Group Accident, Critical Illness/Specified Disease (in New York), and Hospital Indemnity Insurance Employee/Member/Claimant Claim Form

In furnishing this claim form, the Insurance Company[1] does not waive any of its rights or defenses nor admit liability.

Employee/Member/Claimant responsibilities:

1. Complete, sign and date this form electronically or in paper copy. For assistance with completing this form, please call 800-604-4381.
2. To help prove the claim, provide all supporting documentation such as medical records, physician notes, emergency room/hospital discharge papers, radiology/pathology reports, itemized medical/hospital bills, medical Explanation of Benefits (EOBs), toxicology reports, childcare/transportation/lodging receipts or police reports (if applicable following an accident). The claimant is responsible for any fees charged for proof requirements.
3. Mail the form and supporting documentation to Supplemental Insurance Benefit Department, P.O. Box 2076, Grapevine, TX 76099; or fax to 469-417-1977.
4. If you are enrolled for any other group coverage through the Insurance Company for which benefits may be available as a result of the covered event, please submit the appropriate claim(s). Contact the employer/policyholder for assistance if you are uncertain of other coverage.

Section 1: Employer/Policyholder information

Employer/policyholder name	Policy no.

Section 2: Employee/member information

Employee/member last name	First name	M.I.	Social Security or tax ID no.	Date of birth (MM/DD/YYYY)

Gender ☐ Male ☐ Female	Street address	City	State	ZIP code

Email address	Phone no.	Cell/mobile phone no.

May we have your authorization to deliver confidential medical or benefit information via personal cell phone? ☐ Yes ☐ No
Via email? ☐ Yes ☐ No If **yes** to either personal cell phone or email, please initial here to confirm your response: _____

Does the employee/member have major medical insurance or other primary health insurance? ☐ Yes ☐ No If **yes**, provide the following:
Insurance carrier name: _____ Policy no.: _____

Is the employee/member currently actively working?[2] ☐ Yes ☐ No If **yes**, hours worked per week:[2] _____
If **no**, provide the following: Date last worked: _____ (MM/DD/YYYY) Reason not working: _____

Section 3: Dependent information — Complete if this claim is for a dependent of the employee/member.

Dependent last name	First name	M.I.	Social Security or tax ID no.	Date of birth (MM/DD/YYYY)	Relationship to employee/member

Is the dependent insured under Medicaid or any similar Title XIX program? ☐ Yes ☐ No

Is the child incapacitated/disabled? (if applicable) ☐ Yes ☐ No

Is the child married or in a partnership? (if applicable) ☐ Yes ☐ No

Is the child a full-time student? (if applicable) ☐ Yes ☐ No
If **yes**, provide name and contact information for the school: _____

Section 4: Claim information

Type of claim: (Check all that apply) ☐ Accident ☐ Critical Illness/Specified Disease ☐ Hospital Indemnity

Is this the first claim submitted for this event/insured? ☐ First claim ☐ Additional/Follow-up claim

Nature of illness/injury/diagnosis and/or treatment received[3] (For pregnancy, complete *Pregnancy information* section.)

When did symptoms first appear or injury occur?[3] (For accidents, complete *Accident information* section.) Date first diagnosed/treated: _____

Have you ever had this same or similar condition? ☐ Yes ☐ No If **yes**, explain condition and when:[3]

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Employee/member name	Employee/member SSN/tax ID no.	Policy no.

Section 5: Pregnancy information — Complete if this claim is the result of a pregnancy.

Date of delivery/expected delivery date	Type of delivery/expected type of delivery ☐ Vaginal ☐ Elective C-section ☐ Unplanned C-section	First day of last period
Are/were there any complications of pregnancy? ☐ Yes ☐ No If **yes**, explain complication and when:[3]		

Section 6: Accident information — Complete if this claim is the result of an accident.

Date of accident	Time of accident (HH:MM) ☐ AM ☐ PM	Who was involved in the accident? (Check all that apply) ☐ Employee/member ☐ Spouse ☐ Child(ren)
Location of accident (place name, street, city, state and ZIP code)		

Complete the rest of this section only if this claim is the first claim submitted for this injured person for this accident.
Proceed to the *Benefit information* section if this is an additional/follow-up claim.

Was this a motor vehicle accident? ☐ Yes ☐ No
Did any law agency investigate the accident? ☐ Yes ☐ No If **yes**, provide a copy of the report. Please provide agency name and contact information:
Did the accident happen while the injured person was working? ☐ Yes ☐ No If **yes**, will/has a workers' compensation (or equivalent) claim been filed? ☐ Yes/to be filed ☐ No
Provide a detailed explanation of the accident, including how it happened and what the injured person was doing at the time of the accident:[3]

Section 7: Benefit information

Check each illness, injury, service or treatment for which a benefit is requested as a result of the event. If any previous claims have been submitted for this event, only check the benefits that are applicable to this new claim.

Benefits listed below may not be included in all certificates/policies. Refer to the certificate for available benefits, limitations and exclusions.

All relevant supporting documentation, such as medical records, physician notes, ER/hospital discharge papers, radiology/pathology reports, itemized medical bills (hospital, physician, ambulance, etc.), medical EOBs, toxicology reports or child care/transportation/lodging receipts, should be included with this claim submission to help prove the claim. You can prevent the potential of a delay in processing the claim by providing complete and accurate information.

Accident

Emergency, hospital and treatment care

- ☐ Physician visit
- ☐ Urgent care visit
- ☐ Emergency room
- ☐ Diagnostic exam or X-ray
- ☐ Ambulance
- ☐ Hospital confinement
- ☐ Physical or occupational therapy
- ☐ Chiropractic care or acupuncture
- ☐ Rehabilitation facility confinement
- ☐ Transportation or lodging
- ☐ Blood/plasma/platelets
- ☐ Emergency dental - crown/extraction
- ☐ Medical appliance
- ☐ Child care

Specified injury and surgery

- ☐ Concussion or laceration
- ☐ Dislocation or fracture
- ☐ Surgery
- ☐ Burns (second or third degree)
- ☐ Eye injury - surgery or object removal

Catastrophic

- ☐ Death (complete death claim form)
- ☐ Coma
- ☐ Dismemberment or paralysis
- ☐ Home health care
- ☐ Prosthesis

Hospital Indemnity

Confinement

- ☐ Hospital confinement
- ☐ Continuous care confinement

Critical Illness/Specified Disease

Cancer

- ☐ Cancer (invasive or non-invasive)
- ☐ Benign brain tumor
- ☐ Skin cancer

Vascular

- ☐ Heart attack (myocardial infarction)
- ☐ Stroke
- ☐ Coronary artery disease/bypass
- ☐ Heart transplant

Other illnesses

- ☐ Major organ transplant
- ☐ End stage renal (kidney) disease (ESRD)
- ☐ Coma or paralysis
- ☐ Loss of hearing, speech or vision

Neurological

- ☐ Advanced Parkinson's or Alzheimer's
- ☐ Amyotrophic lateral sclerosis (ALS)
- ☐ Advanced multiple sclerosis

Employee/member name	Employee/member SSN/tax ID no.	Policy no.

Section 8: Physician information[3] — Include all physicians consulted for care for this event.

1 Physician name		2 Physician name		3 Physician name	
Date(s) treated	Specialty	Date(s) treated	Specialty	Date(s) treated	Specialty
Address (city, state and ZIP code)		Address (city, state and ZIP code)		Address (city, state and ZIP code)	
Phone no.	Fax no.	Phone no.	Fax no.	Phone no.	Fax no.

Section 9: Facility information[3] — Include any urgent care, emergency room or hospital providing care for this event.

1 Facility name		2 Facility name		3 Facility name	
Date and time seen/admitted Date: _____ Time: _____ ☐ AM ☐ PM		Date and time seen/admitted Date: _____ Time: _____ ☐ AM ☐ PM		Date and time seen/admitted Date: _____ Time: _____ ☐ AM ☐ PM	
Date and time discharged (if applicable) Date: _____ Time: _____ ☐ AM ☐ PM		Date and time discharged (if applicable) Date: _____ Time: _____ ☐ AM ☐ PM		Date and time discharged (if applicable) Date: _____ Time: _____ ☐ AM ☐ PM	
Address (city, state and ZIP code)		Address (city, state and ZIP code)		Address (city, state and ZIP code)	
Phone no.	Fax no.	Phone no.	Fax no.	Phone no.	Fax no.

Section 10: Claimant information — Complete only if the claimant is not the employee/member.

Claimant last name	First name	M.I.	Phone no.	Cell/mobile phone no.
Mailing street address	City	State	ZIP code	Email address

May we have your authorization to deliver confidential medical or benefit information via personal cell phone? ☐ Yes ☐ No
Via email? ☐ Yes ☐ No If **yes** to either personal cell phone or email, please initial here to confirm your response: _____

Section 11: Claimant certification

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.

By signing below, I hereby certify that:

1. The information provided on this form is true and complete to the best of my knowledge and belief; and
2. I have read and understand the "Important Notice – Fraud Warning Statements" that applies to my state of residence.

Claimant signature **X**	Date (MM/DD/YYYY)

1 Used herein, 'Insurance Company' means: In California, Anthem Blue Cross and Anthem Blue Cross Life and Health Insurance Company; In Colorado: Rocky Mountain Hospital and Medical Service, Inc.; In Connecticut; Anthem Health Plans, Inc.; In Georgia: Blue Cross Blue Shield Healthcare Plan of Georgia, Inc.; In Indiana: Anthem Insurance Companies, Inc.; In Kentucky: Anthem Health Plans of Kentucky, Inc;. In Maine: Anthem Health Plans of Maine, Inc.; In Missouri (excluding 30 counties in the Kansas City area): RightCHOICE® Managed Care, Inc. (RIT), Healthy Alliance® Life Insurance Company (HALIC), and HMO Missouri, Inc.; In Nevada: Rocky Mountain Hospital and Medical Service, Inc.; In New Hampshire: Anthem Health Plans of New Hampshire, Inc.; In New York: Empire HealthChoice HMO, Inc., Empire HealthChoice Assurance, Inc., and/or HealthPlus HP, LLC.; In Ohio: Community Insurance Company.; In Virginia: Anthem Health Plans of Virginia, Inc.; or in Wisconsin: Blue Cross Blue Shield of Wisconsin (BCBSWI).

2 Complete these fields only if there is an employer/employee relationship between the employee/member and the group. Do not complete for other group types.

3 If additional space is needed, please provide on a separate sheet of paper and submit with this form. Include the employee/member name, Social Security no. or tax ID no. and policy no.

Group Accident, Critical Illness/Specified Disease (in New York), and Hospital Indemnity Insurance Claim Form

Authorization to Obtain and Disclose Information

Employee/Member/Claimant responsibilities:

1. A copy of this form must be submitted for each person for whom benefits are being claimed. This form is only required once per person per event, regardless of the number of claim submissions. For assistance, please call 800-604-4381.
2. Mail the form(s) to Supplemental Insurance Benefit Department, P.O. Box 2076, Grapevine, TX 76099; or fax to 469-417-1977.

Section 1: Employee/member and policy information

Employee/member last name	First name	M.I.	Last 4 digits of Social Security or tax ID no.	Policy no.

Section 2: Authorization to obtain and disclose information

To any health care provider, employer, benefit plan, insurer, service provider, financial institution, consumer reporting agency, educational institution, or federal, state, or local government agency (including the Social Security Administration and Veterans Administration) – **I AUTHORIZE** you to disclose to the Insurance Company and/or its Third Party Administrator, hereinafter called "TPA," a complete copy of any and all of the following personal or privileged information, records, or documents relative to:

Insured employee/member or dependent last name	First name	M.I.	Date of birth (MM/DD/YYYY)	Last 4 digits of Social Security or tax ID no.

- Any and all medical information or records, including x-ray films, medical histories, physical, mental, or diagnostic examinations, and treatment notes, and including information regarding HIV/AIDS, communicable diseases, alcohol or drug abuse, and mental health;
- Work information and history, including job duties, earnings, personnel records, and client lists;
- Information on any insurance coverage and claims filed, including all records and information related to such coverage and claims; and
- Business transactions billing, invoice, and payment records;

The information obtained by use of this Authorization will be used for the purpose of evaluating and administering my claim for benefits and/or leave request. Such information shall be referred to herein collectively as "My Information."

I UNDERSTAND that once My Information has been disclosed to The Company and/or its TPA as permitted under this Authorization, it may be re-disclosed by The Company and/or its TPA as permitted by law or my further authorization. I further authorize The Company and/or its TPA to use or disclose My Information (i) to my employer for a) functions related to accommodating my disability; b) responding to claims related to accommodation or adverse or discriminatory treatment related to my claim; c) responding to complaints by me or my representative relating to benefits or leave; d) responding to any litigation or agency document production request or lawful subpoena; e) federal, state, or other leave administration; f) fulfilling fiduciary obligations under my benefit plan; or (g) claim or other audits or reviews; (ii) to the administrator or other service providers of my employer's benefit plan, other benefits, and/or leave programs of my employer for plan, benefit, or program related functions or data aggregation and analysis; (iii) to any claim system used for claims processing or insurance broker to carry out functions related to my benefit plan or claim; (iv) to any health care professional who has treated or evaluated me or who may do so; (v) to other persons or entities performing business, medical, or legal services related to my claim; (vi) for other insurance or reinsurance purposes, including workers' compensation insurance; (vii) as may be lawfully required; (viii) as may be reasonably necessary to protect the personal safety of others; or (ix) as may be reasonably necessary to prevent or detect perpetration of a fraud.

I UNDERSTAND that information disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer subject to the privacy protections under HIPAA. I understand that I have the right to revoke this Authorization for future disclosures except to the extent action has been taken in reliance upon this Authorization. I must revoke this Authorization in writing directly to The Company and/or its TPA. I understand that my medical treatment, payment, enrollment or eligibility for benefits cannot be conditioned on my signing this Authorization. I understand that this Authorization expires two years from the date listed below, or upon my revocation, if earlier, but will not exceed the term of my coverage under the policy(ies) or benefit plan or program, except as may be reasonably necessary to prevent or detect perpetration of a fraud or protect the personal safety of others. I understand that I am entitled to receive a copy of this Authorization upon request. A photocopy or facsimile of this Authorization shall be as valid as the original. If there is a conflict between a prior request for restriction on the disclosure of My Information and this Authorization, this Authorization will control.

Signature of insured/claimant or parent/guardian (If insured is under age 18)	Date (MM/DD/YYYY)	Relationship to insured
X		

Group Accident, Critical Illness Critical Illness/Specified Disease (in New York), and Hospital Indemnity Insurance Claim Form

Important Notice – Fraud Warning Statements

Please read the statement that applies to your state of residence prior to signing the claim form and prior to signing this form.

For residents of all states EXCEPT Arizona, California, Colorado, Florida, Kentucky, Maine, Maryland, New Jersey, New York, Oregon, Pennsylvania, Puerto Rico, Tennessee, Virginia and Washington: 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.

For residents of 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.

For residents of 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.

For residents of 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 award payable from insurance proceeds shall be reported to the Colorado Division of insurance within the Department of Regulatory Agencies.

For residents of 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.

For residents of Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim or an application for insurance 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.

For residents of Maine, Tennessee 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 and denial of insurance benefits.

For residents of 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.

For residents of New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties. Any person who includes any false or misleading information on an application for insurance policy is subject to criminal and civil penalties.

For residents of 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 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 such violation.

For residents of Oregon: 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 that the insurer relied upon is subject to a denial and/or reduction in insurance benefits and may be subject to any civil penalties available.

For residents of 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 hereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

For residents of Puerto Rico: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances be present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

For residents of Virginia: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated the state law.

Signature	Date (MM/DD/YYYY)
X	