

LIFE AND DISABILITY CLAIMS Employer manual



The contents of this manual should not be considered legal advice or recommendations. You should work with your company's attorney when interpreting your company's legal responsibility under your employee life and disability plan(s). You should also review applicable state and federal laws and regulations. The contents of this manual may change or be updated at any time.

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Introduction

You, your employees, and your broker/administrator can submit claims online, by phone, or by mail, email, or fax. Online submission is the fastest way to get a claim started. Each claim type will give you information to file a claim online and by mail, email, and fax.

Our easy system lets you enter all the information we need to start your life or disability claim. Go to <u>https://myspecialtyappsanthem.com/Claims/UC</u> and follow the simple steps to submit a claim. The system will guide you through all information needed to get started on a claim. This manual is an additional resource, offering step-by-step instructions to file claims and access your claims reports.

You will be prompted to print all forms needed while you're submitting the claim. You can upload completed forms and other supporting documents while you're submitting the claim online. Make sure all forms are filled out in full.

Missing or incomplete information can delay processing.

Once you submit the claim, you'll receive a reference number. If you give us your email address, you will also receive a confirmation email. Be sure to keep the claim reference number handy – we can help you faster if you have it when you call us with questions.

For assistance while using the online claim system, call 1-800-813-5682 Monday through Friday between 8:30 a.m. and 5:00 p.m. Eastern Time.

Help with life and disability claims

If you have questions with claims, call us:

For life claims, 1-800-552-2137.

For disability claims, 1-800-813-5682, or call your group's Case Manager.

Note for FML Administration clients: FML claims and associated STD claims cannot be submitted by the online claim portal described in this booklet. Employees must call our Leave Management Service Center at 1-888-868-7046 to start a claim.

Register to receive life and disability claims reports

You will access claims reports via the online portal. In order to access reports, you must first submit the Online Claims Reporting/Status Check Application Registration Form. Due to the PHI and PII that claims reporting and status check access affords, an Officer of the Company must sign the form.

We will provide you with a user ID and password for the secure claim reporting portal.

If you have more than one administrator who needs to use the claims reporting portal, just complete the information for all users on the Claims Reporting/Status Check Application Registration Form. Each will receive a user ID and password.

If you want your third party administrator (TPA) to have access to the secure claims reports portal, list the TPA as an authorized user on the form. We will confirm the TPA with you and send them a user ID and password.

You may have already completed this form during your implementation process with UniCare. If you did not, download the form at https://www.anthem.com/docs/public/inline/eleepuseragreement.pdf and complete, sign, and submit it to

dl-socerreporting@anthem.com.

If you have questions or forget your user ID or password, email us at dl-socerreporting@anthem.com or call us at

1-800-232-0113 ext. 4044798627. We will be happy to email your user ID to you and reset your password.

The claims reports site is protected with Computer Associates SiteMinder, an industry standard security framework. A user cannot access any secured pages on the site until they are logged in with a user ID and password. Benefit

administrators can securely change their password and manage their profile. We provide a password to each benefit administrator for their initial login. They must then change their password.

If an invalid password is entered three times, the user account is locked out. Email us at

dl-socerreporting@anthem.com or call 1-800-232-0113 ext. 4044798627 to have it reset.

Getting started – submit claims online

To submit life and disability claims online, go to https://myspecialtyappsanthem.com/Claims/UC.

Select the type of claim you want to submit on the Welcome screen. Your choices are:

- Life
- Accidental dismemberment
- Living benefit
- Life waiver of premium
- Short-term disability note for FML Administration clients: FML claims, and associated STD claims cannot be submitted by the online claim portal described in this booklet. Employees must call our Leave Management Service Center at 1-888-868-7046 to start a claim.
- Long-term disability

Fields marked with an asterisk (*) are required.

the characters from the picture:	\square
Change Words	
Audio Version	
A Audio Version	
	Next
<u>g Claim</u>	

Submitting a life insurance claim

Submitting a life insurance claim online

To submit life insurance claims online, go to <u>https://myspecialtyappsanthem.com/Claims/UC</u>. Select Life in the *Type of Claim* field, then select whether you're submitting a claim for an employee or a dependent. In the *Type of User* field, select Employer. Enter the characters you see in the box, then click *Next*.

lds marked with an asteri	sk (*) are required	
* Type of Claim:	Life	~
Is this claim for a	an Employee or Dependent?	○ Employee ○ Dependent
Type of User:	Employer ~	
 Please retype the char 	acters from the picture:	
TCS	Change Words	
TC5X	Audio Version	

You can print the *Beneficiary Claim Form* we'll need to process the claim from this screen. Select the *Beneficiary Claim Form* link to get a fillable PDF of the form. Click *Continue*.

Additional Information	×
In addition to the information you will enter online, a <u>Beneficiary Claim Form</u> is req for a Life claim. If you don't have this completed form, you can print or download it clicking on the link. If there is more than one beneficiary, each one must complete own form.	uired t by their
If it's possible to have the form completed now, you can upload it at the end of you online application. Otherwise, it can be completed later and sent to our claim office mail, fax or email.	ir by
If you have the enrollment form, beneficiary designation or death certificate now, y can also upload them at the end of your online application.	/ou
Cont	inue

Enter your contact information on the Employer Information screen. Click Next.

Claim Type User Details Claim Details Beneficiary Details Supporting Documents Review Confirmation			
Employer Information			
Fields marked with an asterisk (*)	are required		
∗ Company Name:	ABC Company		
Policy Number:	122233344		
∗ Your First Name:	John		
∗ Your Last Name:	Doe		
* Your Job Title:	HR Manager		
* Your Telephone Number:	111 222 - 3333		
Your Email Address:	ohn.doe@abc.com		
Cancel	Previous Next		

On the Employee Information screen, give us the information we need to begin processing the claim. Click Next.

▶ Claim Type ▶ User Detai	Claim Details Beneficiary Details Suppor	ting Documents > Review > Confirmation
Employee Information		
Fields marked with an asterisk (*) a	required	
* First Name:	Jim	
* Last Name:	Roe	
* Social Security Number:	111-22-2333	
Date Of Birth:	01/01/1970	
* Reason Stopped Work:	Death OIIIness / Disability O Leave	of Absence
	O Dismissed O Vacation O Tempo	rary Layoff
	○ Retired	
* Date Hired:	01/01/1990	
* Last Day Worked:	01/01/2022	
Date of Death:	01/02/2022	
Employee's Work Location or Division:	Headquarters	
Job Title:	Manager	
Amount of Insurance		
	Basic Life: \$50000.00	
Op	nal/Supp Life: \$50000.00	
Accidental Death and D	memberment: \$ 50000.00	
Supp Accidental Death and D	memberment: \$ 50000.00	
	Total: \$ 200000.00	
Cancel		Previous

If you have it, enter the beneficiary information here. Select Add Beneficiary for each beneficiary on file. Click Next.

Claim Type User Details Claim Details Beneficiary Details Supporting Documents Review Confirmation				
Beneficiary Informati	on			
Name:	Social Security Number/ Tax Id:	Age:	Relationship:	Actions:
Add Beneficiary				
Cancel				Previous Next

This is where you enter the beneficiary information. We'll also need a copy of the most recent *Employee Enrollment Form* or *Beneficiary Designation Form*. You can attach the beneficiary form later in the online claim process. Click *Add*.

Beneficiary Information		Ø
First Name	Jane	
Last Name	Roe	
Relationship	Spouse	
Age	50	
Please indicate whether you wish to supply tax id or a social security number?	◉ Social Security Number ○ Tax Id	
Social Security Number	222-33-4444	
Cancel		Add

On this screen, you can upload any additional forms and documents, such as the *Enrollment Form*, *Beneficiary Designation* Form, *Beneficiary Claim Form* and/or death certificate. Select Chose File to find them, then select Upload. Click Next.



Next you can review the information you've entered. You'll also need to agree to the legal statement. If you enter your email address, we'll send you an email confirmation of all the information you entered. You can also add any additional comments about the claim. Click *Submit*.

Claim Type User	Details > Claim Details > Beneficiary Details > Supporting Documents > Review > Confirmation
rieius markeu with an asterisk	(-) are reduired
Employer Informati	ion
Company Name:	ABC Company
Policy Number:	122233344
First Name:	John
Last Name:	Doe
Job Title:	HR Manager
Telephone Number:	111-222-3333
Email Address:	john.doe@abc.com
Employee Informat	ion
First Name:	Jim
Last Name:	K00
Social Security Numb	er: 111-22-2333:
Date Of Birth:	01/01/1970
Reason Stopped Work	k: Death
Date Hired:	01/01/1990
Last Day Worked:	01/01/2022
Date of Death:	01/02/2022
Employee's Work Loc Division:	ation or Headquarters
Job Title:	Manager
Amount of Insura	ince
Basic Life:	\$50,000.00
Optional/Supp Life:	\$50,000.00
Accidental Death and	\$50,000.00
Dismemberment: Supp Accidental Deat	h and \$50.000.00
Dismemberment: Total:	\$200.000.00
Total.	9200,000.00
Any person who knowing containing any false, The laws of some state Alaska: A person who k deceive an insurance o prosecuted under state Arizona: For your prot who knowingly presents civil penalties. Arkansas, Louisiana, a payment of a loss or b guilty of a crime and California: For your p statement to appear or false or fraudulent cl confinement in state c	<pre>Ily and with intent to defraud any insurance company, files a statement of claim incomplete, or misleading information may be subject to criminal penalties. is require us to provide you with the following information: nowingly and with intent to injure, defraud, or ompany files a claim containing false, incomplete,or misleading information may be law. ection Arizona law requires the following statement to appear on this form. Any person is a false or fraudulent claim for payment of a loss is subject to criminal and nd West Virginia: Any person who knowingly presents a false or fraudulent claim for enefit or knowingly presents false information in an application for insurance is may be subject to fines and confinement in prison. rotection californal aw requires the following to this form. Any person who knowingly presents a aim for payment of a loss is guilty of a crime and may be subject to fines and rison.</pre>
* 🗹 I acknowledge that I h	nave read and agree to the above statement
Additional Comments:	
Email Confirmation	
We can send you a copy	of this submission. Just enter your email address below and we will send you a confirmation to your email addresss.
	Canfirm Frank Address:
Our goal is to make your message confirming rec information we collect. V	on-line experience enjoyable and secure. If you choose to give us your email address, we will send you a secure email ipt of your online claim. Your privacy is very important to us and we will make every reasonable effort to safeguard any ke encourage you to review the privacy statement for our website.
Cancel	Previous Submit

Once the claim is complete, you'll get a confirmation summary showing all the information you entered, along with a claim reference number. You can use this number when checking the status of the claim or attaching additional documents. If you entered your email address on the previous screen, you'll also get an email confirmation summary.

m Confirmation Su	nmary		Print this
claim has been submitted	successfully.		
AIM REFERENCE NU	JMBER : 201049 - L	Ife Claim submit	ed by Employer
content in this confirma	tion page reflects what	t you entered.	
mployer information	n		
Company Name:	Test		
First Name:	joe		
Last Name:	test		
Job Title:	boss		
Telephone Number:	111-111-1111@		
mployee Information	n		
First Name:	test		
Last Name:	case		
Social Security	111-11-1111		
Telephone Number:	111-111-1111@		
mployee Information	n		
First Name:	test		
Last Name:	case		
Social Security Number:	111-11-1111		
Reason Stopped Work:	Death		
Date Hired:	01/01/1963		
Last Day Worked:	04/01/2013		
Beneficiary Informati	on		
Name:	Social Security Number/ Tax Id:	Age:	Relationship:
Joe Joens	112-22-2222	41	husband

Submitting a life insurance claim by mail, email, or fax

You can also file life insurance claims by mail, email, or fax:

- Download the *Life Beneficiary Claim Form* at <u>www.unicare.com</u>.
- Complete the *Group Policyholder's Statement* in full. Missing or incomplete information can delay processing.
- Remember to include a copy of the enrollment form or beneficiary designation form.
- Give the beneficiary the remaining pages of this package.

The beneficiary must complete the *Beneficiary Claim Form* in full and return it to you.

- If there is more than one beneficiary, each one must complete a separate form.
- If the beneficiary has a funeral home assignment, please have him or her include the assignment with the claim form.
- If the claim is being filed by an executor or administrator of an estate, he or she must sign the *Beneficiary Claim Form*, enter the estate's Tax ID number and include copies of the appointment papers.
- The beneficiary must submit a copy of the death certificate. Only one death certificate is needed. We can accept a photocopy of the certificate in most cases.
- Send the Group Policyholder's Statement, enrollment form/beneficiary designation, *Beneficiary Claim Form(s)* and death certificate to:

Life Claims Service Center P.O. Box 105448 Atlanta, GA 30348-5448

You may also fax everything to us at 1-877-305-3901 or send by email to <u>lifeclaims@anthem.com.</u>

Please call the Life Claims Service Center with any questions at 1-800-552-2137.

Life insurance benefit payments

For proceeds of less than \$10,000, we will mail a check to the beneficiary.

For proceeds of \$10,000 or more, beneficiaries can choose to receive a check or to have their proceeds deposited into an Access Advantage Account draft account. The beneficiary makes the choice on the *Beneficiary Claim Form*.

If a beneficiary chooses the Access Advantage Account, we mail to the beneficiary drafts after we approve the claim. This gives him or her access to the funds for immediate needs but relieves him or her of making important investment decisions during a time of stress. The account begins earning a competitive interest rate starting the day it is opened. Benefits payable to a beneficiary who is a minor child will automatically be paid into an Access Advantage Account.

Submitting an accidental dismemberment claim

As soon as you learn that an insured person suffered any loss covered under the accidental dismemberment benefit, you can initiate an accidental dismemberment claim.

Submitting an accidental dismemberment claim online

To submit accidental dismemberment insurance claims online, go to <u>https://myspecialtyappsanthem.com/Claims/UC</u>. Select Accidental Dismemberment in the *Type of Claim* field and choose Employer in the *Type of User* field. Then, enter the characters you see in the box and select Next.

Welcome to the Clai	ns Entry site. Please enter details below to submit your claim.	
Fields marked with an asteris	κ () are required	
* Type of Claim:	Accidental Dismemberment 🗸	
Is this claim for a	n Employee or Dependent?	
∗ Type of User:	Employer V	
* Please retype the chara	cters from the picture:	
DP8D	Change Words	
Attach file to existing Claim		Next

You can print the forms we need to process the accidental dismemberment claim from this screen. Select the links to get fillable PDFs of the *Employee's Statement* and *Attending Physician's Statement*. Click *Continue*.

Additional Information	×
In addition to the information you will enter online, the forms listed below are required to file an Accidental Dismemberment claim. If you don't have these completed forms, you can print or download them here:	l
 Employee's Statement Attending Physician's Statement 	
If it's possible to have the forms completed now, you can upload them at the end of your online application. Otherwise, they can be completed later and sent to our claim office by mail, fax or email.	
Continu	e "

Enter your contact information on the Employer Information screen. Click Next.

mployer Information		
ields marked with an asterisk (*	are required	
* Company Name:	ABC Company	
Policy Number:	122233344	
Your First Name:	John	
* Your Last Name:	Doe	
* Your Job Title:	HR Manager	
* Your Telephone Number:	111 222 - 3333	
Your Email Address:	iohn.doe@abc.com	

On the Employee Information screen, provide the information we need to begin processing the claim. Click Next.

Claim Type User D	Details 🄰 Claim Details 🐊 Supporting Documents 🍞 Review 🐊 Co	nfirmation
Employee Information	n	
Fields marked with an asterisk ((*) are required	
* First Name:	Jim	
* Last Name:	Doe	
 Social Security Number: 	111-22-2222	
* Street Address 1:	111 Main Street	
Street Address 2:		
∗ City:	Anytown	
∗ State:	IN ×Zip: 22222	
∗ Country:	United States of America	
★ Primary Telephone Number	ver: 111 222 - 1111	
Gender:	Male Female	
Date Of Birth:	01/01/1970	
∗ Date Hired:	01/01/1990	
Last Day Worked:	01/01/2022	
Employee's Work Location Division:	n or Headquarters	
Job Title:	Manager	
Amount of Benefit:	50000.00	
Accident Information		
Date of Injury:	01/02/2022	
Place of Accident:	Home	
Briefly describe the accident and the extent of the injury:	Slipped on ice. Severed left hand.	
Attending Physician First Name:	Bill	
Attending Physician Last Name:	Billing	
Telephone number of Attending Physician:	222 333 - 4444	
Cancel		Previous Next

If you already have completed forms, you can scan and upload them on this screen. For example, if you have the *Employee's Statement* or *Attending Physician's Statement*, you can scan and attach them here. Click *Next*.

Claim Type 🕽 User Details 🔰 Claim Details 🍃 Beneficiary Details 🍃 Supporting Documents 🔊 Review	Confirmation
Please upload any relevant documents for this claim	
Please click here to access the available forms.	
Choose File No file chosen	
Cancel	Previous Next

Next, you'll get confirmation of the information you entered and you'll agree to the legal statement so we can beginprocessing the claim. You can also enter your email address and we'll send you confirmation of all the information you entered. Click *Submit*.

tus marked with an asterisk	Claim Type >User Details > Claim Details > Beneficiary Details > Supporting Documents > Review > Confi elds marked with an asterisk (*) are required		
Employer Informatio	n		
Company Name:	Test		
First Name:	joe		
Last Name:	test		
Job Title:	boss		
Telephone Number:	111-111 <mark>-1111</mark> @		
Employee Informatio	'n		
First Name:	test		
Last Name:	case		
Social Security Number:	111-11-1111		
Reason Stopped Work:	Death		
faire os fraudailons claurs confinement in estas prinor colorado: To is unlawful to os an insurance company for o an insurance company for a l acknowledge that I hav Additional Comments:	for payment of a loss is guilty of a crime and may be subject to fines and b howingly provide false. incomplete. or misleading facts or information t the purpose of defraulty or attempting to defraud the company. We read and agree to the above statement		
	*		
Entan Commation	of this submission. Just enter your email address below and we will send you		
We can send you a copy a confirmation to your em	ail addresss.		
We can send you a copy a confirmation to your em	iil Address.		
We can send you a copy a confirmation to your em Ema Coni	ail addresss. ail Address. firm Ermail ress.		

You'll receive a confirmation summary showing all the information you entered. If you entered your email address on the previous screen, you'll also get a confirmation summary by email.

Claim Type 💙 User Details	Claim Details > Suppo	orting Documents > Review > 0	onfirmation	
im Confirmation Su	mmary		Print this page	
claim has been submitted	successfully.			
AIM REFERENCE N poloyer content in this confirma	JMBER : 201091 - ,	Accidental Dismemberm at you entered.	ent Claim submitted by	
Employer Informatio	n	100		
Company Name:	test			
Policy Number:	test			
First Name:	test			
Last Name:	test			
Job Title:	test			
Telephone Number:	111-111-1111@	Employee Informatio	n	
		First Name:	test	
		Last Name:	test	
		Social Security Number:	111-11-1111	
		Address 1:	test	
		City:	test	
		State:	AL	
		Zip:	22222	
		Country:	United States of America	1
		Primary Telephone Number:	111-111-1111@	

Our Customer Service number is 800-552-2137 and we are available 8:00 AM to 8:00 PM Eastern Time. You may also leave a message if you call outside of our regular hours.

Submitting an accidental dismemberment claim by mail, email, or fax

To file an accidental dismemberment claim by mail, email, or fax, as soon as you learn that an insured person suffered any loss covered under the accidental dismemberment benefit, complete the *Employer Statement* section of the *Accidental Dismemberment or Loss of Sight Claim Form*. Give the form to the insured person to fill out. His or her doctor must also complete the *Proof of Accidental Dismemberment Attending Physician's Statement*. Benefits are paid by check directly to the employee.

Send us:

- The completed Accidental Dismemberment or Loss of Sight Claim Form.
- Accidental Dismemberment AttendingPhysician's Statement.
- Employee's enrollment form.
- All available newspaper clippings pertaining to the injury and loss, and a police report, if available.

Send all information to:

Life Claims Service Center P.O. Box 105448 Atlanta, GA 30348-5448

You may also fax everything to us at 1-877-305-3901 or by email to <u>lifeclaims@anthem.com</u>. Please call the Life Claims Service Center at 1-800-813-5682 with any questions.

Submitting a living benefit/accelerated death benefit claim

Submitting a living benefit/accelerated death benefit claim online

To submit claims online, go to <u>https://myspecialtyappsanthem.com/Claims/UC</u>. Select Living Benefit in the *Type of Claim* field and select Employer in the *Type of User* field. Then, enter the charactersyou see in the box and click *Next*.

▶ Claim Type ▶ User	r Details 🏷 Claim Details 🏷 Supporting Documents 🏷 Review 🏷 Confirmation	
Velcome to the Clai	ims Entry site. Please enter details below to submit your claim.	
∗Type of Claim:	Living Benefit 🗸	
* Type of User:	Employer 🗸	
* Please retype the char	acters from the picture:	
NR4	Change Words	
tach file to existing Claim		Ne
ttach file to existing Claim		

You can print the forms we need to process the living benefit claim from this screen. Select the links to get fillable PDFs of the forms:

- Employee's Statement
- Attending Physician's Statement
- Disclosure Statement

Click Continue.

Additional Information
In addition to the information you will enter online, the forms listed below are required to file a Living Benefit claim. If you don't have these completed forms, you can print or download them here:
Employee's Statement Attending Physician's Statement Disclosure Statement
If it's possible to have the forms completed now, you can upload them at the end of your online application. Otherwise, they can be completed later and sent to our claim office by mail, fax or email.
Continue

Enter your contact information on the Employer Information screen. Click Next.

mployer Information		
ields marked with an asterisk (*	are required	
* Company Name:	ABC Company	
Policy Number:	122233344	
* Your First Name:	John	
* Your Last Name:	Doe	
* Your Job Title:	HR Manager	
* Your Telephone Number:	111 222 - 3333	
Your Email Address:	john.doe@abc.com	

On the Employee Information screen, provide the information we need to begin processing the claim. Click Next.

ds marked with an asterisk (*) a	re required
First Name:	John
Last Name:	Doe
Social Security Number:	111-11-1111
Address 1:	123 Main Street
Address 2:	
City:	Anytown
State:	IN • Zip: 22222
Country:	United States of America
Primary Telephone Number:	111 222 - 2222
Date Of Birth:	01/01/1970
Gender:	Male Female
Date Hired:	01/01/1990
Last Day Worked:	01/01/2022
Employee's Work Location or Division:	Headquarters
Job Title:	Manager
Amount of Insurance:	\$ [50000.00]

If you have completed forms, you can scan them and upload them on this screen. For example, if you have the *Employee's Statement*, the *Attending Physician's Statement* and/or the *Disclosure Statement*, you can scan and attach them here. Click *Next*.

Claim Type > User Details > Claim Details > Beneficiary Details > Supporting Documents > Review	Confirmation
Please upload any relevant documents for this claim	
Please click here to access the available forms.	
Choose File No file chosen	
Cancel	Previous Next

Next, you'll get confirmation of the information you entered and you'll agree to the legal statement so we can begin processing the claim. You can also enter your email address and we'll send you confirmation of all the information you entered. Click *Submit*.

.tarked with an asterisk (*) are req	luired	
ployer Information		
Company Name:	ABC Company	
Policy Number:	12345678	
ïrst Name:	Jim	
ast Name:	Roe	
ob Title:	HR Manager	
ephone Number:	111-222-3333	
mail Address:	jim.roe@abc.com	
loyee Information		
irst Name:	John	
ast Name:	Doe	
ocial Security Number:	222-22-2222:	
idress 1:	123 Main Street	
ty:	Anytown	Read and Acknowledge
ate:	IN	Fields marked with an asterisk (*) are required
p:	22222	Any person who knowingly and with intent to defraud any insurance company, files a statement of claim
ountry:	United States of America	containing any false, incomplete, or misleading information may be subject to criminal penalties. The laws of some states require us to provide you with the following information:
imary Telephone Number:	222-222-1111	Alaska: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete,or misleading information may be
ate Of Birth:	01/01/1970	prosecuted under state law. Arizona: For your protection Arizona law requires the following statement to appear on this form. Any person
ender:	Male	who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.
ate Hired:	01/01/1990	Arkansas, Louisiana, and West Virginia: 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
st Day Worked:	01/01/2022	guilty of a crime and may be subject to fines and confinement in prison. California: For your protection California law requires the following
mployee's Work Location or ivision:	Headquarters	statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.
b Title:	Manager	* 🗹 I acknowledge that I have read and agree to the above statement
mount of Insurance:	\$50,000.00	Additional Comments:
		Email Confirmation
		We can send you a copy of this submission. Just enter your email address below and we will send you a confirmation to your email address: Email Address: Im.roe@abc.com Confirm Email Address: Im.roe@abc.com Our goal is to make your on-line experience enjoyable and secure. If you choose to give us your email address, we will send you a secu message confirming receipt of your onine calm. Your privacy is very important to us and we will make every reasonable effort to safegu information we collect. We encourage you to review the privacy statement for our webste.
		We can send you a copy of this submission. Just enter your email address below and we will send you a confirmation to your en Email Address: [im.roe@abc.com] Confirm Email Address: [im.roe@abc.com] Our goal is to make your on-line experience enjoyable and secure. If you choose to give us your email address, we will send yo message confirming receipt of your online claim. Your privacy is very important to us and we will make every reasonable effort t information we collect. We encourage you to review the privacy statement for our website.

Once the claim is complete, you'll receive a confirmation summary showing all the information you entered. If you entered your email address on the previous screen, you'll also get a confirmation summary by email.

im Confirmation Su	mmany	Print this par
claim has been submitted	successfully	i init una pa
	IMPED: 201110 Living Deposit C	laim aubmitted by Employer
	JMBER . 201119 - Living Benefic C	tain submitted by Employer
content in this confirma	tion page reflects what you entered.	
mployer Informatio	n	
Company Name:	test	
First Name:	test	
Last Name:	test	
Job Title:	test	
Telephone Number:	111-111-1111@	
First Name:	test	
Last Name:	test	
Social Security Number:	222-22-2222	
Address 1:	test	
City:	test	
State:	NE	
Zip:	11111	
Country:	United States of America	
Primary Telephone	111-111 <mark>-</mark> 1111@	
Number:	01/01/2000	
Number: Date Hired:		

im Confirmation Su	nmary	Print this page
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First Name:	test	
Last Name:	test	
Job Title:	test	
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Employee Informatio	'n	
First Name:	test	
Last Name:	test	
Social Security Number:	222-22-2222	
Address 1:	test	
City:	test	
State:	NE	
Zip:	11111	
Country:	United States of America	
Primary Telephone Number:	111-111 <mark>-</mark> 1111@	
Date Hired:	01/01/2000	

Submitting a living benefit/accelerated death benefit claim by mail, email, or fax

To file claims by mail, download the *Living Benefit Claim Form* at <u>www.unicare.com</u>. Complete the employer section then have the employee and the employee's physician complete their sections. Send all forms to:

Life Claims Service Center P.O. Box 105448 Atlanta, GA 30348-5448

You may also fax everything to us at 1-877-305-3901 or send by email to lifeclaims@anthem.com.

Please call the Life Claims Service Center at 1-800-813-5682 with any questions.

Submitting a life waiver of premium claim

Submitting a life waiver of premium claim online

To submit claims online, go to <u>https://myspecialtyappsanthem.com/Claims/UC</u>. Select Life Waiver of Premium in the *Type of Claim* field and Employer in the *Type of User* field. Enter the characters you see in the bottom box, then click *Next*.

➤ Claim Type >> User Velcome to the Clair	Details > Claim Details > Supporting Documents > Review > Confirmation
elds marked with an asteri	sk (*) are required
* Type of Claim:	Life Waiver of Premium
* Type of User:	Employer 🗸
* Please retype the char	acters from the picture:
<u>IKEEK</u> KBK4	Change Words
ach file to existing Claim	1

You can print the forms we need to process the life waiver of premium claim from this screen. Select the links to get fillable PDFs of the *Life Waiver of Premium Employee's Statement* and the *Life Waiver of Premium Attending Physician's Statement*. Click *Continue*.

Additional Information	×
In addition to the information you will enter online, the forms listed below are required for a Life Waiver of Premium claim. If you don't have these completed forms, you can print or download them here:	I
 Life Waiver of Premium Employee's Statement Life Waiver of Premium Attending Physician's Statement 	
If it's possible to have the forms completed now, you can upload them at the end of your online application. Otherwise, they can be completed later and sent to our claim office by mail, fax or email.	
We will also need a copy of the enrollment form or beneficiary designation. If you have it now, you can also upload it at the end of your online application. Otherwise, it can be sent to our claim office by mail, fax or email.	e
Continu	e

Enter your contact information on the Employer Information screen. Click Next.

▶ Claim Type ▶ User Det	ails 》Claim Details 》Beneficiary Details 》Supporting Documents 》Review 》Confirmation
Employer Information	
Fields marked with an asterisk (*) are required
* Company Name:	ABC Company
Policy Number:	122233344
* Your First Name:	John
* Your Last Name:	Doe
* Your Job Title:	HR Manager
* Your Telephone Number:	111 222 - 3333
Your Email Address:	john.doe@abc.com
Cancel	Previous Ne

On the *Employee Information* screen, provide the information we need to begin processing the life waiver of premium claim. Click *Next*.

Employee Information	
Fields marked with an asterisk (*) a	re required
• First Name:	John
• Last Name:	Doe
- Social Security Number:	123-33-4444
• Address 1:	123 Main Street
Address 2:	
- City:	Anytown
- State:	IN Zip: 22222
Country:	United States of America
Date Of Birth:	01/01/1970
Date Hired:	01/01/1990
Rate of Pay:	20.00 Per Hourly V
Employee's Work Location or Division:	Headquarters
• Job Title:	Manager
• Last Day Worked:	01/01/2022
- Reason Stopped Work:	Illness / Disability O Leave of Absence O Dismissed
	O Vacation O Temporary Layoff O Retired
Does your company have a formal pension plan?	®Yes ○No
Will Employee be able to retire under this plan?	⊖Yes ® No
Please provide normal retirement date:	
Amount of Insurance	
	Basic Life: \$ 50000.00
Op	tional/Supp Life: \$ \$0000.00
	Total: \$ 100000.00

If you have completed forms at the time you enter the claim, you can scan them and upload them on this screen. For example, if you have the *Life Waiver of Premium Employee's Statement* or the *Life Waiver of Premium Attending Physician's Statement*, you can scan and attach them here. Click *Next*.

Claim Type Viser Details Claim Details Beneficiary Details Supporting Documents Review	Confirmation
Please upload any relevant documents for this claim	
Please click here to access the available forms.	
Choose File No file chosen	
Cancel	Previous Next

Next, you'll get confirmation of the information you entered and you'll agree to the legal statement so we can begin processing the claim. You can also enter your email address and we'll send you confirmation of all the information you entered. Click *Submit*.

Company Name: ABD Company Prisk Name: 1246073 First Name: Res Last Name: HR Manager Telephone Number: 1122-23-333 Email Address: jm:ree@abc.com ployee Information		
Pair Number: 1248073 First Name: Jon Last Name: 114222.3333 Tead Address: jun re@bab com popper Information	Company Name:	ABC Company
First Lass Name: Jam Lass Name: Nee Sol Tak: Hi Managar Takephone Number: 111-222-3333 Email Address: Jam / Lass Name: ployge Information Interce globe com First Name: Joh Lass Name: De Social Security Number: 123-32-4444 Address I: 120-32-4444 Address I: 10101070 Basel Rei Pro; 100101072 Basel Rei Pro; 10010202 Basen Stoged Work: 10050020 Doponellouge Life: 10000000 Doponelouge Life:	Policy Number:	12345678
Last Name: Res Job Tite: HPI Marager Tabphone Number: HI222.333 Enail Address: jmi.re@@abc.com Ployce Information	First Name:	Jim
Job Ten: HP Managar Tabaphone Number: 111-222-2333 Email Address: jm roe@abc.com ployee Information	Last Name:	Roe
Teappone Number: 111-222-3333 Email Address: jmin real@abc.com Ployee Information First Name: Joh Lext Name: Doe Statal Sacurity Number: 123-33-4444. Address 1: 123 Man Street City: Anytown State IN Zip: 2222 Country: United States of America Date Of Brin: 0101/1970 Date of Brin: 0101/1970 Date Here: 0101/1970 Date Here: 0101/1970 Date Here: 0101/1970 Date Street: Non- Date Street: 0101/1970 Date Street: 01001/1970 Date Street: 01001/1970 Date Street: 01001/1970 Date Street: 01001/1970 Date Street: 01001/197	Job Title:	HR Manager
Email Address : jm.ree@abc.com ployce Information First Name: John Last Name: De Social Security Number: 123-34-444 . Com Social Security Number: 123-34-34 . Social Security Nu	Telephone Number:	111-222-3333
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Reason Stopped Work: Illness / Disability Does your company have a Yes mail pension plan? Will Employee be able to No retire under this plan? Amount of Insurance Basic Life: \$50,000.00 Optional/Supp Life: \$50,000.00 Total: \$100,000.00 ead and Acknowledge ds marked with an asterisk (*) are required r person who knowingly and with intent to defraud any insurance company, files a statement of claim taining any false, incorplete, or misleading information may be subject to crisinal penalties. I have of some states require us to provide you with the following information: sharked with an asterisk (*) are required r person who knowingly and with intent to defraud any insurance company, files a statement of claim taining any false, incorplete, or misleading information may be subject to crisinal penalties. I have of some states require us to provide you with the following information: sharked with an asterisk (*) are required r person who knowingly and with intent to injure, defraud, or tive an insurance company files a claim containing false, incomplete, or misleading information: shark a person who knowingly and with intent to following information: shark a person who knowingly and with intent to injure, defraud, or tive an insurance company files a claim containing false, incomplete, or misleading information may be isons? (or your protection fraudulent claim for payment of a loss is subject to crisinal and il penalties. ansas, louisinan, and kert Virginia: Any person sho knowingly presents a false or fraudulent claim for maune is if yor a crise and may be subject to fines and confinement in prison. if or your protection California law requires the following informate ention. if or a loss or benefit or knowingly presents a false information in an application for insurance is if yor a crise and may be subject to fines and if address:	Last Day Worked:	01/01/2022
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Basic Life: S50,000.00 Optional/Supp Life: S50,000.00 Tota: S100,000.00 eada and Acknowledge ds marked with an asterisk (*) are required read and Acknowledge ds marked with an asterisk (*) are required read and Acknowledge and the following information may be subject to criminal penalties. I have of score states required use to provide you with the following information: ska: A person who knowingly and with intent to injure, defraud, or eive an insurance company files a claim containing false, incomplete, or misleading information may be secuted under state law. Locan: For your protection Arizona law requires the following statement to appear on this form. Any person k nowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and if penalties. ansas, Louisiana, and West Virginia: Any person who knowingly presents a false or fraudulent claim for ison or beneditor. I act and may be subject to false and confinement in prison. If or a crime and may be subject to false and confinement in prison. If or a crime and may be subject to false sing guilty of a crime and may be subject to fines and finement in state prison. I acknowledge that have read and agree to the above statement dditional Comments:	Amount of Insurance	
Optional/Supp Life: \$50,000.00 Total: \$100,000.00 ead and Acknowledge ds marked with an asterisk (*) are required r person who knowingly and with intent to defraud any insurance company, files a statement of claim taining any false, incomplete, or misleading information may be subject to criminal penalties. shaws of some states require us to provide you with the following information: saks of some states requires scive an insurance company files a claim containing false, incomplete, or misleading information may be subject to criminal and in penalties. zona: 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 marter of a loss or benefit or knowingly preson who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and consingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and consingly presents a last or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and may be subject to fines and consingly presents a last or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and finement in the preson. al acknowledge that I have	Basic Life:	\$50,000.00
Tetai: S100,000.00 edu and Acknowledge ds marked with an asterisk (*) are required r person who knowingly and with intent to defraud any insurance company, files a statement of claim training any false, incomplete, or misleading information may be subject to criminal penalties. base of some states require us to provide you with the following information: uska: A person who knowingly and with intent to injure, defraud, or secured under state law. cona: For your protection Arizona law requires the following statement to appear on this form. Any person invent of a loss or benefit or knowingly presents a false or fraudulent claim for ment of a loss or benefit or knowingly presents false information in an application for insurance is lifernal: For your protection California law requires the following timement of a loss or benefit or knowingly presents false information in an application for insurance is lifernal: For your protection California law requires the following timement of a loss or benefit or knowingly preson who knowingly presents a false or fraudulent claim for ment of a loss or benefit or knowingly preson who knowingly presents a lifernal: For your protection California law requires the following timement to appear on this form. Any person who knowingly presents a lifernal for your protection california law requires the following tate or preson the knowingly present a lifernal for payment of a loss is guilty of a crime and may be subject to fines and difuement in state or prison. I acknowledge that I have read and agree to the above statement dettional Comments:	Optional/Supp Life:	\$50,000.00
ead and Acknowledge ds marked with an asterisk (*) are required / person who knowingly and with intent to defraud any insurance company, files a statement of claim tains of some states require us to provide you with the following information: saka a for some who knowingly and with intent to injure, defraud, or relve an insurance company files a claim containing false, incomplete, or misleading information may be subject to criminal and vil penalties. saka of some protection Arizona law requires the following statement to appear on this form. Any person by knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and vil penalties. cansas, Louisiana, and West Virginia: Any person who knowingly presents a false or fraudulent claim for more to allos or benefit or knowingly presents false information in an application for insurance is lify of a crime and may be subject to fines and confinement in prison. attent of a papear on this form. Any person who knowingly presents a false or fraudulent claim for more of a loss is guilty of a crime and may be subject to fines and finement in a tate prison. at acknowledge that I have read and agree to the above statement dditional Comments: mail Confirmation Ke can send you a copy of this submission. Just enter your email address below and we will send you a confirmation to your email a more galo.com Confirm Email Address: [m.roe@abc.com] Confirm Email Address: [m.roe@abc.com] Confirm	Total:	\$100,000.00
ds marked with an asterisk (*) are required / person who knowingly and with intent to defraud any insurance company, files a statement of Claim tining any false, incomplete, or mileading information may be subject to criminal penalties. a laws of some states require us to provide you with the following information: stat: A person who knowingly and with intent to injure, defraud, or retive an insurance company files a claim containing false, incomplete, or misleading information may be sociated under state law. izona: For your protection Arizona law requires the following statement to appear on this form. Any person b knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and if penalties. cansas, Louisiana, and West Virginia: Any person who knowingly presents a false or fraudulent claim for ment of a loss or benefit or knowingly presents false information in an application for insurance is lify of a crime and may be subject to fines and confineent in prison. Lifornia: for your protection California law requires the following teement to appear on this form. Any person who knowingly presents a les or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and finement in state orison. I acknowledge that I have read and agree to the above statement dditional Comments:	ead and Acknowledge	
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It a lake will subtrain the state will send you a confirmation to your email address below and we will send you a confirmation to your email address: Confirm Email Address: Confirm Email Address: Im.re@abc.com Dur goal is to make your on-line experience enjoyable and secure. If you choose to give us your email address, we will send you a set for the statement of your online claim. Your privacy is very important to us and we will make every reasonable effort to safe formation we collect. We encourage you to review the privacy statement for our website.	y person who knowley and training any false, incompl a laws of some states requi saks: A person who knowingl ceive an insurance company soccuted under state law. izona: For your protection o knowingly presents a fals vil penalties. Kansas, Louisiana, and West yment of a loss or benefit lifornia: For your protecti lifornia: For your protecti life or fraudulent claim for	Alth intent to derivate any insurante company, files a statement of claim tee, or mileading information may be subject to criminal penalties. re us to provide you with the following information: y and with intent to injure, defraud, or files a claim containing false, incomplete, or misleading information may be Arizona law requires the following statement to appear on this form. Any person or fraudulent claim for payment of a loss is subject to criminal and Virginia: Any person who knowingly presents a false or fraudulent claim for or knowingly presents false information in an application for insurance is subject to fines and confinement in prison. on California law requires the following orm. Any person who knowingly presents a payment of a loss is guilty of a crime and may be subject to fines and
dditional Comments: mail Confirmation We can send you a copy of this submission. Just enter your email address below and we will send you a confirmation to your email a Email Address: Confirm Email Address: Jur goal is to make your on-line experience enjoyable and secure. If you choose to give us your email address, we will send you a se message confirming receipt of your online claim. Your privacy is very important to us and we will make every reasonable effort to safe formation we collect. We encourage you to review the privacy statement for our website.	I acknowledge that I have read	and agree to the above statement
mail Confirmation We can send you a copy of this submission. Just enter your email address below and we will send you a confirmation to your email a Email Address: Confirm Email Address: Jim.roe@abo.com Dur goal is to make your on-line experience enjoyable and secure. If you choose to give us your email address, we will send you a se message confirming receipt of your online claim. Your privacy is very important to us and we will make every reasonable effort to safe formation we collect. We encourage you to review the privacy statement for our website.	dditional Comments:	
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We can send you a copy of this submission. Just enter your email address below and we will send you a confirmation to your email a Email Address: Confirm Email Address: Jim.roe@abc.com Dur goal is to make your on-line experience enjoyable and secure. If you choose to give us your email address, we will send you a s message confirming receipt of your online claim. Your privacy is very important to us and we will make every reasonable effort to safe formation we collect. We encourage you to review the privacy statement for our website.	mail Confirmation	
Email Address: [im.re@abc.com] Confirm Email Address: [im.re@abc.com] Dur goal is to make your on-line experience enjoyable and secure. If you choose to give us your email address, we will send you a sessage confirming receipt of your online claim. Your privacy is very important to us and we will make every reasonable effort to safe formation we collect. We encourage you to review the privacy statement for our website.	Ne can send you a copy of this s	ubmission. Just enter your email address below and we will send you a confirmation to your email addresss
Confirm Email Address: [jim.roe@sbc.com] Dur goal is to make your on-line experience enjoyable and secure. If you choose to give us your email address, we will send you a sine sagge confirming receipt of your online claim. Your privacy is very important to us and we will make every reasonable effort to sak information we collect. We encourage you to review the privacy statement for our website.	Email	Address: jim.roe@abc.com
Our goal is to make your on-line experience enjoyable and secure. If you choose to give us your email address, we will send you a s message confirming receipt of your online claim. Your privacy is very important to us and we will make every reasonable effort to sak nformation we collect. We encourage you to review the privacy statement for our website.	Confirm	n Email Address: jim.roe@abc.com
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Once the claim is complete, you'll get a confirmation summary showing all the information you entered. If you provided an email address on the previous screen, you'll also get a confirmation summary by email.

laim Type 💙 User Details 🕽	Claim Details > Supporting Documents > Revie	w Confirmation
im Confirmation S	ummary	Print thi
claim has been submitted	successfully.	
AIM REFERENCE NU ployer	IMBER : 201207 - Life Walver of Pre	mium Claim submitted b
mployer Informati	on	
Company Name:	ABC CO	
First Name:	oL	
Last Name:	Smith	
Job Title:	Manager	
Job Title: Telephone Number: mployee Informati	Manager 111-222-3333@	
Job Title: Telephone Number: mployee Informati	Manager 111-222-3333@	
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Submitting a life waiver of premium claim by mail, email, or fax

To file claims by mail, download the *LIFE WAIVER CLAIM FORM* at www.unicare.com. Complete the employer section, and then have the employee and the employee's physician complete their sections. Send all completed forms within 12 months of the date of disability to:

Life Claims Service Center P.O. Box 105448 Atlanta, GA 30348-5448

You may also fax everything to us at 1-877-305-3901 or send an email to lifeclaims@anthem.com. Please call the Life Claims Service Center at 1-800-813-5682 with any questions.

Submitting a short-term disability claim

For customers with administrative services only (ASO) disability plans, some of this information may not apply. Refer to your ASO Agreement for specific claim information.

For customers with FML Administration and/or New York DBL PFL Administration, this section does not apply. See your Leave Claims Manual for instructions on how to file claims for both Leave and Short Term Disability.

Submitting short-term disability claims by phone

Employees can call us at 1-800-232-0113 to initiate their short-term disability claim.

Submitting short-term disability claims online

To submit claims online, go to <u>https://myspecialtyappsanthem.com/Claims/UC</u>. Select Short-Term Disability in the *Type of Claim* field and Employer in the *Type of User* field. Enter the characters you see in the bottom box, then click *Next*.

is marked with an astern	sk (*) are required	
Type of Claim:	Short Term Disability 🗸	
Type of User:	Employee	
	Change words	
B8J6	Audio Version	
88,16	🛀 🛶 Audio Version	

You can print the forms we need to process the short-term disability claim from this screen. Select the links to get fillable PDFs of the forms:

- Authorization for Automatic Deposit(s) form
- Attending Physician's Statement
- Individual Authorization Form
- *Reimbursement Agreement*
- Communication Consent

Click Continue.



Enter your contact information on the Employer Information screen. Click Next.

▶ Claim Type ▶ User Det	tails > Claim Details > Beneficiary Details > Supporting Documents > Review > Confirmation
Employer Information	
Fields marked with an asterisk (*) are required
* Company Name:	ABC Company
Policy Number:	122233344
Your First Name:	John
Your Last Name:	Doe
Your Job Title:	HR Manager
Your Telephone Number:	111 222 - 3333
Your Email Address:	john.doe@abc.com
Cancel	Previous Next

On the *Employee Information* screen, enter as much information as you have about the employee. Click Next.

Claim Type User Details Claim Details Supporting Documents Review Confirmation					
Employee Information					
Fields marked with an asterisk (*) ar	e required				
* Your First Name:	John				
• Your Last Name:	Doe				
▲Address 1:	123 Main Street				
Address 2:					
* City:	Anytown				
* State:	IL ×Zip: 22222				
• Country:	United States of America				
The state the Employee works in if other than where they live:	L V				
Your Work location:					
★Social Security Number:	111-22-2333				
∗ Date Of Birth:	01/01/1970				
Gender:	Male Female				
Date Last Worked:	01/01/2022				
Number of hours worked on last Day Worked:	8				
★ First Day Absent Due to Disability:	01/02/2022				
* Primary Telephone Number:	111 333 - 4444				
Alternate Telephone Number:					
Email Address:	John.doe@abc.com				
Employer Information					
Fields marked with an asterisk (*) a	re required				
∗ Group Name:	ABC Inc.				
Group Policy Number:	123334				
Contact First Name:	Jim				
Contact Last Name:	Roe				
Contact Job Title:	HR Manager				
Contact Telephone Number:	222 333 - 4444				
Contact Fax Number:					
Contact Email Address:	[im.roe@abc.com				
Your Job Information					
Fields marked with an asterisk (*) a	re required				
★ Job Title:	Mananer				
* Hours Worked per Week:	40				
* Date Hired:	01/01/1990				
* Please provide a brief	Manager of Accounting				
description of your job duties:					
Are you an Hourly or Salaried Employee:	Salaried 🗸				
* Are you a Union Member?	⊖ Yes ⊛ No				
Cancer		Previous Next			

On the *Disability Information* screen, enter as much information as you can about the disabling condition. The questions will vary based on the reason the employee stopped work:

- Illness
- Injury
- Maternity
- Unknown

Click Next.

Claim Type User Detail	s 🔰 Claim Details 🔰 Supporti	ng Documents 🕽 Review 🔰 Conf	irmation]		
Disability Information						
Fields marked with an asterisk (*) ar	re required					
* Date Of Disability:	01/03/2022					
* Reason Stopped Work:	Injury 🗸					
Please tell us what duties you are unable to perform as a result of your disability:	Unable to sit, unable to use	computer.				
 Have you returned to work? 	○ Yes ○ No		//			
Injury Information						
Fields marked with an asterisk (*) an	re required					
* Date of injury:	01/03/2022					
 Describe your injury or diagnosis: 	Car accident - broken leg, he	ead injury				
. Wee the injury werk related			11		1	
 was the injury work related? 	Doctor Information					
	Fields marked with an asterisk (*) a	are required				
	 Name of the doctor certifying your disability: 	Tom Thoms				
	Doctor's Street Address 1:	456 Main Street				
	Doctor's Street Address 2:					
	City:	Anytown				
	State:	IN 🗸 Zip	22222			
	Country:	United States of America	~			
	Doctors Telephone Number:	444 555 - 6666				
	Doctor's specialty:	Emergency medicine				
				1.		
	Date of First Office Visit:	01/03/2022				
	Date of Last Office Visit:	01/07/2022	Other lasers			
	Date of Next Office Visit:	01/10/2022	Fields marked with an asteriek (*) a	are required		
	Were you Hospitalized:	● Yes ○ No		reserving any of the following herefits	0	
	Hospital Name:	General Hospital	Social Security:	O Yes No	1	
	Hospital Address:	666 Main Street, Anytown, I	Pension or Retirement:	○ Yes ⊛ No		
	Admission Date:	01/03/2022	Employer Paid Time Off:	● Yes ○ No		
	Discharge Date:	01/06/2022	Approved:	● Yes ○ No		
	Did you have Outpatient Surgery:	⊖ Yes ⊛ No	From 01/03/2022	Through 01/20/2022		
			State Disability:	○ Yes		
			Other Income:	○ Yes		
			Cancel			Previous Next

If you have completed forms at the time you enter the claim, such as the *Authorization for Automatic Deposit(s) form*, *Attending Physician's Statement*, the *Individual Authorization Form* and/or the *Reimbursement Agreement and Communication Consent*, you can scan and attach them here. Click *Next*.

Claim Type 🕽 User Details 🗲 Claim Details 🏷 Beneficiary Details 🏷 Supporting Documents 🔊 Review	Confirmation
Please upload any relevant documents for this claim	
Please click here to access the available forms.	
Choose File No file chosen	
Cancel	Previous Next

Next, you'll get confirmation of the information you entered and agree to the legal statement so we can begin processing the claim. You can also enter your email address and we'll send you confirmation of all the information you entered. Click *Submit*.

Claim Type 🕽 User Details 🕽	Claim Details 🔰 Supporting Documents 🍑 Review 🐌 Confirm	ation	Doctor Information	
Fields marked with an asterisk (*) are re-	quired			
			Name of the doctor certifying your disability:	Tom Thoms
Employee Information			Doctor's Street Address 1:	456 Main Street
			City:	Anytown
Your First Name:	John		State:	IN
Your Last Name:	Doe		Zip:	22222
Address 1:	123 Main Street		Country:	United States of America
City:	Anytown		Doctors Telephone Number:	444-555-6666
State:	IL .		Doctor's specialty:	Emergency medicine
Zip:	22222		Date of First Office Visit:	01/03/2022
Country:	United States of America		Date of Last Office Visit:	01/07/2022
The state the Employee works in if other than where	IL I		Date of Next Office Visit:	01/10/2022
they live:	444 00 0000		Were you Hospitalized:	Yes
Social Security Number:	111-22-2333:		Hospital Name:	General Hospital
Date Or Birth.	Mala National States and Sta		Hospital Address:	666 Main Street, Anytown, IL
Data Last Warked:	Male		Admission Date:	01/03/2022
Number of hours worked on	010112022		Discharge Date:	01/08/2022
last Day Worked:	0		Did you have Outpatient	No
First Day Absent Due to	01/02/2022		Surgery:	10
Primary Telephone Number:	111-333-4444			
Email Address:	iohn.doe@abc.com		Other Income	
			Other Income	
Employer Information			Have you applied for or are you rece	eiving any of the following benefits?
			Social Security:	No
Group Name:	ABC Inc		Pension or Retirement:	No
Group Policy Number:	123334		Employer Paid Time Off:	Yes
Contact First Name:	lim		Approved:	Yes
Contact Last Name:	Roe		From:	01/03/2022 Through 01/20/2022
Contact Job Title:	HR Manager		State Disability:	No
Contact Telephone Number:	222-333-4444	-		
Contact Email Address:	iim.roe@abc.com		Read and Acknowledge	
			Fields marked with an asterisk (*) are r	required
Your Job Information			Any person who knowingly and wi containing any false, incomplet	ith intent to defraud any insurance company, files a statement of claim
			The laws of some states require Alaska: A person who knowingly	e us to provide you with the following information: and with intent to injure, defraud, or
Job Title:	Manager		deceive an insurance company fi prosecuted under state law.	iles a claim containing false, incomplete,or misleading information may be
Hours Worked per Week:	40		Arizona: For your protection Ar	rizona law requires the following statement to appear on this form. Any person
Date Hired:	01/01/1990		civil penalties.	Wenterlas Any access the baselinely accesses a false as forevaluate along for
Please provide a brief description of your job duties:	Manager of Accounting		payment of a loss or benefit or	virginia: Any person who knowingly presents a false or fraudulent claim for r knowingly presents false information in an application for insurance is
Are you an Hourly or Salaried	Salaried		guilty of a crime and may be su California: For your protection	ubject to fines and confinement in prison. n California law requires the following v
Employee:			statement to appear on this for false or fraudulent claim for p	rm. Any person who knowingly presents a payment of a loss is guilty of a crime and may be subject to fines and
Are you a Union Member?	No		confinement in state prison.	1
			 I acknowledge that I have read a 	and agree to the above statement
Disability Information			Additional Comments:	
Date Of Disability:	01/03/2022			
Reason Stopped Work:	Injury			
Please tell us what duties you	Unable to sit, unable to use computer.			· · · · · · · · · · · · · · · · · · ·
result of your disability:			Email Confirmation	
Have you returned to work?	No		10/2	
			Email Ad	ddress:
Injury Information			Confirm	Email Address:
			Our applie to make your op line ov	im.roe@acc.com
Date of injury:	01/03/2022		message confirming receipt of your	specialities anglysed and secure. In you choose to give us your email address, we will send you'a secure email r online claim. Your privacy is very important to us and we will make every reasonable effort to safeguard any reasonable review the privacy attempt for our underline.
Describe your injury or	Car accident - broken leg, head injury		mormation we collect. we encoura	ge you to review the privacy statement for our website.
diagnosis:	*		L	
Was the injury work related?	No			
		r	Canad	Providence Protocola
		L	verified and a second s	
		-		

Once the claim is complete, you'll receive a confirmation summary showing all the information you entered. If you entered your email address on the previous screen, you'll also get a confirmation summary by email.

Claim Type Viser Details C	Taim Details > Supporting Documents > Review > Confirmation	(
Claim Confirmation Sur	mmary	F	Print this p	age			
This claim has been submitted su	ccessfully.						
CLAIM REFERENCE NUM Employer	BER : 201204 - Short Term Disability Claim sub	omitt	ted by				
The content in this confirmatio	n page reflects what you entered.						
Employer Information	n						
Group Name:	test						
Your First Name:	J						
Your Last Name:	Smith						
Your Job Title:	Manager						
Your Telephone	123-333-6666@						
Employee Information	n				1		
Employee First Name:	Bob			1			
Employee Last Name:	Jones						
Address 1:	12 Main St						
City:	Columbus						
State:	ОН						
Zip:	44444						
Country:	United States of America						
Social Security Number:	111-22-2333						
Employee's Primary Phone Number:	222-333-4444@						
First Day Absent Due to Disability:	05/01/2013		Has	the	employee	No	_
Disability Information			retur	ned	to work?		
Disability mormation			Salary	Int	formation		
Reason Stopped	liness					India (1991)	
WORK.			Emp of las	oloye st da	e's salary as ay worked:	\$10,000.00	
			Sala	iry Fi	requency:	Annually	
			Is the	e Em	ployee Hourly	Hourly	
			Is thi	sau	union	No	
			emp	loye	e:	Mar.	
			rece	ive s	salary	res	
			pay:	nua	I OI OI SICK		
			Plea date	ise p	provide the end	05/03/2013	
			Arepr	eser	ntative from our o	ffice will be contacting you if any additional information is needed for your	
			Failure	e to r	respond to our re	equest for information may cause a delay in claim processing.	
			lf you v	wou	ld like to enter a	another claim, please click <u>here</u> .	
		Ou ma	ur Custom ay also lea	er S ve a	ervice number i I message if you	is 800-813-5682gg and we are available 8:00 AM to 8:00 PM Eastern Time. Yo u call outside of our regular hours.	D

Submitting short-term disability claims by mail, email, or fax

To file claims by mail, download the Short-term Disability Claim Form at www.unicare.com. You can download the form and print it.

Complete the employer section, and then have the employee and the employee's physician complete their sections. Send all completed forms to:

Disability Claims Service Center P.O. Box 105426 Atlanta, GA 30348-5426

You may also fax everything to us at 1-800-850-0017 or by email to disability@anthem.com. Please call the Disability Claims Service Centerwith any questions at 1-800-232-0113.

Short-term disability benefit payments

Short-term disability claims are then paid weekly unless you, the employer, requested an alternative payment schedule. Checks are mailed to the employee.

Failure to complete all employee, physician and employer questions for any claim could delay claim processing and determination.

Submitting a long-term disability claim

Short-term to long-term disability claims when both plans are with UniCare

When you have both short- and long-term disability plans with UniCare, your employees experience a seamless transition from short- to long-term disability benefits.

When it's evident that a disability leave will extend into long-term disability benefits, we begin gathering information for the transition 60 days before the end of the short-term disability period.

We work proactively with you, your employee and the employee's doctor, so the employee will have a continuous income while he or she is unable to work.

Long-term disability claims when you have a different short-term disability carrier

Submitting long-term disability claims online

To submit claims online, go to <u>https://myspecialtyappsanthem.com/Claims/UC</u>. Select Long-Term Disability in the *Type of Claim* field and Employer in the *Type of User* field. Enter the characters you see in the bottom box, then click *Next*.

💙 Claim Type 📡 User	Details 🔰 Claim Details 🄰 Supporting Documents 🍃 Review 🍃 Confirmation	
Welcome to the Clain Fields marked with an asterisk	ns Entry site. Please enter details below to submit your claim.	
• Type of Claim:	Long Term Disability 🗸	
• Type of User:	Employer 🗸	
Please retype the charac	cters from the picture:	
NGUM Men	Change Words	
Attach file to existing Claim		Next

You can print the forms we need to process the long-term disability claim from this screen. Select the links to get fillable PDFs of the forms:

- Authorization for Automatic Deposit(s) form
- Attending Physician's Statement
- Individual Authorization Form
- *Reimbursement Agreement*
- Communication Consent

Click Continue.

Additional Information
In addition to the information you will enter online, the forms listed below are necessary for a Disability claim. Direct Deposit is the fastest way to receive your Disability benefits, please complete the form below if you would like your benefits paid by direct deposit. If you don't have these completed forms, you can print or download them here:
<u>Authorization for Automatic Deposit(s) form</u> <u>Attending Physician's Statement</u> <u>Individual Authorization Form</u> <u>Reimbursement Agreement</u> <u>Communication Consent</u>
If it's possible to have the forms completed now, you can upload them at the end of your online application. Otherwise, they can be completed later and sent to our claim office by mail, fax or email.
Continue

Enter your contact information on the Employer Information screen. Click Next.

Claim Type User Det	alls 》Claim Details 》Beneficiary Details 》Supporting Documents 》Review 》Confirmation
Employer Information	
Fields marked with an asterisk (*) are required
Company Name:	ABC Company
Policy Number:	122233344
• Your First Name:	John
* Your Last Name:	Doe
• Your Job Title:	HR Manager
* Your Telephone Number:	111 222 - 3333
Your Email Address:	John.doe@abc.com
Cancel	Previous Next

On the Employee Information screen, enter the employee's information. Click Next.

Employer Information	
Fields marked with an asterisk (*) a	re required
• Group Name:	ABC Inc.
Group Policy Number:	112312312
• Your First Name:	Jim
• Your Last Name:	Roe
• Your Job Title:	HR Manager
Your Telephone Number:	123 123 - 1212
Your Fax Number:	[242] 413 - 1234
Your Email Address:	[im.roe@abc.com
Employee Information	
• Employee First Name:	John
• Employee Last Name:	Doe
• Employee Address 1:	123 Main Street
Employee Address 2:	
• City:	Anytown
• State:	IN V 22222
- Country:	United States of America
The state the Employee works in if other than where they live:	
Employee Work Location or Division:	Headquarters
Job Title:	Manager
Scheduled Hours Worked per Week:	[40
Effective Date of Coverage:	01/02/1990
Number of hours worked on last Day Worked:	8
Social Security Number:	123-12-3123
Date Of Birth:	01/01/1970
Gender:	O Male O Female
 Employee's Primary Phone Number: 	458 789 - 2342
Employee's Alternate Phone Number:	
Date Hired:	01/01/1990
 First Day Absent Due to Disability: 	06/01/2021
Date Last Worked:	
Please provide a brief description of the employees job duties:	Manager of Accounting Department

On the *Disability Information* screen, enter as much information as you can about the disabling condition. The questions will vary based on the reason the employee stopped work:

- Illness
- Injury
- Maternity
- Unknown

Click Next.

,,		
lds marked with an asterisk (*) a	e required	
Reason Stopped Work:	Illness 🗸	
Has the employee returned to work?	○ Yes ◉ No	
Employee's salary as of last day worked:	50000.00	
Salary Frequency:	Annualiy 🗸	
	○ Hourly ⑧ Salaried	
 Is the Employee Hourly or Salaried: 		
 Is the Employee Hourly or Salaried: Is this a union employee: 	O Yes ® No	

If you have completed forms at the time you enter the claim, such as the *Authorization for Automatic Deposit(s) form*, *Attending Physician's Statement*, the *IndividualAuthorization Form* and/or the *Reimbursement Agreement and Communication Consent*, you can scan and attach them here. Click *Next*.

Claim Type > User Details > Claim Details > Beneficiary Details > Supporting Documents > Review	Confirmation
Please upload any relevant documents for this claim	
Please click here to access the available forms.	
Choose File No file chosen Upload	
Cancel	Previous Next

Next, you'll get confirmation of the information you entered and agree to the legal statement so we can begin processing the claim. You can also enter your email address and we'll send you confirmation of all the information you entered. Click *Submit*.

narked with an asterisk (*) are rec	luired	
ployer Information		
Group Name:	ABC Inc.	
Group Policy Number:	112312312	
Your First Name:	Jim	
Your Last Name:	Roe	
Your Job Title:	HR Manager	
Your Telephone Number:	123-123-1212	
Your Fax Number:	242-413-1234	
Your Email Address:	jim.roe@abc.com	
ployee Information		
Employee First Name:	John	
Employee Last Name:	Doe	
Address 1:	123 Main Street	
City:	Anytown	
State:	IN	
Zip:	22222	
Country:	United States of America	
The state the Employee works in if other than where they live:	IN	
Employee Work Location or Division:	Headquarters	
Job Title:	Manager	
Scheduled Hours Worked per Week:	40	
Effective Date of Coverage:	01/02/1990	
Number of hours worked on last Day Worked:	8	
Social Security Number:	123-12-3123:	
Date Of Birth:	01/01/1970	
Employee's Primary Phone Number:	456-789-2342	
Date Hired:	01/01/1990	
First Day Absent Due to Disability:	06/01/2021	
sability Information		
Reason Stopped Work:	Illness	Read and Acknowledge
Has the employee returned to	No	Any person who knowingly a

Salary Information

Employee's salary as of last day worked:	\$50,000.00	
Salary Frequency:	Annually	
Is the Employee Hourly or Salaried:	Salaried	
Is this a union employee:	No	
Did the employee receive salary continuation or sick pay:	No	

<pre>Any person who knowingly and with intent to defraud any insurance company, files a statement of claim containing any faise, incomplete, on misleading information may be subject to criminal penalties. The laws of some states require us to provide you with the following information: Llasks: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing failse, incomplete, or misleading information may be prosecuted under state law. Arizona: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a faile or fraudulent claim for payment of a loss is subject to criminal civil penalties. Arkanas, louislang, and West Virginia: Any person who knowingly presents a failes or fraudulent claim for payment of a loss or benefit or knowingly person who knowingly presents a failes or fraudulent claim for payment of a loss or benefit or knowingly person who knowingly presents a fails or fraughant claim forme. Any person who knowingly presents a fails or fraughant claim forme, Any person who knowingly presents a fails or fraughant claim forme. Any person who knowingly presents a fails or fraughant claim forme, Any person who knowingly presents a fails or fraughant claim forme. Any person who knowingly presents a fails or fraughant claim forme, Any person who knowingly presents a fails or fraughant claim. Additional Comments:</pre>	Fields marked with an asterisk (*) are	required	
Sective an insurance company files a claim containing false, incorplete,or misleading information may be prosecuted under state law. 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. Arkanasa, Louisiana, and West Virginia: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false in fraudulent claim for payment of a loss or benefit or knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state enrich. California: For your protection California 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 guilty of a crime and may be subject to fines and confinement in a state enrich. I a cknowledge that have read and agree to the above statement Additional Comments: Email Confirmation We can send you a copy of this submission. Just enter your email address below and we will send you a confirmation to your email address: Confirm Email Address: Confirm Email Address: Our goal is to make your on-line experience enjoyable and secure. If you choose to give us your email address, we will send you a secure eminormation we collect. We encourage you to review the privacy statement for our website.	Any person who knowingly and w containing any false, incomple The laws of some states requir- Alacka: A person who knowingly	ith intent to defraud any insurance company, files a statement of claim te, or misleading information may be subject to criminal penalties. e us to provide you with the following information: and with intent to injune. defraud or	
<pre>provide the second of the</pre>	deceive an insurance company f	iles a claim containing false, incomplete,or misleading information may be	
I is in the submission of the submission. Just enter your email address below and we will send you a socure email address: Confirm Email Address: <	Arizona: For your protection A who knowingly presents a false	rizona law requires the following statement to appear on this form. Any perso or fraudulent claim for payment of a loss is subject to criminal and	n
guilty of a crime and may be subject to fines and confinement in prison. California: for your protection California law requires the following statement to appear on this form, Any person who knowingly presents a false or fraudulent California for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison. • If a converse the above statement Additional Comments: Email Confirmation We can send you a copy of this submission. Just enter your email address below and we will send you a confirmation to your email address. Email Address: Confirm Email Address: Confirm Email Address: Confirm Email Address: Confirm Email Address: Munce@abc.com Our goal is to make your on-line experience enjoyable and secure. If you choose to give us your email address, we will send you a secure emi message confirming receipt of your online claim. Your privacy is very important to us and we will make every reasonable effort to safeguard and information we collect. We encourage you to review the privacy statement for our website.	civil penalties. Arkansas, Louisiana, and West payment of a loss or benefit o	Virginia: Any person who knowingly presents a false or fraudulent claim for r knowingly presents false information in an application for insurance is	
statement to appear on this form: Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crise and may be subject to fines and confinement in state orison. • I acknowledge that I have read and agree to the above statement Additional Comments: Email Confirmation We can send you a copy of this submission. Just enter your email address below and we will send you a confirmation to your email address. Email Confirmation Our goal is to make your on-line experience enjoyable and secore. If you choose to give us your email address, we will send you a secure emininformation to sold to safeguard an information we collect. We encourage you to review the privacy statement for our website.	guilty of a crime and may be s California: For your protectio	ubject to fines and confinement in prison. n California law requires the following	-
False on Fraudulent Claim for payment of a loss is guilty of a crime and may be subject to fines and confineent in state prison. • I acknowledge that I have read and agree to the above statement Additional Comments: Email Confirmation We can send you a copy of this submission. Just enter your email address below and we will send you a confirmation to your email address. Email Confirmation Our goal is to make your on-line experience enjoyable and secure. If you choose to give us your email address, we will send you a secure emininformation we collect. We encourage you to review the privacy statement for our website.	statement to appear on this fo	rm. Any person who knowingly presents a	
	false or fraudulent claim for confinement in state prison.	payment of a loss is guilty of a crime and may be subject to fines and	11
Additional Comments: Email Confirmation We can send you a copy of this submission. Just enter your email address below and we will send you a confirmation to your email address. Email Address: Confirm Email Address: Confirm Email Address: Im.roe@abc.com Our goal is to make your on-line experience enjoyable and secure. If you choose to give us your email address, we will send you a secure emi message confirming receipt of your online claim. Your privacy is very important to us and we will make every reasonable effort to safeguard an information we collect. We encourage you to review the privacy statement for our website.	* 🖬 I acknowledge that I have read	and agree to the above statement	
Email Confirmation We can send you a copy of this submission. Just enter your email address below and we will send you a confirmation to your email addresss. Email Address: Confirm Email Address: Im.roe@abc.com Our goal is to make your on-line experience enjoyable and secure. If you choose to give us your email address, we will send you a secure emi message confirming receipt of your online claim. Your privacy is very important to us and we will make every reasonable effort to safeguard an information we collect. We encourage you to review the privacy statement for our website.	Additional Comments:		
Email Confirmation We can send you a copy of this submission. Just enter your email address below and we will send you a confirmation to your email addresss. Email Address: Confirm Email Address: Im.roe@abc.com Our goal is to make your on-line experience enjoyable and secure. If you choose to give us your email address, we will send you a secure email more again to us and we will make every reasonable effort to safeguard an information we collect. We encourage you to review the privacy statement for our website.			
Email Confirmation We can send you a copy of this submission. Just enter your email address below and we will send you a confirmation to your email address. Email Address: Confirm Email Address: Im.roe@abc.com Our goal is to make your on-line experience enjoyable and secure. If you choose to give us your email address, we will send you a secure emi message confirming receipt of your online claim. Your privacy is very important to us and we will make every reasonable effort to safeguard an information we collect. We encourage you to review the privacy statement for our website.			
Email Confirmation We can send you a copy of this submission. Just enter your email address below and we will send you a confirmation to your email address. Email Address: Confirm Email Address: Confirm Email Address: Our goal is to make your on-line experience enjoyable and secure. If you choose to give us your email address, we will send you a secure emi message confirming receipt of your online claim. Your privacy is very important to us and we will make every reasonable effort to safeguard an information we collect. We encourage you to review the privacy statement for our website.			
Email Confirmation We can send you a copy of this submission. Just enter your email address below and we will send you a confirmation to your email addresss. Email Address: Confirm Email Address: Confirm Email Address: Confirm Email Address: Confirm Enail Address: Confirm En	1		11
We can send you a copy of this submission. Just enter your email address below and we will send you a confirmation to your email address. Email Address: Confirm Email Address: Confirm Email Address: Confirm Email Address: Cour goal is to make your on-line experience enjoyable and secure. If you choose to give us your email address, we will send you a secure emi message confirming receipt of your online claim. Your privacy is very important to us and we will make every reasonable effort to safeguard an information we collect. We encourage you to review the privacy statement for our website.	Email Confirmation		
Email Address: Confirm Email Address: Im.ree@abc.com Our goal is to make your on-line experience enjoyable and secure. If you choose to give us your email address, we will send you a secure emi message confirming receipt of your online claim. Your privacy is very important to us and we will make every reasonable effort to safeguard an information we collect. We encourage you to review the privacy statement for our website.	We can send you a copy of this su	bmission. Just enter your email address below and we will send you a confirmation to your en	ail addresss.
Confirm Email Address: Im.roe@abc.com Our goal is to make your on-line experience enjoyable and secure. If you choose to give up your email address, we will send you a secure em message confirming receipted for your online olimin. Your privacy is very innortant to us and we will make every reasonable effort to safeguard an information we collect. We encourage you to review the privacy statement for our website.	Email A	ddress: [im.roe@abc.com	
Our goal is to make your on-line experience enjoyable and secure. If you choose to give us your email address, we will send you a secure emi message confining receipt of your online claim. Your privacy is very important to us and we will make every reasonable effort to safeguard an information we collect. We encourage you to review the privacy statement for our website.	Confirm	Email Address: jim.roe@abc.com	
	Our goal is to make your on-line ex message confirming receipt of your information we collect. We encoura	perience enjoyable and secure. If you choose to give us your email address, we will send you conline claim. Your privacy is very important to us and we will make every reasonable effort to ge you to review the privacy statement for our website.	a secure ema safeguard an
	·		

Submitting long-term disability claims by mail, email, or fax

To file claims by mail or fax, download the Long-Term Disability Claim Form at <u>www.unicare.com</u>.

Complete the employer section, and then have the employee and the employee's physician complete their sections. If the claimant has more than one treating physician, give the claimant extra forms to complete.

All portions of the Long-Term Disability Claim Form package must be completed to avoid any delay in processing the claimant's request for benefits.

Send completed forms to: Disability Claims Service Center P.O. Box 105426 Atlanta GA 30348-5426

Phone: 1-800-232-0113 Fax: 1-800-850-0017 Email: <u>disability@anthem.com</u>

Long-term disability benefit payments

We make monthly payments for approved long-term disability claims unless the employer requested an alternate payment schedule. Checks are mailed to the employee.

We will ask for evidence of continued disability to determine ongoing eligibility for benefits.

Failure to complete all employee, physician and employer questions for any claim could delay claim processing and determination.

Once the claim is complete, you'll receive a confirmation summary showing all the information you entered. If you entered your email address on the previous screen, you'll also get a confirmation summary by email.

mmary uccessfully.	Print this page	
IBER:201204 - Long Term Dis	sability Claim submitted by	
n		
test		
J		
Smith		
Manager		
123-333-6666@		
Bob		
Jones		
12 Main St		
Columbus	Has the employee	No
ОН	returned to work?	
44444	Salany Information	
United States of America	Salary mormation	
111-22-2333	Employee's salary as	\$10,000.00
222-333-4444@	of last day worked:	Appually
05/01/2013	Is the Employee Hourly or Salaried	Hourly
	Is this a union	No
	Did the employee receive salary continuation or sick	Yes
liness	pay: Please provide the end date:	05/03/2013
	A representative from our claim. Failure to respond to our re	office will be contacting you if any additional information is needed for your equest for information may cause a delay in claim processing.
	In test J Smith Manager 123-333-6666@ Bob Jones 12 Main St Columbus OH 44444 United States of America 111-22-2333 222-333-4444@ 05/01/2013	Lam Dealer P Supporting Localized P Reveet P Common mmary Print this page uccessfully. IBER : 201204 - Long Term Disability Claim submitted by on page reflects what you entered. n test J Smith Manager 123.333-6666@ Bob Jones 12 Main St Columbus OH 44444 United States of America 111-22.2333 222-333.4444@ 0501/2013 Bis the Employee Hourly or Salared Illness Did the employee receive salary as of last day worked. Salary Frequency: Is the Employee Hourly or Salared Is this a union employee. Did the employee receive salary as of last day worked. Salary Frequency: Is the Employee thourly or Salared Illness Piease provide the end date.

Attaching documents to an existing claim

You can add additional information to an existing claim. You must wait 24 hours after you submitted the claim online to attach additional documents to it. Go to <u>https://myspecialtyappsanthem.com/Claims/UC</u> and click on *Attach file to existing Claim*.

Claim Type User D	etails 💙 Claim Details 🍑 St	upporting Documents > Review > Confirmation	1
Welcome to the Claim	s Entry site. Please ente (*) are required	r details below to submit your claim.	
* Type of Claim:	Select an option		
 Please retype the charact 	ers from the picture:		
PAGY	Change Words	2	b
			Next
Attach file to existing Claim			

You can also access the screen to add additional information to an existing claim on the **Please choose one of the following options** screen. Select Submit a Claim online, then click on *Attach file to existing Claim*.

Claim Search		
Check the status on a pa	rticular employee's claim, or all claims for your group within	the past 2 years.
Group Statistics Report	ts for Disability Claims	
View statistical information	n about disability benefits your group may have purchased.	
Group Statistics Report	ts for Life Claims	Ν
View statistical information	n about life benefits your group may have purchased.	10
Group Advice to Pay Re	eport	
For self funded Advice to	Pay Groups only	
Group Paid Claims Rep	ort	
View monthly, quarterly a	and Annual Tax Reports	

You will need the *Claim Number* or Claim *Reference Number* and the employee's date of birth. Also select the *User Type*. Click *Browse* to find the file you want to attach to the claim, then click *Upload*. Click *Submit*.

ds marked with an asterisk (*) are	required			
* Claim Number:		enter da	te as	,
Or.		/ mm/dd	уууу	
* Reference Number:				
* Member DOB:	11/16/1959			
• User Type:	Select an option 🗸			
	Browse	(m)		
Upload				

You'll get a confirmation showing that the documents uploaded successfully. Click OK.



Claim appeal procedures

For customers with administrative services only (ASO) disability plans, some of this information may not apply. Refer to your ASO Agreement for specific claim information.

If we deny a claim, the claimant/beneficiary, or someone acting on his or her behalf, can appeal the decision. Appeals must be submitted in writing and include the reason we should reconsider the claim decision. The person asking for the appeal also can submit additional documents or information relevant to the claim. For some benefit types, there may be a limit to the time allowed for filing an appeal. See the contract for important details on appealing a denied claim.

For disability claims

Send appeal letters to:

Disability Claims Service Center Attn: Appeal Coordinator P.O. Box 105426 Atlanta, GA 30348-5426

For life claims

Send appeal letters to:

Life Claims Service Center Attn: Appeal Coordinator P.O. Box 105448 Atlanta, GA 30348-5448

Checking claim status

You can check the status of claims submitted for your employees online using the secure portal: <u>https://myspecialtyappsanthem.com/benadmin/Account/logon/unicare</u>. You can check status online no matter how the claim was submitted – online, by mail, email, or fax.

We'll provide a username and temporary password for you upon receipt of your completed *Online Claims Reporting/Status Check Application Registration Form*. See page three for directions on how to access the *Online Claims Reporting/Status Check Application Registration Form* and how to submit it to us. Only group administrators or their designated representative can check claim status. Employees do not have access.

Enter your User Name and Password. Click Proceed.

Welcome to the Employer Portal	
* Indicates a Required Field	
* User Name	
* Password	If you do not have access click here for the application.
PROCEED	If you are having problems logging into your account, please cal 800-232-0113 ext. 4044798627 or email di-socerreporting@anthem.com

The first time you log on with your temporary password, you'll be prompted to change your password. You'll then get confirmation that your password was changed.

The first time you log on, you'll also need to complete your profile. Enter the information and click Proceed.

* Email address			
1			
* Challenge Question			
what school did you attend for the th	rd grade?	~	
* Challenge Answer			

To check the status of submitted claims, select Claim Search.



You can search for a claim by:

- Social Security number.
- Reference number the number provided when the claim was entered online.
- Claim number assigned by us.
- Type of claim.
- Claim status.

Only the Group Number, Type of Claim, Claim Status fields, and date range information is required. Click Search.

and the second s				will	
Fields marked with an	asterisk (*) are requir	ed	auto	opopulate	
Group Number	[aure	spoparate	
Subgroup Number					
Social Security Number					
	Enter the employee's Socia employees' claims at one til	I Security Number to search me, leave this field blank.	for all claims for a spec	ific employee. To search for mu	ultiple
Reference Number					
	Enter the Reference Number search for multiple employe	er provided with the OnLine es' claims at one time, leave	Claim Submission to se e this field blank.	arch for a specific employee's c	:laim. To
Claim Number					
	Enter the Claim Number to time, leave this field blank.	search for a specific claim for	or an employee. To sear	ch for multiple employees' clain	ms at one
Type of Claim*	Select an option	~			
	Select the desired type of cl	laim to search or select All C	Claim Types to search al	I claims.	

You can search for open claims, closed claims or all claims for your group. Click Search.

laim Search			Print	this page
Fields marked with an	asterisk (*) are require	ed		
Group Number	ABC123	×		
Subgroup Number				
Social Security Number	r			
	Enter the employee's Social employees' claims at one tim	Security Number to search for a ne, leave this field blank.	I claims for a specific employee. To search for multiple	
Reference Number				
	Enter the Reference Number search for multiple employee	r provided with the OnLine Claim es' claims at one time, leave this	Submission to search for a specific employee's claim. To field blank.	
Claim Number				
	Enter the Claim Number to s time, leave this field blank.	earch for a specific claim for an	employee. To search for multiple employees' claims at one	ENTER DATES WITH
Type of Claim*	All Claim Types	~		mm/dd/yyyy FORMA
	Select the desired type of cla	aim to search or select All Claim	Types to search all claims.	
Claim Status*	All Claims	V		
Start Date*				
End Date*				
	Please enter Start and End of	dates for a listing of all claims pro	cessed within the date range.	

You can review claims online or export the claims report to Excel. To export the report to Excel, select the *Export All Results to Excel* button above the list of claims. You can hold your mouse over the *Claim Status* to get further information on the status.

laim Search					P	rint this page
Fields marked wi	th an asterisk (*) are require	ed				
Group Number	ABC123	×				
Subgroup Numbe	r					
Social Security Nu	umber					
	Enter the employee's Social employees' claims at one tin	Security Number to se ne, leave this field blank	arch for all claims fo k.	or a specific employee. T	o search for multiple	
Reference Numbe	er					
	Enter the Reference Number search for multiple employed	r provided with the OnL es' claims at one time, I	ine Claim Submiss eave this field blank	ion to search for a specit	fic employee's claim. To	
Claim Number						
	Enter the Claim Number to s time, leave this field blank.	search for a specific cla	im for an employee	. To search for multiple e	employees' claims at on	ē
Type of Claim*	All Claim Types	$\mathbf{\mathbf{v}}$				
	Select the desired type of cl	aim to search or select	All Claim Types to	search all claims.		
Claim Status*	All Claims	\checkmark				
Start Date*	01/01/2020					
End Date*	12/31/2020					
Date of Inquiry CANCEL SEARC	06/11/2021	s report are those	within the view	ving rights of the u	user. 975	Records Fo
ed's Name SSN/	Employee Line of Coverage/	Product	Date Or Date	proved Thru Last	Status ge <u>Number</u>	LocClaim St
	GROUP AD&D		08/28/2011	02/26	5/2020 LC0008746	1 CLOSED
	GROUP TERM L	IFE	08/28/2011	02/20	5/2020 LC0008746	1 CLOSED
	VOLUNTARY GR EMPLOYEE	OUP TERM LIFE	08/28/2011	02/26	5/2020 LC0008746	1 CLOSED
	GROUP TERM L	FE	12/28/2019	01/13	3/2020 LC0016875	3 CLOSED

Getting reports

You can get reports of your group's life and/or disability claims. For groups with Administrative Services Only Short-Term Disability Advice to Pay or Financial Advice to Pay plans, you can also get your Advice to Pay (ATP) claim reports.

You can access claims reports on the secure portal: https://myspecialtyappsanthem.com/benadmin/Account/logon/alic.

Only group administrators or their designated representatives can access statistics reports. Employees don't have access to reports.

To access disability claims reports, select Group Statistics Reports for Disability Claims. To access life claims reports, select Group Statistics Reports for Life Claims. For self-funded Advice to Pay groups only, to access ATP claim reports, select Group Advice to Pay Report. To access paid claims reports, select Group Paid Claims Report.

Claim Se	arch
Check the	status on a particular employee's claim, or all claims for your group within the past 2 years.
Group St	atistics Reports for Disability Claims
View stati	stical information about disability benefits your group may have purchased.
Group St	atistics Reports for Life Claims
View stati	stical information about life benefits your group may have purchased.
Group Ac	tvice to Pay Report
For self fu	Inded Advice to Pay Groups only
Group Pa	id Claims Report
View mon	thly, quarterly and Annual Tax Reports

To search the Group Statistics Reports for Disability Claims status page:

- Enter the range of dates you'd like to search in the *Start Date* and *End Date* fields.
- Select Search.

Searches will display 12 months of results.

Select the claim type you want from the Claim Type drop-down box: Short-term disability or Long-term disability.

Enter the range of dates you'd like to search in the Start Date and End Date fields, then select Search.

Fields marked w	vith an asterisk (*)	are required		
Group Number* Disability Type Start Date* End Date*	(None Selected)		ß	
Cancel Search		nd dates for a listing o	aii claims processed within the date range.	

You can review the report online or export the full report to Excel. To export it to Excel, select *Export All Results to Excel* above the list of claims.

Here's a sample group statistics report for disability claims.

	1		-	
Field	ds marked v	vith an asterisk (*) are requi	red	
Gro	up Number*	ABC123	×	
Disa	ability Type	(None Selected)		
Star	rt Date*	01/01/2020		
End	d Date*	04/01/2020 Please enter Start and End dates for Clear	a listing of all claims processed within the date	range.
End Can rt All R	d Date*	04/01/2020 Please enter Start and End dates for Clear	a listing of all claims processed within the date s report are those within the viewing Number of Claims Closed in Reporting	range. g rights of the user.
End Can rt All R	t Date* Search tesults To Exce Number o Period	04/01/2020 Please enter Start and End dates for Clear Claim data showing in thi f Claims Received in Reporting	s report are those within the viewing Number of Claims Closed in Reporting Period	range. g rights of the user. g Average Duration (days) of Claim Closed in Reporting Period
End Can Int All R	t Date* Search tesults To Exce Number o Period 250	04/01/2020 Please enter Start and End dates for Clear Claim data showing in thi f Claims Received in Reporting	a listing of all claims processed within the date s report are those within the viewing Number of Claims Closed in Reporting Period 266	range. g rights of the user. Average Duration (days) of Claim Closed in Reporting Period 24.45

Here's a sample group statistics report for life claims.

Fields marked	with an asterisk (*) a	re required	
Group Number*	ABC123	×	
Start Date*	01/01/2020		
End Date	10/01/0000		
End Date*	Please enter Start and En	d dates for a listing of all cla	ims processed within the date range.
Cancel Search	Please enter Start and En	d dates for a listing of all cla	those within the viewing rights of the user.

Advice to Pay groups only

You can access your self-funded Advice to Pay reports on the secure portal:

https://myspecialtyappsanthem.com/benadmin/Account/logon/unicare. For self-funded Advice to Pay groups only, to access ATP claim reports, select *Group Advice to Pay Report*.

Your current and recent reports are shown on this screen. You can view and export the full report to Excel by selecting *Export Report*.

If you'd like to recreate a report for a certain time period not shown, enter the range of dates you'd like to search in the *Start Date* and *End Date* fields. Click *Search*.

iroup	Advice to Pay	Report			Print this page
Fields	marked with an aster	isk (*) are require	d		
Group	Number* ABC123		×		
Start D)ate*				
End Da	ate*				
Cancel	Please enter St	art and End dates for a	I listing of all ATP/FATP Report	wumn me date range.	₽
Cancel ort All Resu	Please enter St	art and End dates for a	report are those within	the viewing rights of the u	lser.
Cancel ort All Resu p No	Please enter St	art and End dates for a a showing in this Class No	report are those within report Report	the viewing rights of the u	lser.
Cancel ort All Resu p No	Please enter St	a showing in this Class No 01	report are those within Report Run Date 4/26/2021	the viewing rights of the u Is Report Available No	Iser.
Cancel rt All Resu p No	Please enter St. Search Clear utts To Excel Claim dat. Sub Group No	a showing in this Class No 01 02	report are those within Report Run Date 4/26/2021 4/26/2021	the viewing rights of the u Is Report Available No Yes	Iser.
Cancel rt All Resu p No	Please enter St. Search Clear utts To Excel Claim dat. Sub Group No	a showing in this Class No 01 02 02	Report are those within 4/26/2021 4/26/2021	the viewing rights of the u Is Report Available No Yes No	Iser.

Group disability paid claims reports

You can access claims reports on the secure portal:

https://myspecialtyappsanthem.com/benadmin/Account/logon/unicare. You can view your disability paid claims reports monthly, quarterly, or annually. You can also view either a summary of paid disability claims or details of each claim.

Select the frequency you want to see. Also, enter your group number, if it did not auto-populate, and choose Summary or Detail as the *Report Option*. Then, click *Search*.

roup Paid Claims F	Report Print thi
The Insurance Compar in your Paid Claims Re	y will produce a 1099-M for all NY Paid Family Leave benefits. These records are not included ports.
The insurance compan according to the IRS gu	y provides a W2 statement for the third party sick pay and it will be mailed directly to the claimant idelines. If you have any questions please contact the claim office.
The insurance compan plan, if applicable, and responsible for paying l contact the claim office	y provides FICA Employer match for the third party sick pay for certain classes of benefits in the t is paid directly to the agencies under the insurance company's EIN. The employer is FICA match for some of the classes of benefits in the plan. If you have any questions, please
Fields marked with an aste	isk (*) are required
Group Number*	ABC123 ×
Report Frequency*	Monthly
Report Option* Summary Cancel Search Clear	r O Detail
data showing in this report	are those within the viewing rights of the user.
020	Export Report
020	Export Report
	Export Report
020	
020 20	Export Report



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