ANTHEM LIFE INSURANCE COMPANY

Home Office: 6740 North High Street, Suite 200, Worthington, Ohio 43085
Administrative Office: Bay Bridge Administrators, P.O. Box 161690, Austin, Texas 78716
Telephone: 800-845-7519
Fax: 512-275-9355

STATEMENT OF CLAIMAINT
FOR PHYSICIAN EXPENSE FOR INJURY OR SICKNESS OR WELLNESS
(Do NOT use this form when filing for Disability)

Name of Employee_____ Social Security Number _____-_____-_____
Last Name First Name Middle Initial

Policy Number_____ Date of Birth _____
Month Day Year

Employee's Residence Address _____
Street City State Zip Code

Telephone Number(s): (Day) _____ (Evening) _____

I am employed at CARRIZO SPRINGS CISD Occupation_____

Section I

1. Is this for a wellness visit (wellness is defined as routine & preventive in nature-not seen for an injury or illness) Yes or No Date of Visit_____

   If Yes, skip Questions 2-6

2. Date of accident or illness began? _____
3. Nature of illness or accident? _____
4. Date of Treatment Office/Hospital _____
5. Were you scheduled to work on the day of medical treatment? Yes or No
   If no, explain (Semester break, holiday, week-end, etc.)_____
6. If yes, were you totally disabled and unable to work one full day on the date of medical treatment? Yes or No
   Date unable to work_____

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.

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.

_____ _____
Date Signed Employee's Signature

(CONTINUE TO SECTION II)

Section II- To be completed by Employer (Please Print).

Name of Employee_____ Social Security Number _____-_____-_____
Last Name First Name Middle Initial

Occupation_____

5. Did employee miss a day of work? Yes or No

   If yes,
   a. Date employee was actually last at work? _____

   b. Has employee returned to work? If yes, please indicate date _____

6. Amount of Salary Monthly or Annually_____

Name of Employer___ CARRIZO SPRINGS CISD_____

Address_____

Signature of Employee Representative_____Date_____

Printed Name & Title or Position_____

Employer's Telephone Number_____Fax Number_____

Email Address_____

Fax or mail the claim to the following address with a bill or medical documentation which list the date of service and the medical reason for your visit:

Bay Bridge Administrators, LLC
PO Box 161690
Austin TX 78716
Fax (512) 275-9355