Claim Form for Accidental Dismemberment or Loss of Sight
Employer Statement

We need to get some information before we can start processing your employee's benefit claim.

Who needs to fill out each section:

1) You, the employer, need to fill out "Section 1: Employer statement."
2) The employee, or a legally appointed guardian, needs to fill out "Section 2: Employee statement."
3) The attending physician needs to fill out the third page: "Section 1: Patient information" and "Section 2: Attending physician statement."

Also, the following things need to come along with this form:

- Copy of employer's Group Insurance Application and record card.
- Any newspaper clippings/online information about the injury or loss.
- If available, a police/accident report.

Employer is responsible for sending this completed form to:

The Standard
Life Claims Service Center
P.O. Box 2717
Portland, OR 97208-9830

Or send via fax at 877-305-3901

Need help? Call us at 800-552-2137 or email us at AL-Claims@standard.com

This claim is for: ☐ An employee ☐ A dependent

Section 1: Employer statement

Group no.			Class no.
Employee last name	First name	M.I.	Occupation
Date when full-time employment started: (MMDDYYYY)			
Date last worked: (MMDDYYYY)			Amount of benefit: $ _____
Was employee paying the premium up until the date of the accident? ☐ Yes ☐ No If no, date of last premium payment (MMDDYYYY)			
Date when coverage started: (MMDDYYYY)			Earnings at last date of employment: $_____ per _____
Date of accident: (MMDDYYYY)			Time of accident: _____
Place of accident: _____			Did accident occur on the job? ☐ Yes ☐ No

Dependent data — Complete this section if this claim is for an insured dependent

Insured dependent full name	Social Security no.	Date of birth (MMDDYYYY)	Gender ☐ Male ☐ Female
Dependent address (no. and street)	City	State	ZIP code
Relationship to insured employee: ☐ Husband ☐ Child ☐ Wife ☐ Domestic Partner	If spouse, was he/she divorced or legally separated? ☐ Yes ☐ No		
If child, was he/she: Married? ☐ Yes ☐ No Employed? ☐ Yes ☐ No Full-time student? ☐ Yes ☐ No			
If employed, was employment: ☐ Full time ☐ Part time Date employed: (MMDDYYYY)			
Date dependent insured under the group policy: (MMDDYYYY)			
Was insurance terminated? ☐ Yes ☐ No If yes, date: (MMDDYYYY)			
Amount of dependent's insurance claimed: $ _____	Date of dependent's death: (MMDDYYYY)		

My signature below means that as far as I know, everything I've written/chosen above is correct.

Company name			Company phone no.
Company address (no. and street)	City	State	ZIP code
Name of authorized company representative	Title		
Signature of authorized company representative X			Date (MMDDYYYY)

Si usted necesita ayuda en Español para entender este documento, puede solicitarlo sin ningun costo adicional llamando al número de servicio al cliente que se encuentra en este documento.

‡The Standard is a marketing name for StanCorp Financial Group, Inc. and subsidiaries. Insurance products are offered by Standard Insurance Company of Portland, Oregon, in all states except New York, where insurance products are offered by The Standard Life Insurance Company of New York of White Plains, New York.

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Claim Form for Accidental Dismemberment or Loss of Sight
Employee Statement

Section 2: Employee statement

Last name	First name	M.I.	Social Security no.	Date of birth (MMDDYYYY)

Address (no. and street)	City	State	ZIP code	Phone no.

Claim is for: ☐ Myself ☐ My dependent – Name: _____ Relationship: ☐ Spouse ☐ Domestic Partner ☐ Child

Date of injury: (MMDDYYYY)

Date of loss: (MMDDYYYY)

Date first treated by physician: (MMDDYYYY)

Name of attending physician

Extent of loss

Describe how accident happened

As far as I know, everything I've written above is correct. I understand that my signature below allows one or more of the following, herein referred to as "Insurance Company:" Standard Insurance Company, The Standard Life Insurance Company of New York, to get information about the accident from any hospital, physician or any other institutions or person who provided care. I also understand that a copy of my authorization can be used instead of the original.

For New York residents, the following statement applies: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation.

Signature of employee **X**	Date (MMDDYYYY)

For Anthem use only

Claim no.	Examiner	Total benefit $	Date approved/denied

Notice about telephone service reviews: To make sure our customers get quality service, we randomly select phone calls for monitoring. These calls, between our customers and employees, are evaluated by supervisors. This is to guarantee our members get quick and reliable help in a professional way. We are licensed by the Georgia Public Service Commission to use this type of reviewing tools.

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The laws of some states require us to provide you with the following information

Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

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 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.

Arkansas: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

California: For your protection California law requires the following statement to appear on this form. Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

Delaware: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

District of Columbia: 'WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Hawaii: Any person who knowingly presents false information in an application for insurance or life settlement contract is guilty of a crime and may be subject to fines and confinement in prison.

Idaho: Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

Indiana: A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

Kansas: 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 may be guilty of insurance fraud as determined by a court of law and may be subject to fines and confinement in prison.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Louisiana: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Maine: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Minnesota: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Hampshire: Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New Mexico: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

New York: For New York residents, the following statement applies: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact materials thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation.

Ohio: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Rhode Island: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Tennessee, Virginia, and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Texas: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Vermont: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

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 guilty of a crime and may be subject to fines and confinement in prison.

Attending Physician Statement About Accidental Dismemberment or Loss of Sight

The employee seeking benefits is responsible for getting this information at his/her own expense.

The Standard
Life Claims Service Center
P.O. Box 2717
Portland, OR 97208-9830
Or send via fax at 877-305-3901
Need help? Call us at 800-552-2137 or email us at
AL-Claims@standard.com

Section 1: Patient information

Last name	First name	M.I.	Date of birth (MMDDYYYY)

Section 2: Attending physician statement — Space is available on the reverse side if you wish to amplify your answers.

When did the accident happen? (MMDDYYYY)

When did the patient first see you for this condition? (MMDDYYYY)

Has patient ever had same or similar condition? ☐ Yes ☐ No
If yes, state when and describe: _____

Did the loss/injury happen as a result of an accident? ☐ Yes ☐ No
If no, what disease/condition contributed to the loss/injury? _____

Is the patient able to endorse checks and be responsible to manage funds? ☐ Yes ☐ No

Complete this part for loss of sight

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

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

Write in the date you first determined that central visual acuity was irrecoverably reduced to 20/200 or less with correction: (MMDDYYYY)

SNELLEN notes on that date:	Uncorrected	Corrected
O.D.V		
O.S.V.		

Complete this part for loss of limb(s)

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

What limb(s) have been severed?

Date of severance (MMDDYYYY)

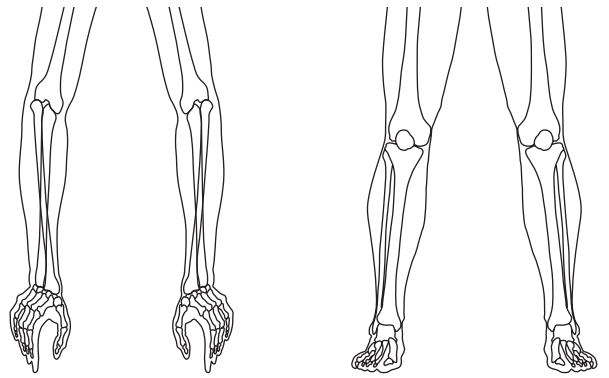
Right hand:

Left hand:

Right foot:

Left foot:

Please indicate the exact point of the loss of limb(s):



Right arm Left arm Right leg Left leg

Attending physician last name	First name	M.I.	Degree

Address (no. and street)	City	State	ZIP code	Phone no.

My signature below means that as far as I know, everything I've written/chosen above is correct.

Signature of attending physician	Date (MMDDYYYY)
X	

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Use this space for any additional information