Accidental Dismemberment or Loss of Sight Claim Form

The furnishing of forms does not constitute an admission of liability on the part of the Company.

INSTRUCTIONS: As soon as you learn that an insured person has suffered any of the losses covered under the policy, this form (completed by the policyholder, claimant and the attending physician) should be sent to the address shown.

Include the following material:
1. Group Insurance Application and record card.
2. All available newspaper clippings pertaining to the injury and loss, and a police or accident report, if available.

Life Claims Service Center
PO Box 105448
Atlanta, GA 30348-5448
Phone: 800-552-2137 Fax: 877-305-3901
Email: lifeclaims@wellpoint.com

Notice to Customers Regarding Telephone Service Observance
To ensure our customers receive quality service, we randomly select phone calls for monitoring. These calls, between our customers and employees, are evaluated by supervisors. This is to guarantee that prompt, consistent assistance, and accurate information is delivered in a professional manner. We have been properly licensed by the Georgia Public Service Commission to use such observing equipment.

SECTION 1: EMPLOYER STATEMENT

Group no.	Class no.	Employee name	
170001			
Date of full-time employment	Occupation	Date last worked (MM/DD/YYYY)	Amount of benefit $
Was coverage continued to date of accident on a premium paying basis? ☐ Yes ☐ No	If no, date of last premium payment	Original effective date of insurance	Earnings at date last worked $
Date of accident (MM/DD/YYYY)	Time of accident	Place of accident	Did accident occur on the job? ☐ Yes ☐ No

I hereby certify that the statements contained above are true to the best of my knowledge and belief.

Company name		Company phone no.	
Southern California IBEW-NECA Health Trust Fund			
Company address (no. and street)	City	State	ZIP code
PO Box 910918	Los Angeles	CA	90091
Name of authorized company representative	Title		

Signature of authorized company representative	Date (MM/DD/YYYY)
X	

SECTION 2: EMPLOYEE STATEMENT — All questions should be fully answered by the insured or his/her legally appointed guardian or committee

Name	Social security no.	Date of birth (MM/DD/YYYY)	
Address (no. and street)	City	State	ZIP code / Employee phone no.
Date of injury (MM/DD/YYYY)	Date of loss (MM/DD/YYYY)	Date first treated by physician	Name of attending physician
Extent of loss			
Describe in detail how accident occurred			

I certify that the above statements by me are complete, true, and correctly recorded. I hereby authorize any hospital, physician or any other institutions or person who has attended or examined me to disclose to Anthem Blue Cross Life and Health Insurance Company all information acquired by reason of, and records pertaining to, such hospitalization, examination and attendance. I authorize that a photostat of this authorization be accepted with the same authority as the original.

Signature of employee	Date (MM/DD/YYYY)
X	

FOR ANTHEM BLUE CROSS LIFE AND HEALTH LIFE USE ONLY

Claim no.	Examiner	Total benefit	Date approved/denied
		$	

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.

Proof of Accidental Dismemberment
Attending Physician's Statement

SECTION 1: PATIENT INFORMATION

Name	Date of birth (MM/DD/YYYY)

SECTION 2: ATTENDING PHYSICIAN STATEMENT – The patient is responsible for completion of this form without expense to the company

Space is available on the reverse side if you wish to amplify your answers.	When did the accident happen?	When did the patient first consult you for this condition?

Has patient ever had same or similar condition?? ☐ Yes ☐ No	If yes, state when and describe.
Was the loss solely the result of an accidental injury?? ☐ Yes ☐ No	If no, what disease or condition was a contributory cause?

Is the patient competent to endorse checks and direct the proceeds thereof? ☐ Yes ☐ No

TO BE COMPLETED FOR LOSS OF SIGHT

Did the accidental injury result in the total and irrevocable loss of sight of:

	Date of loss	Was the eye enucleated?	Date
Right eye: ☐ Yes ☐ No		☐ Yes ☐ No	
Left eye: ☐ Yes ☐ No		☐ Yes ☐ No	

State the date you first determined that central visual acuity was irrecoverably reduced to 20/200 or less with correction:

Date (MM/DD/YYYY)

SNELLEN notations on that date:

	Uncorrected	Corrected
O.D.V		
O.S.V.		

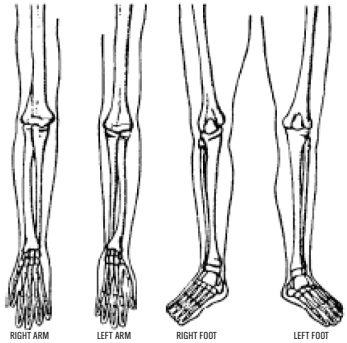
TO BE COMPLETED FOR LOSS OF LIMB(S)

Did the accidental injury result in a loss of limb(s)? ☐ Yes ☐ No

What limb(s) have been severed?

	Date of severance
☐ Right Hand	
☐ Left Hand	
☐ Right Foot	
☐ Left Foot	

Please indicate exact point of severance:



Attending physician name				Degree
Address (no. and street)	City	State	ZIP code	Phone no.

I certify that the above answers and statements are true and complete according to the best of my knowledge and belief.

Signature of attending physician	Date (MM/DD/YYYY)
X	

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