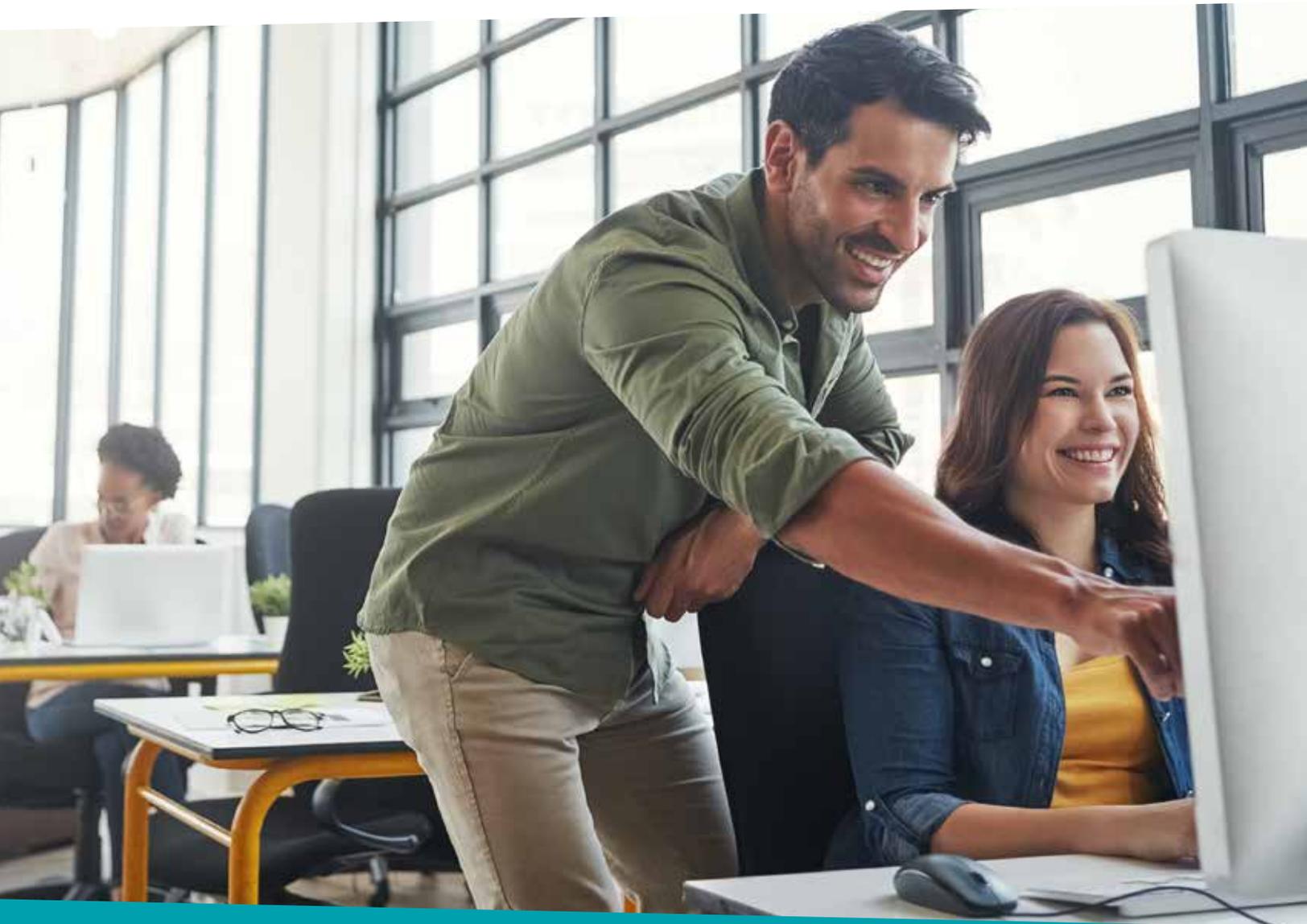


Anthem<sup>®</sup>Life



## Disability online claims submission

Employee Manual | VACORP Hybrid Disability Plan offered by Anthem Life Insurance Company (Anthem Life)



## Table of contents

Introduction .....	2
Getting started .....	3
Submitting a short-term disability claim .....	4
Submitting a long-term disability claim .....	13

## Introduction

Our online claim submission site provides a convenient way for you to submit disability claims (short-term and long-term disability). It saves you time by not having to mail or fax your claim to us and can speed up the process because your claim gets sent directly to our system.

This manual offers step-by-step instructions on how to submit your claims online. If you have questions, you can call 1-844-404-2111 or your disability case manager.

You will see a different phone number on the system screens – remember 1-844-404-2111 is the dedicated VACORP number.

# Getting started

To access online Disability Claims Submission, go to <https://myspecialtyappsanthem.com/Claims/ALIC>. You'll select the type of claim you want to submit on the *Welcome* screen. You'll see a list of claim types:

- Accidental dismemberment\*
- Living benefit\*
- Life waiver of premium\*
- Short-term disability
- Long-term disability

\* These coverages are not included in the VACORP plan. The VACORP coverage is for short-term disability or long-term disability. Select one of those options.

The screenshot shows a web interface for filing a claim. At the top, a navigation menu includes: Claim Type (highlighted), User Details, Claim Details, Supporting Documents, Review, and Confirmation. Below the menu is a bold heading: "Welcome to the Claims Entry site. Please enter details below to submit your claim." A note states: "Fields marked with an asterisk ( \*) are required". The main form area contains a dropdown menu for "Type of Claim" with the text "Select an option" and a green checkmark icon. Below this is a CAPTCHA section with the text "Please retype the characters from the picture:" and a box containing the letters "EXWC". To the right of the CAPTCHA are two buttons: "Change Words" and "Audio Version". A "Next" button is located at the bottom right of the form area. At the bottom of the page, there is a message: "If you do not have all of the required information, you can call our Customer Service number for Life Claims call: 1-800-552-2137, for Disability claims call: 1-800-813-5682 to see if we may be able to assist you with filing the claim."

Fields marked with an asterisk (\*) are required.

# Submitting a short-term disability claim

Select **Short-Term Disability** in the *Type of Claim* field and **Employee** in the *Type of User* field.  
Enter the characters you see in the bottom box, then choose **Next**.

➤ **Claim Type** ➤ User Details ➤ Claim Details ➤ Supporting Documents ➤ Review ➤ Confirmation

**Welcome to the Claims Entry site. Please enter details below to submit your claim.**

Fields marked with an asterisk ( \* ) are required

\* Type of Claim:

\* Type of User:

\* Please retype the characters from the picture:



If you do not have all of the required information, you can call our Customer Service number for Life Claims call: 1-800-552-2137, for Disability claims call: 1-800-813-5682 to see if we may be able to assist you with filing the claim.

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:

- *Attending Physician's Statement*
- *Individual Authorization Form*
- *Reimbursement Agreement*

In addition to the information you will enter online, the forms listed below are required for a Disability claim. If you don't have these completed forms, you can print or download them here:

- [Attending Physician's Statement](#)
- [Individual Authorization Form](#)
- [Reimbursement Agreement](#)

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 and all the information you have about your disabling condition on the *Employee Information* screen. Be sure to give us as much detail as you have, to help us process your claim.

[Claim Type](#) > [User Details](#) > [Claim Details](#) > [Supporting Documents](#) > [Review](#) > [Confirmation](#)

### Employee Information

Fields marked with an asterisk (\*) are required

*Your First Name:	<input type="text"/>
*Your Last Name:	<input type="text"/>
*Address 1:	<input type="text"/>
Address 2:	<input type="text"/>
*City:	<input type="text"/>
*State:	<input type="text" value="Please select ..."/>
*Zip:	<input type="text"/>
*Country:	<input type="text" value="United States of America"/>
The state the Employee works in if other than where they live:	<input type="text" value="Please select ..."/>
Your Work location:	<input type="text"/>
*Social Security Number:	<input type="text"/>
Your Work location:	<input type="text"/>
*Social Security Number:	<input type="text"/>
*Date Of Birth:	<input type="text"/>
Gender:	<input type="radio"/> Male <input type="radio"/> Female
Date Last Worked:	<input type="text"/>
Number of hours worked on last Day Worked:	<input type="text"/>
*First Day Absent Due to Disability:	<input type="text"/>
*Primary Telephone Number:	<input type="text"/> - <input type="text"/>
Alternate Telephone Number:	<input type="text"/> - <input type="text"/>
Email Address:	<input type="text"/>

Next, enter your employer's contact information and information about your job.

### Your Job Information

*Job Title:	<input type="text"/>
*Hours Worked per Week:	<input type="text"/>
*Date Hired:	<input type="text"/> 
*Please provide a brief description of your job duties:	<input type="text"/>
*Are you an Hourly or Salaried Employee:	Select an option 
*Are you a Union Member?	<input type="radio"/> Yes <input type="radio"/> No

[Claim Type](#) > [User Details](#) > [Claim Details](#) > [Supporting Documents](#) > [Review](#) > [Confirmation](#)

### Employer Information

Fields marked with an asterisk (\*) are required

*Group Name:	<input type="text"/>
Group Policy Number:	<input type="text"/>
*Your First Name:	<input type="text"/>
*Your Last Name:	<input type="text"/>
*Your Job Title:	<input type="text"/>
*Your Telephone Number:	<input type="text"/> <input type="text"/> - <input type="text"/>
Your Fax Number:	<input type="text"/> <input type="text"/> - <input type="text"/>
Your Email Address:	<input type="text"/>

Next, you'll give us information about your disabling condition. Be sure to provide as much detailed information as you can.

[Claim Type](#) > [User Details](#) > [Claim Details](#) > Supporting Documents > Review > Confirmation

### Disability Information

Fields marked with an asterisk ( \* ) are required

\*Date Of Disability:

\*Reason Stopped Work:

Please tell us what duties you are unable to perform as a result of your disability:

\*Have you returned to work?  Yes  No

If you do not have all of the required information, you can call our Customer Service number

Be sure to provide as much detail as you can to help us in processing your claim.

### Injury Information

\*Date of injury:  

\*Describe your injury or diagnosis:

\*Was the injury work related?  Yes  No

### Doctor Information

\*Name of the doctor certifying your disability:

Doctor's Street Address 1:

Doctor's Street Address 2:

Doctors Telephone Number:  -

Doctor's specialty:

Date of First Office Visit:  

Date of Last Office Visit:  

Date of Next Office Visit:  

Were you Hospitalized:  Yes  No

Did you have Outpatient Surgery:  Yes  No

### Other Income

Have you applied for or are you receiving any of the following benefits?

Social Security:  Yes  No

Pension or Retirement:  Yes  No

Employer Paid Time Off:  Yes  No

State Disability:  Yes  No

Other Income:  Yes  No

If you do not have all of the required information, you can call our Customer Service number 1-800-813-5682 to see if we may be able to assist you with filing the claim.

If you have forms completed at the time you enter the claim, such as the *Attending Physician's Statement*, *Individual Authorization Form* or *Reimbursement Agreement*, you can scan and attach them here.

➤ 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.](#)

If you do not have all of the required information, you can call our Customer Service number 1-800-552-2137 to see if we may be able to assist you with filing the claim.

Next, you'll get confirmation of the information you entered and you'll give your certification to us so that 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.

➤ Claim Type ➤ User Details ➤ Claim Details ➤ Supporting Documents ➤ **Review** ➤ Confirmation

Fields marked with an asterisk (\*) are required

### Employee Information

Your First Name:	*
Your Last Name:	*
Address 1:	*
City:	*
State:	ME
Zip:	12345
Country:	United States of America
Social Security	111-11-1111

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**

\*  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 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 email message confirming receipt of your online claim. Your privacy is very important to us and we will make every reasonable effort to safeguard any information we collect. We encourage you to review the privacy statement for our website.

If you do not have all of the required information, you can call our Customer Service number 1-800-813-5682 to see if we may be able to assist you with filing the claim.

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](#) [➤ User Details](#) [➤ Claim Details](#) [➤ Supporting Documents](#) [➤ Review](#) [➤ Confirmation](#)

**Claim Confirmation Summary** [Print this page](#)

This claim has been submitted successfully.

**CLAIM REFERENCE NUMBER : 201223 - Short Term Disability Claim submitted by Employee**

The content in this confirmation page reflects what you entered.

Employee Information	
Your First Name:	t
Your Last Name:	t
Address 1:	t

# Submitting a long-term disability claim

Select **Long-Term Disability** in the *Type of Claim* field and **Employee** in the *Type of User* field.  
Enter the characters you see in the bottom box, then choose **Next**.

➤ **Claim Type** ➤ User Details ➤ Claim Details ➤ Supporting Documents ➤ Review ➤ Confirmation

**Welcome to the Claims Entry site. Please enter details below to submit your claim.**

Fields marked with an asterisk ( \*) are required

\* Type of Claim:

\* Type of User:

\* Please retype the characters from the picture:



[Change Words](#)

[Audio Version](#)

**Next**

If you do not have all of the required information, you can call our Customer Service number for Life Claims call: 1-800-552-2137, for Disability claims call: 1-800-813-5682 to see if we may be able to assist you with filing the claim.

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:

- *Attending Physician's Statement*
- *Individual Authorization Form*
- *Reimbursement Agreement*

In addition to the information you will enter online, the forms listed below are required for a Disability claim. If you don't have these completed forms, you can print or download them here:

- [Attending Physician's Statement](#)
- [Individual Authorization Form](#)
- [Reimbursement Agreement](#)

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 and your employer's contact information on this screen.

### Employee Information

Fields marked with an asterisk ( \* ) are required

*Your First Name:	<input type="text"/>
*Your Last Name:	<input type="text"/>
*Address 1:	<input type="text"/>
Address 2:	<input type="text"/>
*City:	<input type="text"/>
*State:	<input type="text" value="Please select ..."/>
*Zip:	<input type="text"/>
*Country:	<input type="text" value="United States of America"/>
The state the Employee works in if other than where they live:	<input type="text" value="Please select ..."/>
Your Work location:	<input type="text"/>
*Social Security Number:	<input type="text"/>
*Date Of Birth:	<input type="text"/>
Gender:	<input type="radio"/> Male <input type="radio"/> Female
Date Last Worked:	<input type="text"/>
Number of hours worked on last Day Worked:	<input type="text"/>
*First Day Absent Due to Disability:	<input type="text"/>
*Primary Telephone Number:	<input type="text"/>
Alternate Telephone Number:	<input type="text"/>
Email Address:	<input type="text"/>

### Employer Information

*Group Name:	<input type="text"/>
Group Policy Number:	<input type="text"/>
Contact First Name:	<input type="text"/>
Contact Last Name:	<input type="text"/>
Contact Job Title:	<input type="text"/>
Contact Telephone Number:	<input type="text"/>
Contact Fax Number:	<input type="text"/>
Contact Email Address:	<input type="text"/>

Be sure to give us as much information about your job as you can.

**Your Job Information**

\*Job Title:

\*Hours Worked per Week:

\*Date Hired:  

\*Please provide a brief description of your job duties:

\*Are you an Hourly or Salaried Employee:

\*Are you a Union Member?  Yes  No

If you do not have all of the required information, you can call our Customer Service number 1-800-813-5682 to see if we may be able to assist you with filing the claim.

On the *Disability Information* screen, enter information about the disabling condition.

➤ Claim Type ➤ User Details ➤ **Claim Details** ➤ Supporting Documents ➤ Review ➤ Confirmation

### Disability Information

Fields marked with an asterisk ( \* ) are required

\*Date Of Disability:

\*Reason Stopped Work:

Please tell us what duties you are unable to perform as a result of your disability:

\*Have you returned to work?  Yes  No

If you do not have all of the required information, you can call our Customer Service number 1-800-813-5682 to see if we may be able to assist you with filing the claim.

The questions will vary based on the reason you stopped work:

- Illness
- Injury
- Maternity

Regardless of the reason, you'll need to give as much information about your doctor and your other income as possible.

**Injury Information**

\*Date of Injury:  

\*Describe your injury or diagnosis:

\*Was the injury work related?  Yes  No

**Doctor Information**

\*Name of the doctor certifying your disability:

Doctor's Street Address 1:

Doctor's Street Address 2:

City:

Doctors Telephone Number:  -

Doctor's specialty:

Date of First Office Visit:  

Date of Last Office Visit:  

Date of Next Office Visit:  

Were you Hospitalized:  Yes  No

Did you have Outpatient Surgery:  Yes  No

**Other Income**

Have you applied for or are you receiving any of the following benefits?

Social Security:  Yes  No

Pension or Retirement:  Yes  No

Employer Paid Time Off:  Yes  No

State Disability:  Yes  No

Other Income:  Yes  No

If you do not have all of the required information, you can call our Customer Service number 1-800-813-5682 to see if we may be able to assist you with filing the claim.

If you have completed forms at the time you enter the claim, such as the *Attending Physician's Statement*, *Individual Authorization Form* or *Reimbursement Agreement*, you can scan and attach them here.

➤ 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.](#)

If you do not have all of the required information, you can call our Customer Service number 1-800-552-2137 to see if we may be able to assist you with filing the claim.

Next, you'll get confirmation of the information you entered and you'll give your certification to us 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.

<b>Employee Information</b>	
Your First Name:	t
Your Last Name:	t
Address 1:	t
City:	t
State:	NH
Zip:	44444
Country:	United States of America
Social Security Number:	444-33-3222
Date Of Birth:	11/11/1960
First Day Absent Due to Disability:	06/01/2013
Primary Telephone Number:	111-222-3333
<b>Employer Information</b>	
Group Name:	t
<b>Your Job Information</b>	

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.

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 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 email message confirming receipt of your online claim. Your privacy is very important to us and we will make every reasonable effort to safeguard any information we collect. We encourage you to review the privacy statement for our website.

If you do not have all of the required information, you can call our Customer Service number 1-800-552-2137 to see if we may be able to assist you with filing the claim.

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 ➤ User Details ➤ Claim Details ➤ Supporting Documents ➤ Review ➤ Confirmation

### Claim Confirmation Summary [Print this page](#)

This claim has been submitted successfully.

**CLAIM REFERENCE NUMBER : 201352 - Long Term Disability Claim submitted by Employee**

The content in this confirmation page reflects what you entered.

#### Employee Information

Your First Name:	t
Your Last Name:	t
Address 1:	t
City:	t
State:	NH
Zip:	44444
Country:	United States of America
Social Security Number:	444-33-3222
Date Of Birth:	11/11/1960
First Day Absent Due to Disability:	06/01/2013

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