sections.

Employee's Name	Social Security Number	Date of Birth
Employee's Home Address (Street, City, State, Zip)		

1. Employment

a. Insurance class/plan

b. Employee's date of hire

c. Date employee became insured

d. Date employee was actually last at work

e. Number of hours worked on last day

f. Occupation as of last date worked **(Attach job description):**

g. Worked schedule at time last worked

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

h. Reason for stopping work

i. Has employee returned to work? ☐ Yes ☐ No

Full-time date

Part-time date

j. Is employee's job being held open?

2. Income

a. How was employee paid?

☐ Hourly Rate $_____hr
☐ Straight Salary amt. $_____
☐ Salary and Commission amt. $_____
☐ Commissions per year amt. $_____

b. Effective date of earnings rate:

c. Premium contribution:

Employee Pays _____% ☐ before tax ☐ after tax

Employer Pays _____%

3. Other Benefits

a. Did disability result from job activity?

☐ Yes
☐ No

b. Has a Workers' Compensation claim been filed?

☐ Yes
☐ Pending
☐ Denied (enclose copy)

c. Worker's Compensation weekly benefit (please enclose documentation regarding amount)

$

Date Commenced

d. Has employee received other income since date last worked?

☐ Yes
☐ No

Type of other income benefit: _____

Amount $ _____ Per _____

Start Date: _____

End Date: _____

4. Name Of Employer

Name of Employer (Association or Policyholder, if other)	
Address	
Signature of Employee Representative **X**	Date Signed
Printed Name and Title or Position	Employer's Telephone Number
Email Address	Employer's Fax Number

Modified 8/7/2006

Please return original copy to:
Bay Bridge Administrators, LLC
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ATTENDING PHYSICIAN'S STATEMENT OF DISABILITY

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Section 4: To Be Completed By Attending Physician

Any person who knowingly and with intent to injure, defraud, or deceive any insurance company or other person submits an insurance application or statement of claim containing any materially false, incomplete or misleading information may be committing a crime and subject to civil or criminal penalties.

Name of Patient		Date of Birth
Height	Weight	Blood Pressure (last visit)

We must have comprehensive medical information in order to evaluate the insured's claim for Short or Long Term Disability Benefits. Any charge required for completion of this form is the responsibility of the patient.

****If filing a claim due to pregnancy, include delivery date with diagnosis. DO NOT have forms completed prior to delivery.**
-Cannot process the claim until after the delivery unless complications occur.**

1. HISTORY

(a) When did symptoms first appear or accident happen? Month Day Year

(b) Date disability commenced Month Day Year

(c) Has patient ever had same or similar condition? ☐ Yes ☐ No
If "Yes" state when and describe

(d) Is condition due to injury or sickness arising out of patient's employment? ☐ Yes ☐ No ☐ Unknown

(e) Please submit copies of all office notes since disablity commenced.

2. DIAGNOSIS (including any complications)

(b) Diagnosis (including any complications and ICD 9) **If totally disabled due to pegnancy, please include delivery date and type of delivery**

(c) Subjective symptoms

(d) Objective findings (including current X-rays, EKG's Laboratory Data and any clinical findings)

3. DATES OF TREATMENT

(a) Date of first visit Month Day Year

(b) Date of last visit Month Day Year

(c) Frequency ☐ Weekly ☐ Monthly ☐ Other (Specify)

4. NATURE OF TREATMENT

Please describe course of treatment.

5. PROGRESS

(a) Give prognosis with reasonable estimate of return to work date.

(b) Has patient been hospital confined? ☐ Yes ☐ No
If "Yes", give Name and Address of Hospital | Confined from | through

6. CARDIAC (if Applicable)

(a) Functional capacity (American Heart Ass'n) ☐ Class 1 (No limitation) ☐ Class 2 (Slight limitation) ☐ Class 3 (Marked limitation) ☐ Class 4 (Complete limitation)

(b) Blood Pressure (last visit)

(c) Results of stress test.

7. LIMITATIONS **(what the patient CANNOT do)**

8. RESTRICTIONS **(what the patient SHOULD NOT do)**

9. PHYSICAL IMPAIRMENT (*as defined in Federal Dictionary of Occupational Titles)

- ☐ Class 1 - No limitation 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 minimal (sedentary*) activity (75-100%)

Remarks:

10. MENTAL/ NERVOUS IMPAIRMENT (if applicable)

Please define "stress" as it applies to this claimant.

- ☐ 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:

Mental Impairment (if applicable) Provide 5 AXIS Diagnosis

I _____ IV _____

II _____ V _____

III _____

Do you believe the patient is competent to endorse checks and direct the use of proceeds thereof? ☐ Yes ☐ No

11. EXTENT OF DISABILITY

	From Patient's Regular Occupation	From Any Occupation
(a) Is patient now totally disabled?	☐ Yes ☐ No	☐ Yes ☐ No
(b) If yes, when do you think patient will be able to resume any work?	Approximate Date Mo. Day Yr.	Approximate Date Mo. Day Yr.

12. REHABILI-TATION

	Patient's Job	Any Other Work
(a) When could trial employment commence?	Mo. Day Yr.	Mo. Day Yr.

Describe rehabilitation needs:

13. REMARKS

Signature (Attending Physician)	Specialty	Date
Name of Physician (Please Print):	Telephone Number	Fax Number
Address (Street, City or Town, State or Province, Zip Code)		Tax ID Number