Living Benefit Claim Form
Employer Statement

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

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

INSTRUCTIONS:

1. Check that the employee has completed, dated and signed this claim form. Verify that all required information has been provided.
2. Be sure that the employee has retained a copy of this claim form and all required documentation for their records.
3. Complete all of Section 1: Employer Statement.
4. Include a copy of the employee's signed application.
5. Send this claim form and all required documents to: Attn: **Anthem Blue Cross Life and Health Insurance Company**
   Life Claims Service Center
   PO Box 105448
   Atlanta, GA 30348-5448

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

Company Southern California IBEW-NECA Health Trust Fund		Group policy no. 170001	Class no.
Company address (no. and street) PO Box 910918		City Los Angeles	State CA / ZIP code 90091
Employee name	Social Security No.		Date of birth (MM/DD/YYYY)
Employee address (no. and street)		City	State / ZIP code
Gender ☐ Male ☐ Female	Marital status ☐ Married ☐ Single ☐ Divorced ☐ Widowed	Weekly earnings $	Amount of insurance $
Occupation		Date of full-time employment	Date last physically at work full-time
Reason for leaving work			
Is coverage continuing on a premium paying basis? ☐ Yes ☐ No			If no, date of last premium payment
Beneficiary name		Relationship to employee	Age
Beneficiary address (no. and street)		City	State / ZIP code

Employer representative name and title	Employer phone no.
Employer representative signature **X**	Date signed (MM/DD/YYYY)

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.

Living Benefit Claim Form
Employee Statement

INSTRUCTIONS:

1. Answer all of Section 2: Employee Statement.
2. Have your doctor complete the Attending Physician Statement.
3. If applicable, provide the following documentation:
   - If you are divorced, a copy of the court approved divorce settlement agreement.
   - If you have assigned your rights under the group policy to an assignee or an irrevocable beneficiary, written consent from that assignee or irrevocable beneficiary, for payment of a living benefit claim.
4. Be sure to keep a copy of this claim form and all additional documentation for your records. Give the employer this claim form and all additional documentation.

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

Section 2. EMPLOYEE STATEMENT

All questions should be fully answered by the insured or his/her legally appointed guardian or committee.

Name		Date of birth (MM/DD/YYYY)	
Address (no. and street)	City	State	ZIP code
Qualifying medical condition as the reason for this claim		Social Security No./Tax ID no.	
Date last physically at work full-time	Amount of benefit are you claiming	Are you now in the process or have you converted your Group Life Coverage to an Individual Policy? ☐ Yes ☐ No	

Anthem Life reserves the right to request an Independent Medical Examination at the Company's expense.

Have divorce proceedings ever been instituted by or against you? ☐ Yes ☐ No	If yes, when and where? (If you answer yes to this question, please refer to no. 3 in the Employee Instructions portion of this form.)

Have you assigned your rights under the group policy to an assignee or irrevocable beneficiary? ☐ Yes ☐ No

CERTIFICATION

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct Taxpayer Identification Number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding either because I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of failure to report all interest and dividends, or the IRS has notified me that I am no longer subject to backup withholding.

Certification Instructions: You must cross out item (2) above if you have been notified by the IRS that you are subject to backup withholding because of underreporting interest or dividends on your tax return. However, if after being notified by the IRS that you were subject to backup withholding you received another notification from the IRS that you are no longer subject to backup withholding, do not cross out item (2).

Claimant signature **X**	Relationship to insured	Date signed (MM/DD/YYYY)	
Claimant address (no. and street)	City	State	ZIP code

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

Witness **X**	Date signed (MM/DD/YYYY)
Employee signature **X**	Date signed (MM/DD/YYYY)

Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false or misleading information may be subject to criminal penalties.

FOR USE BY ANTHEM BLUE CROSS LIFE ONLY

Examiner	Claim no.	Total – Benefit and Interest	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.

Living Benefit Claim Form
Disclosure Statement

Any Living Benefit paid to you may be taxable. If so, you may incur a tax obligation. You should seek assistance from a qualified tax advisor prior to your receipt of this benefit.

Receipt of any Living Benefit may affect your eligibility for public assistance programs such as medical assistance (Medicaid), aid to families with dependent children, and supplemental security income. Prior to your receipt of any Living Benefit you should consult with the appropriate social services agency concerning how receipt of this benefit will affect your and/or your family's eligibility for these programs.

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

EFFECT OF PAYMENT OF PERSONAL ACCELERATED DEATH BENEFIT ON YOUR REMAINING PERSONAL LIFE INSURANCE AND SUPPLEMENTAL LIFE INSURANCE BENEFITS	
$	Your (combined amount of personal life insurance and supplemental life insurance) Benefit prior to payment of your Living Benefit
– $	Minus your Living Benefit
$	Your (combined amount of personal life insurance and supplemental life insurance) Benefit remaining after payment of your Living Benefit

This Living Benefit is not a long-term care policy or a nursing home insurance policy. The amount this benefit pays you may not be enough to cover your medical, nursing home, or other bills. You may use your Living Benefit for any purpose.

I, (name) _____, acknowledge that I have made application for this benefit of my own free will, and without coercion of a third party.

Applicant signature **X**	Date signed (MM/DD/YYYY)

I, (name of spouse)_____, acknowledge that I have made application for this benefit of my own free will, and without coercion of a third party.

Spouse signature **X**	Date signed (MM/DD/YYYY)
Notary public signature **X**	Date signed (MM/DD/YYYY)

Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false or misleading information may be subject to criminal penalties.

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.

Living Benefit Claim Form
Attending Physician's Statement

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

Patient name		Date of birth (MM/DD/YYYY)	
Address (no. and street)	City	State	ZIP code
Patient employer Southern California IBEW-NECA Health Trust Fund		Social Security No.	

ATTENDING PHYSICIAN'S 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. If no. 4 is not completed in full, claim processing will be delayed.

1	DIAGNOSIS:		
2	a. Subjective symptoms		
	b. Objective findings: Include results of current x-rays, EKGs or any other special tests relevant to your judgment of prognosis.		
	c. Is patient: ☐ Ambulatory ☐ Bed confined ☐ House confined ☐ Hospital confined		
3	TREATMENT:	Date of first visit for above condition	Date of most recent visit
4	PROGNOSIS: "In my best medical judgment, the above patient's life expectancy is _____ months or less, or not more than _____ months."		
5	MENTAL CONDITION: Is the patient competent to endorse checks and direct the proceeds thereof? ☐ Yes ☐ No		

REMARKS

Attending physician name		Degree	
Address (no. and street)	City	State	ZIP code
Attending physician signature **X**		Date signed (MM/DD/YYYY)	

Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false or misleading information may be subject to criminal penalties.

TO THE ATTENDING PHYSICIAN:

Please mail or fax this report directly to the **Life Claims Service Center** (see above).

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.