



LIFE AND DISABILITY ONLINE CLAIMS

Employee tools



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

It's faster and more convenient to submit claims a through our online portal:

<https://myspecialtyappsanthem.com/Claims/UC>.

Note – if UniCare administers FML leave for your employer, 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.

The site guides you through the process. This manual is an additional resource, offering step-by-step instructions to file claims and access your reports. If you have questions, call us:

- For life claims, 1-800-552-2137.
- For disability claims, 1-800-813-5682, or call your group's Case Manager.

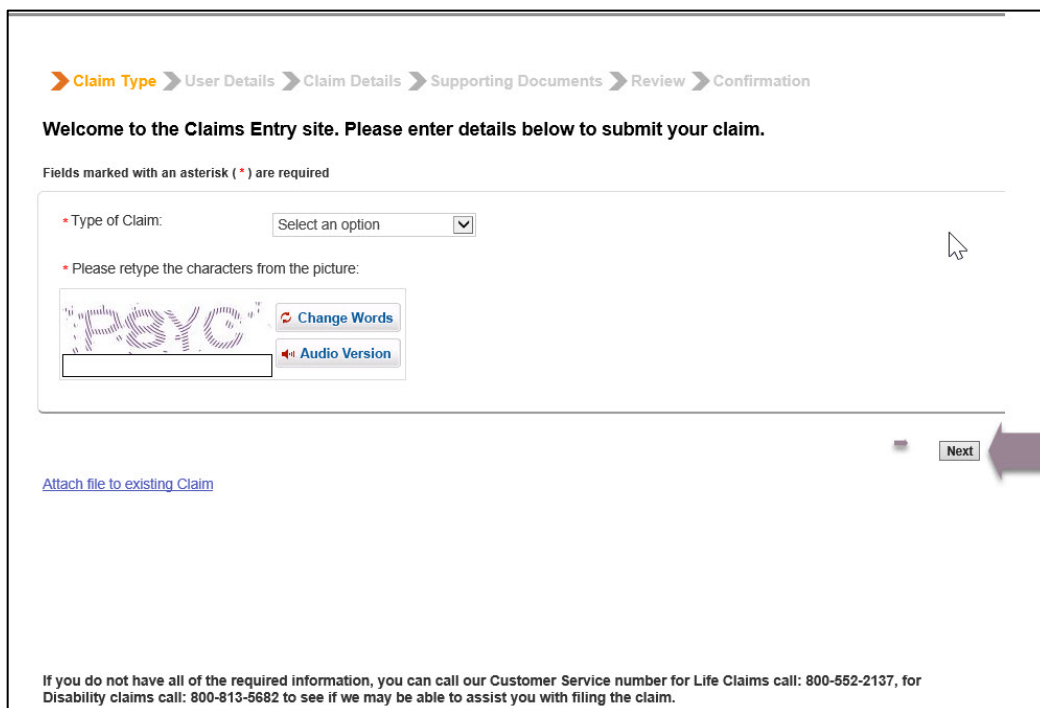
Getting started

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:

- Accidental dismemberment
- Living benefit
- Life waiver of premium
- Short-term disability - **note if UniCare administers FML leave for your employer, 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 screenshot shows the 'Welcome to the Claims Entry site' page. At the top, there is a progress bar with the following steps: Claim Type (highlighted in orange), User Details, Claim Details, Supporting Documents, Review, and Confirmation. Below the progress bar, the text reads: '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 form contains two required fields: 'Type of Claim' with a dropdown menu showing 'Select an option', and 'Please retype the characters from the picture:' with a CAPTCHA image of the word 'PASSY'. Below the CAPTCHA are buttons for 'Change Words' and 'Audio Version'. A 'Next' button is located at the bottom right of the form area, with a purple arrow pointing to it. At the bottom left, there is a link: 'Attach file to existing Claim'. At the bottom of the page, there is a footer: 'If you do not have all of the required information, you can call our Customer Service number for Life Claims call: 800-552-2137, for Disability claims call: 800-813-5682 to see if we may be able to assist you with filing the claim.'

Submitting an accidental dismemberment claim

Select Accidental Dismemberment in the *Type of Claim* field and choose Employee in the *Type of User* field. Then, enter the characters you see in the box and select Next.

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


Fields marked with an asterisk (*) are required

* Type of Claim:

Is this claim for an Employee or Dependent? Employee Dependent

* Type of User:

* Please retype the characters from the picture:



[Change Words](#) [Audio Version](#)

[Attach file to existing Claim](#)

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:

- [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.

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

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

Employee Information

Fields marked with an asterisk (*) are required

* First Name:

* Last Name:

* Social Security Number:

* Street Address 1:

Street Address 2:

* City:

* State: * Zip:

* Country:

* Primary Telephone Number: -

Gender: Male Female

Date Of Birth:

* Date Hired:

Last Day Worked:

Employee's Work Location or Division:

Job Title:

Amount of Benefit:

Accident Information

Date of Injury:

Place of Accident:

Briefly describe the accident and the extent of the injury:

Attending Physician First Name:

Attending Physician Last Name:

Telephone number of Attending Physician: -

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

Upload

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*.

Employee Information

First Name:	test
Last Name:	case
Social Security Number:	111-11-1111
Reason Stopped Work:	Death

statements 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 imprisonment 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.

Cancel Previous Submit

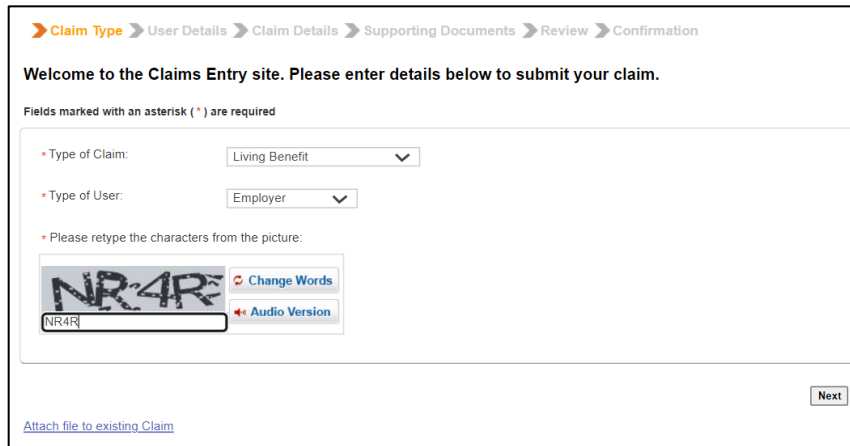
If you do not have all of the required information, you can call our Customer Service number 800-552-2137 to see if we may be able to assist you with filing the claim.

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 Confirmation Summary	Print this page
This claim has been submitted successfully.	
CLAIM REFERENCE NUMBER : 201115 - Accidental Dismemberment Claim submitted by Employee	
The content in this confirmation page reflects what you entered.	
Employee Information	
First Name:	test
Last Name:	test
Social Security Number:	111-11-1111
Address 1:	test
City:	test
State:	NH
Zip:	11111
Country:	United States of America
Primary Telephone Number:	111-111-1111g
Date Of Birth:	01/01/1960
Gender:	Male
Date Hired:	01/01/1980
Employer information	
Company Name:	test
Accident Information	
Date of Injury:	04/01/2013
If you would like to enter another claim, please click here .	
Our Customer Service number is 1-800-552-2137 and we are available 8:00 a.m. to 8:00 p.m. Eastern time. You may also leave a message if you call outside of our regular hours.	

Submitting a living benefit/accelerated death benefit claim

Select Living Benefit in the *Type of Claim* field and select Employee in the *Type of User* field. Then, enter the characters you see in the box and click *Next*.

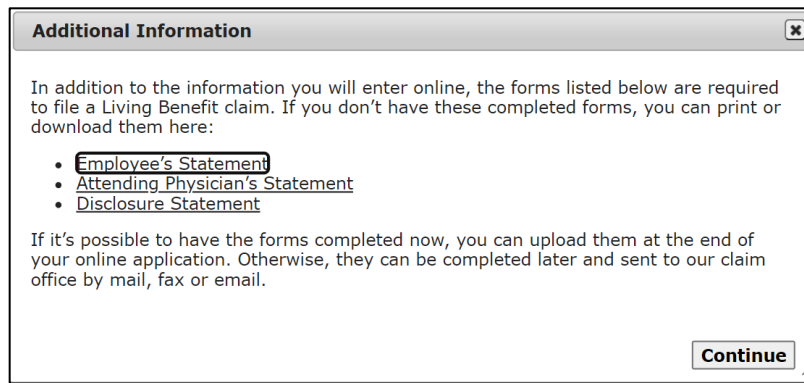


The screenshot shows a web form titled "Welcome to the Claims Entry site. Please enter details below to submit your claim." The breadcrumb trail at the top is: Claim Type > User Details > Claim Details > Supporting Documents > Review > Confirmation. Below the header, it states "Fields marked with an asterisk (*) are required". The form contains three required fields: "Type of Claim" (a dropdown menu with "Living Benefit" selected), "Type of User" (a dropdown menu with "Employer" selected), and a CAPTCHA challenge. The CAPTCHA image shows the characters "NR4R" in a stylized font. Below the image is a text input field containing "NR4R". To the right of the image are two buttons: "Change Words" and "Audio Version". At the bottom right of the form is a "Next" button. At the bottom left, there is a link: "Attach 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*.



The screenshot shows a dialog box titled "Additional Information" with a close button (X) in the top right corner. The text inside reads: "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:". Below this text is a bulleted list of three links: "Employee's Statement", "Attending Physician's Statement", and "Disclosure Statement". The first link is highlighted with a yellow background. Below the list, the text says: "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." At the bottom right of the dialog box is a "Continue" button.

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

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

Employee Information

Fields marked with an asterisk (*) are required

* First Name:

* Last Name:

* Social Security Number:

* Address 1:

Address 2:

* City:

* State: * Zip:

* Country:

* Primary Telephone Number: -

Date Of Birth:

Gender: Male Female

* Date Hired:

Last Day Worked:

Employee's Work Location or Division:

Job Title:

Amount of Insurance: \$

Enter your Employer's 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:

Policy Number:

* Your First Name:

* Your Last Name:

* Your Job Title:

* Your Telephone Number: -

Your Email Address:

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.](#)

No file chosen

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*.

Employee Information	
First Name:	John
Last Name:	Doe
Social Security Number:	222-22-2222
Address 1:	123 Main Street
City:	Anytown
State:	IN
Zip:	22222
Country:	United States of America
Primary Telephone Number:	222-222-1111
Date Of Birth:	01/01/1970
Gender:	Male
Date Hired:	01/01/1990
Last Day Worked:	01/01/2022
Employee's Work Location or Division:	Headquarters
Job Title:	Manager
Amount of Insurance:	\$50,000.00

Read and Acknowledge

Fields marked with an asterisk (*) are required

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. 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.

* 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.

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 : 201119 - Living Benefit Claim submitted by Employer

The content in this confirmation page reflects what you entered.

Employee Information

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:	111-111-1111@
Date Hired:	01/01/2000

If you would like to enter another claim, please click [here](#).

Submitting a life waiver of premium claim

Select Life Waiver of Premium in the *Type of Claim* field and Employee in the *Type of User* field. Enter the characters you see in the bottom box, then click *Next*.

The screenshot shows a web interface for submitting a claim. At the top, a breadcrumb trail reads: > Claim Type > User Details > Claim Details > Supporting Documents > Review > Confirmation. Below this, a heading states: "Welcome to the Claims Entry site. Please enter details below to submit your claim." A note indicates: "Fields marked with an asterisk (*) are required". The form contains three main sections: 1) "Type of Claim:" with a dropdown menu set to "Life Waiver of Premium"; 2) "Type of User:" with a dropdown menu set to "Employer"; 3) "Please retype the characters from the picture:" which includes a CAPTCHA image showing the characters "K8K4", a "Change Words" button, and an "Audio Version" button. Below the CAPTCHA is a text input field containing "K8K4". At the bottom right of the form is a "Next" button. A link at the bottom left says "Attach file to existing Claim".

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*.

The screenshot shows a dialog box titled "Additional Information" with a close button in the top right corner. The text inside reads: "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:" followed by a bulleted list:

- [Life Waiver of Premium Employee's Statement](#)
- [Life Waiver of Premium Attending Physician's Statement](#)

 Below the list, it says: "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." The final sentence reads: "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." A "Continue" button is located at the bottom right of the dialog box.

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 (*) are required

* First Name:

* Last Name:

* Social Security Number:

* Address 1:

Address 2:

* City:

* State: * Zip:

* Country:

* Date Of Birth:

* Date Hired:

Rate of Pay: Per

Employee's Work Location or Division:

* Job Title:

* Last Day Worked:

* Reason Stopped Work: Illness / Disability Leave of Absence Dismissed
 Vacation Temporary Layoff 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: \$

Optional/Supp Life: \$

Total: \$

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 ➤ 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.](#)

No file chosen

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*.

Employee Information	
First Name:	John
Last Name:	Doe
Social Security Number:	123-33-4444
Address 1:	123 Main Street
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
Employee's Work Location or Division:	Headquarters
Job Title:	Manager
Last Day Worked:	01/01/2022
Reason Stopped Work:	Illness / Disability
Does your company have a formal pension plan?	Yes
Will Employee be able to retire under this plan?	No
Amount of Insurance	
Basic Life:	\$50,000.00
Optional/Supp Life:	\$50,000.00
Total:	\$100,000.00

Read and Acknowledge	
Fields marked with an asterisk (*) are required	
<p>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. 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</p> <p><small>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.</small></p>	
<input checked="" type="checkbox"/> I acknowledge that I have read and agree to the above statement	
Additional Comments:	<div style="border: 1px solid black; height: 40px;"></div>
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:	<input type="text" value="jim.roe@abc.com"/>
Confirm Email Address:	<input type="text" value="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 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.	

<input type="button" value="Cancel"/>	<input type="button" value="Previous"/> <input type="button" value="Submit"/>
---------------------------------------	---

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.

[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 : 201207 - Life Waiver of Premium Claim submitted by Employer

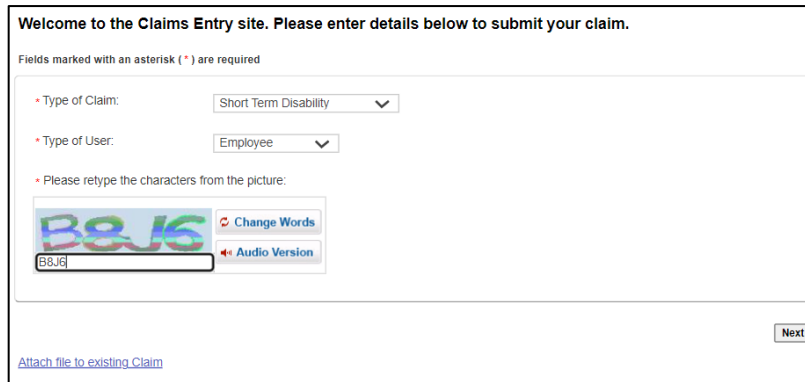
The content in this confirmation page reflects what you entered.

Employee Information

First Name:	Tim
Last Name:	Jones
Social Security Number:	111-22-2333
Address 1:	12 Main Street
City:	Columbus
State:	OH
Zip:	43211
Country:	United States of America
Date Of Birth:	01/01/1960
Date Hired:	01/01/1980
Job Title:	Operator
Last Day Worked:	01/02/2013
Reason Stopped Work:	Illness / Disability

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 click *Next*.



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

Fields marked with an asterisk (*) are required

* Type of Claim: Short Term Disability

* Type of User: Employee

* Please retype the characters from the picture:

B&J6

Change Words

Audio Version

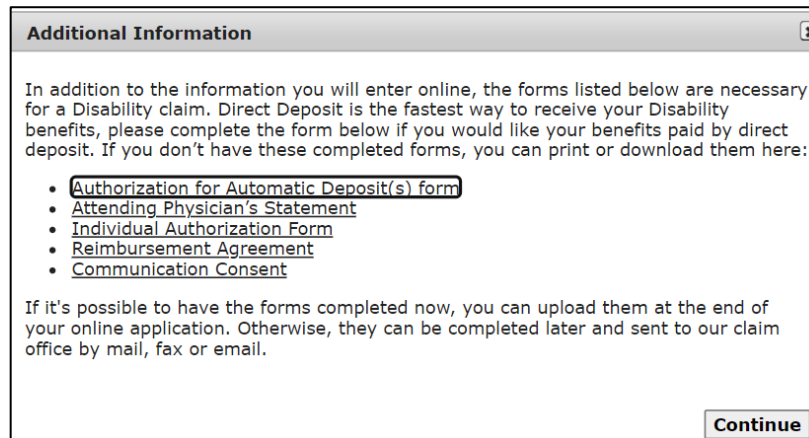
Next

[Attach file to existing 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:

- *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:

- [Authorization for Automatic Deposit\(s\) form](#)
- [Attending Physician's Statement](#)
- [Individual Authorization Form](#)
- [Reimbursement Agreement](#)
- [Communication Consent](#)

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

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 (*) are required

* Your First Name:

* Your Last Name:

* Address 1:

Address 2:

* City:

* State: * Zip:

* Country:

The state the Employee works in if other than where they live:

Your Work location:

* Social Security Number:

* Date Of Birth:

Gender: Male Female

Date Last Worked:

Number of hours worked on last Day Worked:

* First Day Absent Due to Disability:

* Primary Telephone Number: -

Alternate Telephone Number: -

Email Address:

Employer Information

Fields marked with an asterisk (*) are required

* Group Name:

Group Policy Number:

Contact First Name:

Contact Last Name:

Contact Job Title:

Contact Telephone Number: -

Contact Fax Number: -

Contact Email Address:

Your Job Information

Fields marked with an asterisk (*) are required

* 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

Enter your employer's contact information and information about your job. Click *Next*

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

Employer Information

Fields marked with an asterisk (*) are required

* Company Name:

Policy Number:

* Your First Name:

* Your Last Name:

* Your Job Title:

* Your Telephone Number: -

Your Email Address:

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

- Illness
- Injury
- Maternity
- Unknown

Click *Next*.

➤ 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

Injury Information

Fields marked with an asterisk (*) are required

* Date of injury:

* Describe your injury or diagnosis:

* Was the injury work related?

Doctor Information

Fields marked with an asterisk (*) are required

* Name of the doctor certifying your disability:

Doctor's Street Address 1:

Doctor's Street Address 2:

City:

State: Zip:

Country:

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

Hospital Name:

Hospital Address:

Admission Date:

Discharge Date:

Did you have Outpatient Surgery: Yes No

Other Income

Fields marked with an asterisk (*) are required

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

Approved: Yes No

From Through

State Disability: Yes No

Other Income: 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 *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.](#)

No file chosen

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](#)
[Confirmation](#)

Fields marked with an asterisk (*) are required

Employee Information

Your First Name: John
 Your Last Name: Doe
 Address 1: 123 Main Street
 City: Anytown
 State: IL
 Zip: 22222
 Country: United States of America
 The state the Employee works in if other than where they live: IL
 Social Security Number: 111-22-2333
 Date Of Birth: 01/01/1970
 Gender: Male
 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
 Email Address: john.doe@abc.com

Employer Information

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 Email Address: jim.roe@abc.com

Your Job Information

Job Title: Manager
 Hours Worked per Week: 40
 Date Hired: 01/01/1990
 Please provide a brief description of your job duties: Manager of Accounting
 Are you an Hourly or Salaried Employee: Salaried
 Are you a Union Member? No

Disability Information

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? No

Injury Information

Date of injury: 01/03/2022
 Describe your injury or diagnosis: Car accident - broken leg, head injury
 Was the injury work related? No

Doctor Information

Name of the doctor certifying your disability: Tom Thoms
 Doctor's Street Address 1: 456 Main Street
 City: Anytown
 State: IN
 Zip: 22222
 Country: United States of America
 Doctors Telephone Number: 444-555-6666
 Doctor's specialty: Emergency medicine
 Date of First Office Visit: 01/03/2022
 Date of Last Office Visit: 01/07/2022
 Date of Next Office Visit: 01/10/2022
 Were you Hospitalized: Yes
 Hospital Name: General Hospital
 Hospital Address: 666 Main Street, Anytown, IL
 Admission Date: 01/03/2022
 Discharge Date: 01/06/2022
 Did you have Outpatient Surgery: No

Other Income

Have you applied for or are you receiving any of the following benefits?
 Social Security: No
 Pension or Retirement: No
 Employer Paid Time Off: Yes
 Approved: Yes
 From: 01/03/2022 Through 01/20/2022
 State Disability: No

Read and Acknowledge

Fields marked with an asterisk (*) are required

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. 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.

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.

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.

<p>Claim Type > User Details > Claim Details > Supporting Documents > Review > Confirmation</p> <p>Claim Confirmation Summary Print this page</p> <p>This claim has been submitted successfully.</p> <p>CLAIM REFERENCE NUMBER : 201204 - Short Term Disability Claim submitted by Employer</p> <p>The content in this confirmation page reflects what you entered.</p>																					
Employee Information																					
<table><tr><td>Employee First Name:</td><td>Bob</td></tr><tr><td>Employee Last Name:</td><td>Jones</td></tr><tr><td>Address 1:</td><td>12 Main St</td></tr><tr><td>City:</td><td>Columbus</td></tr><tr><td>State:</td><td>OH</td></tr><tr><td>Zip:</td><td>44444</td></tr><tr><td>Country:</td><td>United States of America</td></tr><tr><td>Social Security Number:</td><td>111-22-2333</td></tr><tr><td>Employee's Primary Phone Number:</td><td>222-333-4444</td></tr><tr><td>First Day Absent Due to Disability:</td><td>05/01/2013</td></tr></table>		Employee First Name:	Bob	Employee Last Name:	Jones	Address 1:	12 Main St	City:	Columbus	State:	OH	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
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<p>A representative from our office will be contacting you if any additional information is needed for your claim.</p> <p>Failure to respond to our request for information may cause a delay in claim processing.</p> <p>If you would like to enter another claim, please click here.</p> <p>Our Customer Service number is 800-813-5682 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.</p>																					

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 click *Next*.

The screenshot shows a web form titled "Welcome to the Claims Entry site. Please enter details below to submit your claim." The form includes a breadcrumb trail: "Claim Type > User Details > Claim Details > Supporting Documents > Review > Confirmation". Below the breadcrumb, there is a message: "Fields marked with an asterisk (*) are required". The form contains three main sections: 1. "Type of Claim:" with a dropdown menu set to "Long Term Disability". 2. "Type of User:" with a dropdown menu set to "Employer". 3. "Please retype the characters from the picture:" featuring a CAPTCHA image with the characters "N9JY", a "Change Words" button, and an "Audio Version" button. A text input field below the CAPTCHA contains the characters "N9JY". At the bottom right of the form is a "Next" button. At the bottom left, there is a link: "Attach file to existing 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:

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

Click *Continue*.

The screenshot shows a dialog box titled "Additional Information" with a close button (X) in the top right corner. The text inside reads: "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:". Below this text is a bulleted list of five links: "Authorization for Automatic Deposit(s) form", "Attending Physician's Statement", "Individual Authorization Form", "Reimbursement Agreement", and "Communication Consent". The first link is highlighted with a yellow background. At the bottom right of the dialog box is a "Continue" button.

Enter your contact information and your Employer's contact information. Click *Next*.

Employee Information

* Employee First Name:

* Employee Last Name:

* Employee Address 1:

Employee Address 2:

* City:

* State: * Zip:

* Country:

The state the Employee works in if other than where they live:

Employee Work Location or Division:

Job Title:

Scheduled Hours Worked per Week:

Effective Date of Coverage:

Number of hours worked on last Day Worked:

* Social Security Number:

Date Of Birth:

Gender: Male Female

* Employee's Primary Phone Number: -

Employee's Alternate Phone Number: -

Date Hired:

* First Day Absent Due to Disability:

Date Last Worked:

Please provide a brief description of the employees job duties:

Employer Information

Fields marked with an asterisk (*) are required

* Group Name:

Group Policy Number:

* Your First Name:

* Your Last Name:

* Your Job Title:

* Your Telephone Number: -

Your Fax Number: -

Your Email Address:

Give us as much information about your job as you can. Click *Next*.

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 as much information as you can about the disabling condition. The questions will vary based on the reason you stopped work:

- Illness
- Injury
- Maternity
- Unknown

Click *Next*.

The screenshot shows a web form titled "Disability Information". At the top, a breadcrumb trail reads: "Claim Type > User Details > Claim Details > Supporting Documents > Review > Confirmation". The "Claim Details" step is highlighted in orange. Below the breadcrumb, the form has a sub-header "Disability Information" and a note: "Fields marked with an asterisk (*) are required".

The form contains two main sections:

- Disability Information:**
 - "Reason Stopped Work:" with a dropdown menu showing "Illness".
 - "Has the employee returned to work?" with radio buttons for "Yes" and "No".
- Salary Information:**
 - "Employee's salary as of last day worked:" with a text input field containing "\$50000.00".
 - "Salary Frequency:" with a dropdown menu showing "Annually".
 - "Is the Employee Hourly or Salaried:" with radio buttons for "Hourly" and "Salaried" (selected).
 - "Is this a union employee:" with radio buttons for "Yes" and "No".
 - "Did the employee receive salary continuation or sick pay:" with radio buttons for "Yes" and "No".

At the bottom of the form, there are three buttons: "Cancel", "Previous", and "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*.

The screenshot shows a web form titled "Supporting Documents". At the top, a breadcrumb trail reads: "Claim Type > User Details > Claim Details > Beneficiary Details > Supporting Documents > Review > Confirmation". The "Supporting Documents" step is highlighted in orange.

The form has a sub-header "Please upload any relevant documents for this claim" and a link: "Please click here to access the available forms." Below this, there is a file upload area with a "Choose File" button, the text "No file chosen", and an "Upload" button. At the bottom of the form, there are three buttons: "Cancel", "Previous", and "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*.

Employee 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

Disability Information

Reason Stopped Work:	Illness
Has the employee returned to work?	No

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

Read and Acknowledge

Fields marked with an asterisk (*) are required

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. 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.

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.

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 : 201204 - Long Term Disability Claim submitted by Employer

The content in this confirmation page reflects what you entered.

Employee Information

Employee First Name:	Bob
Employee Last Name:	Jones
Address 1:	12 Main St
City:	Columbus
State:	OH
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

Disability Information

Reason Stopped Work:	Illness
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Has the employee returned to work?	No
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Salary Information

Employee's salary as of last day worked:	\$10,000.00
Salary Frequency:	Annually
Is the Employee Hourly or Salaried:	Hourly
Is this a union employee:	No
Did the employee receive salary continuation or sick pay:	Yes
Please provide the end date:	05/03/2013

A representative from our office will be contacting you if any additional information is needed for your claim.

Failure to respond to our request for information may cause a delay in claim processing.

If you would like to enter another claim, please click [here](#).

Our Customer Service number is 800-813-5682 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.

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 <https://myspecialtyappsanthem.com/Claims/UC> and click on *Attach file to existing Claim*.


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:

* Please retype the characters from the picture:



[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*.

Please choose one of the following options


[Claim Search](#)
Check the status on a particular employee's claim, or all claims for your group within the past 2 years.

[Group Statistics Reports for Disability Claims](#)
View statistical information about disability benefits your group may have purchased.

[Group Statistics Reports for Life Claims](#)
View statistical information about life benefits your group may have purchased.

[Group Advice to Pay Report](#)
For self funded Advice to Pay Groups only

[Group Paid Claims Report](#)
View monthly, quarterly and Annual Tax Reports

[Submit a claim online](#) 

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*.



Please upload relevant documents for your claim

Fields marked with an asterisk (*) are required

* Claim Number:

Or:

* Reference Number:

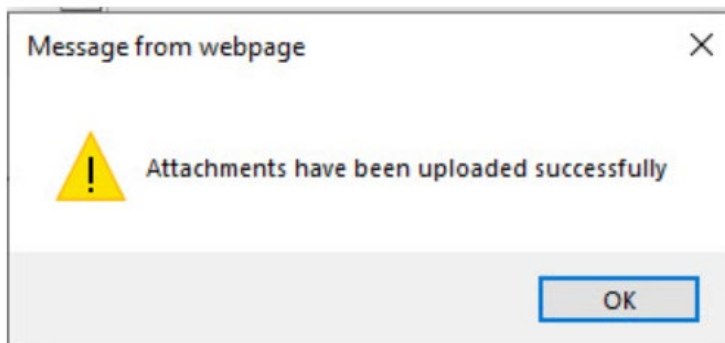
* Member DOB: 

* User Type:

enter date as mm/dd/yyyy

Annotations: Arrows point to the 'Upload' button, the 'Browse...' button, and the 'Submit' button. A callout box points to the Member DOB field.

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





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3/2022