

Accelerated Death Benefit Claim Form for Blue Shield of California Life & Health Insurance Company (Blue Shield Life)

This form is supplied by Blue Shield Life upon request and without verification of the status of the insurance. Verification will be made upon receipt of the completed form. **Send completed form to: Blue Shield Life, 4203 Town Center Blvd., El Dorado Hills, CA, 95762, (888) 800-2742.**

Note: Please complete the entire claim form. This form cannot be processed if information is incomplete. Please print using ink.

Important notice: 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.

Section 1 – Employer to complete this section

| | | | | | |
|--|--|------------------------------------|---|---------------------------|------------------------|
| Name of the insured employee | | Job title – occupation of employee | | | |
| Address of insured employee | | | | | Birth date (mo/day/yr) |
| Group number | Employee's Social Security number | Basic annual earnings \$ | | Amount of insurance \$ | |
| Date employed | Is employee still working? <input type="checkbox"/> Yes <input type="checkbox"/> No If not, date last worked: | | Was employee terminated? <input type="checkbox"/> Yes <input type="checkbox"/> No Date of termination: | | |
| Reason <input type="checkbox"/> Illness <input type="checkbox"/> Discharged <input type="checkbox"/> Retired <input type="checkbox"/> Resigned <input type="checkbox"/> Other (specify) | | | | | |
| Employer name | | | Completed by Signature _____ | | |
| Address | | | Title | | |
| City | | State | ZIP | Telephone number | Date |

Section 2 – Employee to complete this section

| | | | | |
|--|--|---------------------------------|---|-----|
| Name | | Birth date | Gender <input type="checkbox"/> M <input type="checkbox"/> F | |
| Address | | Telephone number () | | |
| Condition contributing to your need for living benefits | | Date condition first identified | | |
| What important daily duties are you unable to perform? | | | | |
| When do you expect to resume the majority of your duties? | | | | |
| If you are currently in a location other than your own home, please provide complete address <small>Type of place (relative's home, hospital, etc.)</small> | | | Telephone number () | |
| Address | | City | City | ZIP |

Authorization to obtain and release medical information

I hereby authorize any hospital, healthcare facility, physician and surgeon, or other healthcare professional to provide Blue Shield Life, its agents or employees, or independent administrators acting on its behalf, all information pertaining to any examination or treatment furnished to the above-named patient or to any illness, injury, or condition the patient has had at any time in the past, or in the future up until the expiration of this authorization. I understand this information is collected in connection with claim(s) for insurance benefits and to determine eligibility for benefits. This authorization is valid for the term of coverage of the policy. A photocopy of this authorization is as valid as the original. My authorized representative or I am entitled to receive a copy of this form.

Insured/patient _____
Print name
Signature
Date

(reverse side to be completed by physician)

The claimant is responsible for any charges made by the physician/healthcare provider who may be supplying the information necessary to the completion process.

Section 3 – To be completed by attending physician (please print)

Name of patient _____ Birth date (mo/day/yr) _____

Diagnosis: primary and secondary. Describe complications, if any.

Date last illness began _____ Dates patient was totally disabled and unable to work
From _____ 20____ To _____ 20____

Please indicate how frequently your patient requires, and for what length of time he/she has required, the indicated level of assistance in the following activities of daily living (ADLs)

| | Never/rarely (once/Week) | Sometimes (1+/week) | Always (every time) | Length of time (in months) |
|--------------|-----------------------------|------------------------|------------------------|-------------------------------|
| Bathing | _____ | _____ | _____ | _____ |
| Dressing | _____ | _____ | _____ | _____ |
| Transferring | _____ | _____ | _____ | _____ |
| Mobility | _____ | _____ | _____ | _____ |
| Toileting | _____ | _____ | _____ | _____ |
| Eating | _____ | _____ | _____ | _____ |

Treatment plan (Include current medication and dosages, as well as any support or health-related services in place)

Appears that patient's current level of functional impairment will remain the same for: 3-6 mos. 6-12 mos. 1-2 yrs. 2 yrs.

Hospital name and address, if applicable _____ Dates of hospitalization _____

Names and addresses of other treating physicians

Is your patient presently (today) in: Own home Hospital Nursing home Other (specify)

If in hospital/health center, please provide

Name: _____ Admission date: _____ Anticipated Discharge date: _____

Address _____ City _____ State _____ ZIP _____

Remarks

Name of attending physician (please print) _____ Degree _____

Address _____ City _____ State _____ ZIP _____

Signature _____ Telephone number () _____ Date _____