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

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, 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 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 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 and Idaho: 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 containing any false, incomplete or misleading information is guilty of a felony of the third degree.

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

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.

Maine, 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 may include imprisonment, fines or denial of insurance benefits.

Minnesota: A person who files a claim with intent to defraud or helps to 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 N.H. Rev. Stat. Ann. §638:20.

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

New Mexico: A 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: 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 and 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 o 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.

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.

SHORT TERM DISABILITY CLAIM FORM

Anthem Life

Anthem Life Insurance Company
800-813-5682
When complete, send to: NHADA
P.O. Box 2337, Concord, NH 03302-2337
800-852-3372

Important Notice to Employee – Please Read Carefully

You or someone acting on your behalf should complete Section I and then have your employer complete Section II. Have your physician complete Section III within ten days. After all three sections are completed; submit the form to NHADA at the address listed above. Your cooperation will facilitate payments promptly when they are due.

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

SECTION I: To be completed by the Employee

1 Name of Employee	2 Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	3 Gender ☐ Male ☐ Female	4 Date of Birth

5 Address of Employee (Street Name/Number, City, State, Zip)	6 Phone Number:
	7 Cell Number:
	8 Fax Number:

9 E-mail Address	10 Social Security Number:

11 Date you last worked due to your disability(MM/DD/YYYY):	14 Disability due to: ☐ Illness ☐ Injury – Type: ☐ Auto ☐ Worker's Comp ☐ Home ☐ Other
12 Date you returned to work (MM/DD/YYYY):	
13 If not yet returned, date you expect to return (MM/DD/YYYY):	If due to injury, please provide complete details to accident, date and time (attach a separate sheet if necessary):
15 Employer Name: (Member of NHADA)	

I authorize the release to or by Anthem Life Insurance Company (Anthem Life) any medical or insurance information required to process my claim. I understand that any information obtained pursuant to this authorization will be used only to evaluate my claim and may be transferred to any organization or person employed by or representing Anthem Life to assist with this purpose. This authorization is valid for the duration of my claim. I understand I have a right to request and receive a copy of this authorization. A photocopy of this authorization is as valid as the original.

The above statements are true and complete to the best of my knowledge and belief. (Your signature is required for benefit consideration.)

EMPLOYEE'S SIGNATURE: _____ DATE: _____

SECTION II: To be completed by the Employer

17 Group Policy Number 000032	18 Date Employed	19 Effective Date of Insurance	20 Occupation/Job Title	21 Standard number of hours worked per week?

22 Social Security Number	23 Employee Number (if applicable)	24 Employee Benefit Class:	25 Amount of Weekly Benefits:

26a Date Employee last worked and number of hours: ☐ AM ☐ PM	27 Employee's Wage: $ per ☐ hour ☐ week ☐ year ☐ Hourly ☐ Salaried
26b Date Employee scheduled to return to work: ☐ AM ☐ PM	
26c Date Employee returned to work: ☐ AM ☐ PM	

28 Did injury or illness arise out of or in course of employment for wages or profit? ☐ Yes ☐ No	29 Is claim being made for Worker's Compensation? ☐ Yes ☐ No	30 What percentage of the Short Term Disability premium does the Employer Pay?	31 If the employee contributes to the premium, are contributions made Pre- or Post-Tax? ☐ Pre-Tax ☐ Post-Tax

32 Comments:	33 Employee status on last day worked or current employee status:

34 Insured Group Name (Member of NHADA)	35 Branch or Division Address:	36 Phone Number:

37 Printed Name	38 Title

39 **SIGNATURE OF EMPLOYER'S REPRESENTATIVE**	40 **DATE**
_____	_____

SHORT TERM DISABILITY CLAIM FORM (Continued)

Group Number 000032 - NHADA

Anthem Life

Anthem Life Insurance Company
800-813-5682
When complete, send to: NHADA
P.O. Box 2337, Concord, NH 03302-2337
800-852-3372

SECTION III: To be completed by Physician

Note to Physician:

Completion of this form will assist your patient in presenting claim for group and/or individual disability benefits. Please complete all areas of the form; *if a section is non-applicable, please enter N/A in the response area.*

1 Patient's Name	2 Date of Birth
3 Current Diagnosis:	4 ICD-9 code/DSM IV:
5 Subjective Findings:	6 Objective Findings:
7 Has patient ever had same or similar condition? ☐ Yes ☐ No If yes, please specify dates if treatment:	8 Did injury or illness arise out of or in course of Employment for wages or profit? ☐ Yes ☐ No ☐ Unknown If yes, please explain:

9 Is Disability due to pregnancy? ☐ Yes ☐ No

If Yes: LMP (MM/DD/YYY) EDU (MM/DD/YYY) Type of Delivery: ☐ Vaginal ☐ C-Section

10 Was patient hospitalized? ☐ Yes ☐ No If yes, please provide dates of confinement and name of hospital/facility:	11 Nature of surgical procedure, if any. (Describe in full.) Date performed:

Treatment

12 Date patient first unable to perform job duties:	13 Date of first visit	14 Date of last visit
15 Patient's present condition: ☐ Recovered ☐ Improved ☐ Unchanged ☐ Regressed	16 Frequency of visits: ☐ weekly ☐ Monthly Other:	
17 Treatment Plan:		
18 Functional Impairments:	19 Current Medications and Dosages:	

Extent of Disability

20 Patient released to return to work? ☐ Yes ☐ No

If Yes: ☐ Full-time, no restrictions Date Return to Full Duty:

☐ Light Duty (Please specify restrictions, limitations, hours, graduated return to work schedule, etc.):

Date Return to Light Duty:

21 Is patient a suitable candidate for a rehabilitation program? ☐ Yes ☐ No

Psychiatric Condition

22 Is this patient competent to endorse checks and direct the proceeds thereof? ☐ Yes ☐ No If No, please attach supporting documentation.

23 Physician's Name (Please Print):	24 Physician's Specialty:
25 Physician's Address (Street Name/Number, City, State, Zip)	26 Phone Number:
	27 Fax Number:
	28 E-mail Address:

PHYSICIAN'S SIGNATURE: _____ DATE: _____