UniCare®

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.

3/2022

Contents

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.

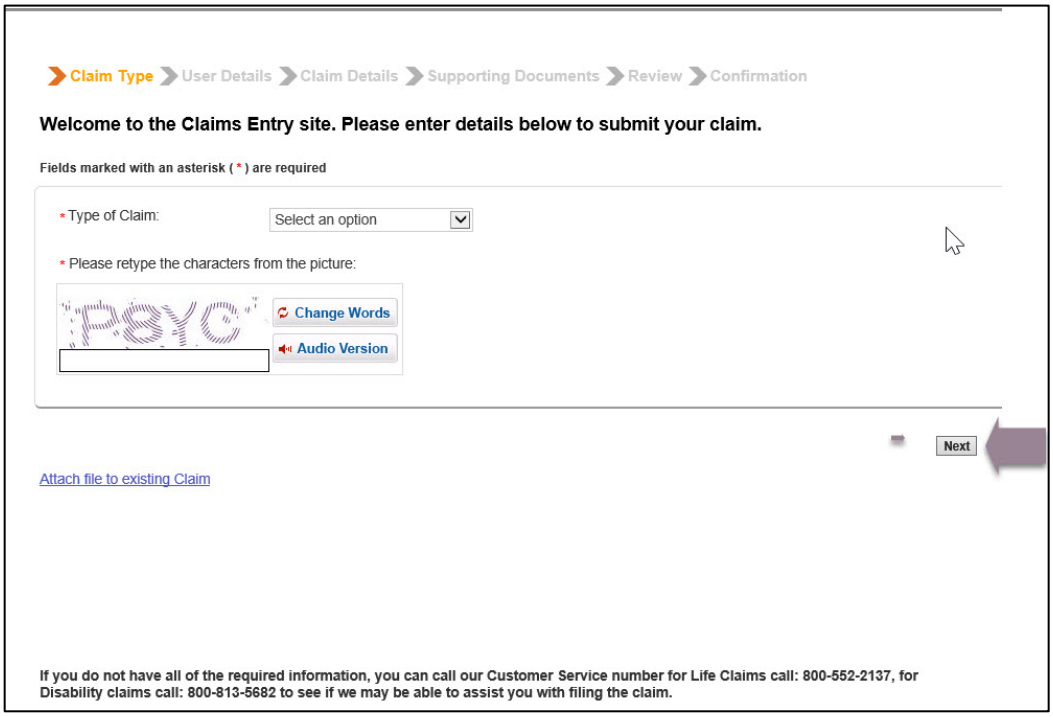
Getting started

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:

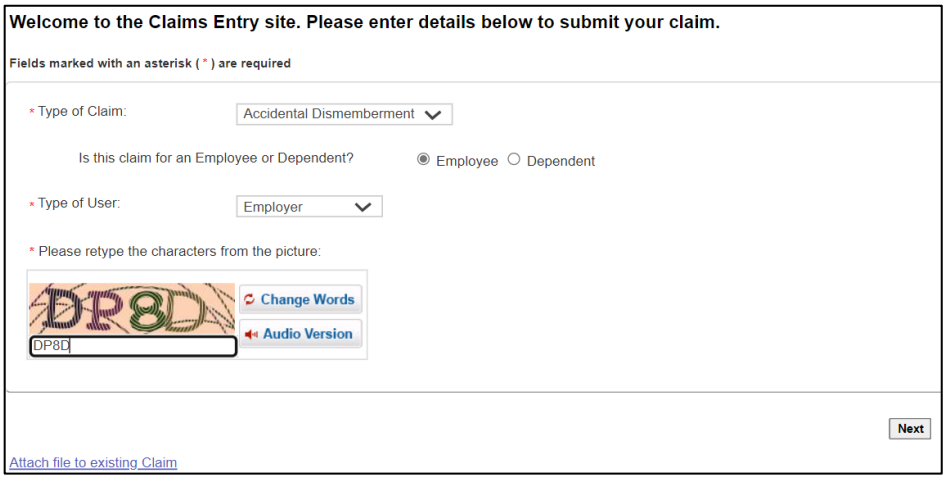
- Accidental dismemberment
- Living benefit
- Life waiver of premium
- Short-term disability - **note if UniCare administers FML leave for your employer, FML claims, and associated STD claims cannot be submitted by the online claim portal described in this booklet. Employees must call our Leave Management Service Center at 1-888-868-7046 to start a claim.**
- Long-term disability

Fields marked with an asterisk (*) are required.

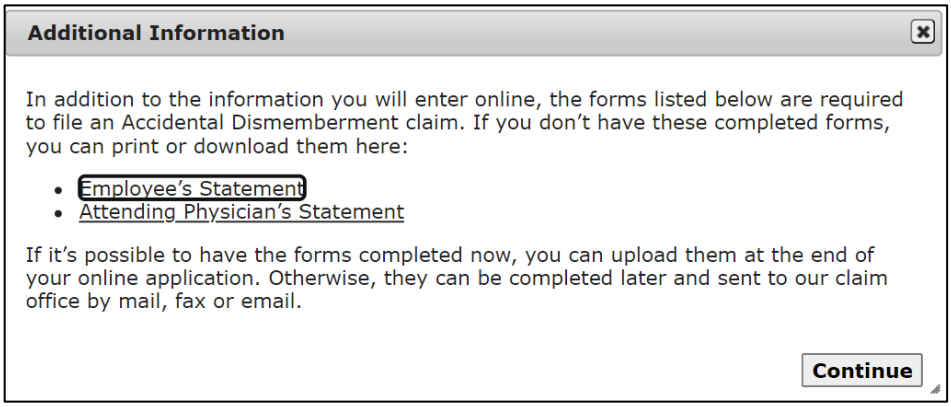


Submitting an accidental dismemberment claim

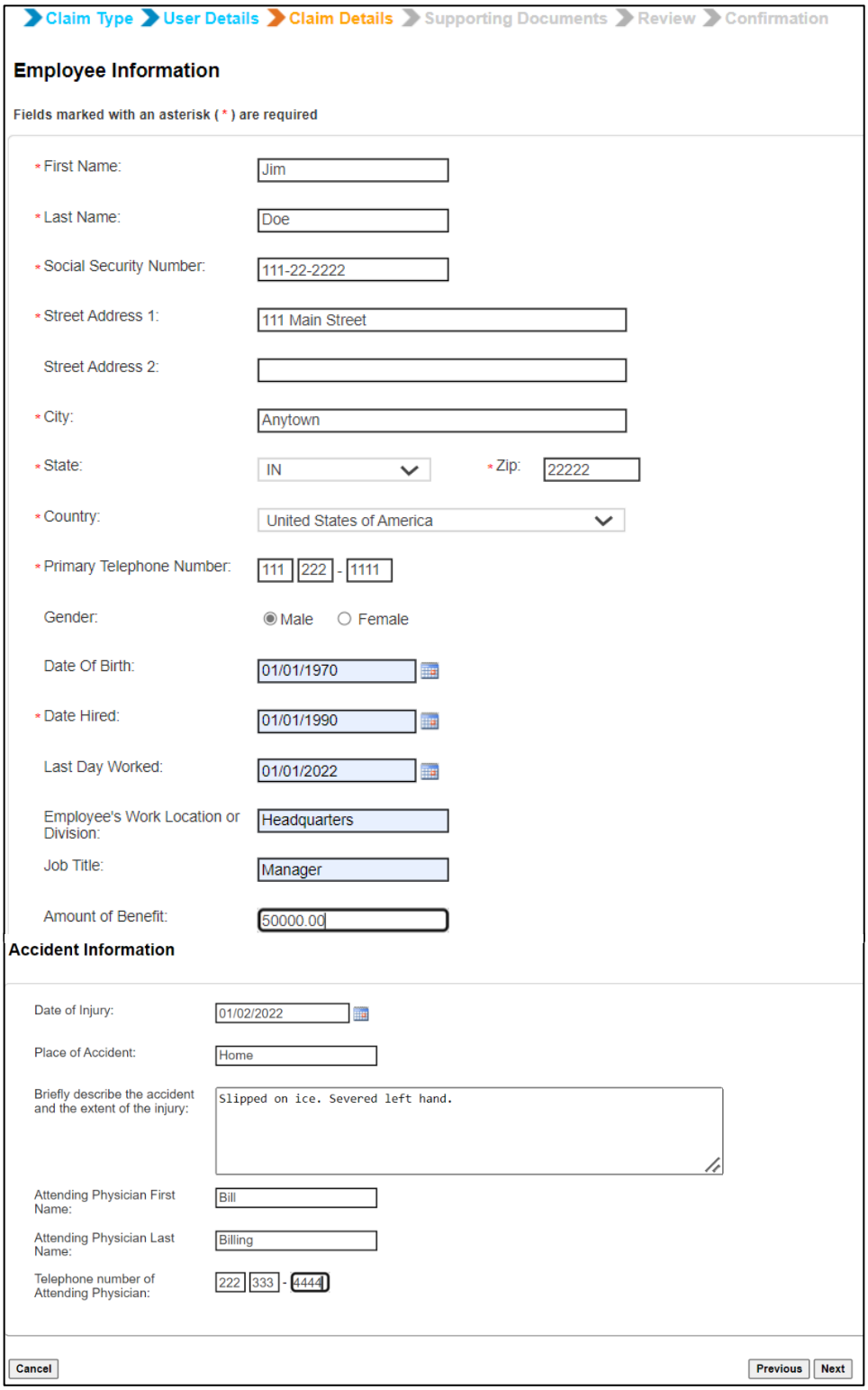
Select Accidental Dismemberment in the *Type of Claim* field and choose Employee in the *Type of User* field. Then, enterthe characters you see in the box and select Next.



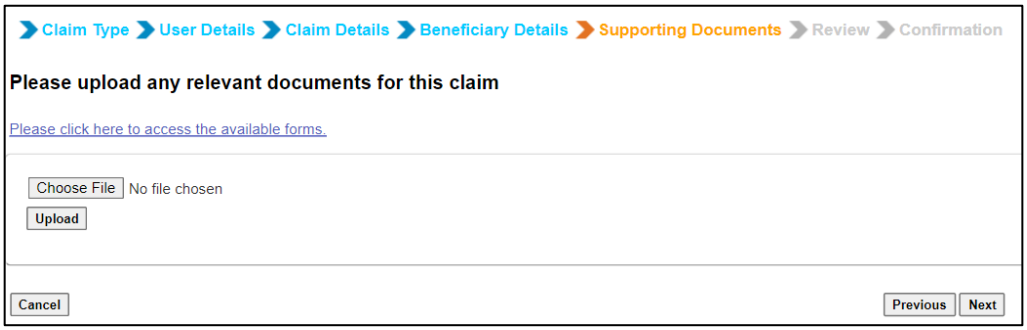
You can print the forms we need to process the accidental dismemberment claim from this screen. Select the links to get fillable PDFs of the *Employee's Statement* and *Attending Physician's Statement*. Click *Continue*.



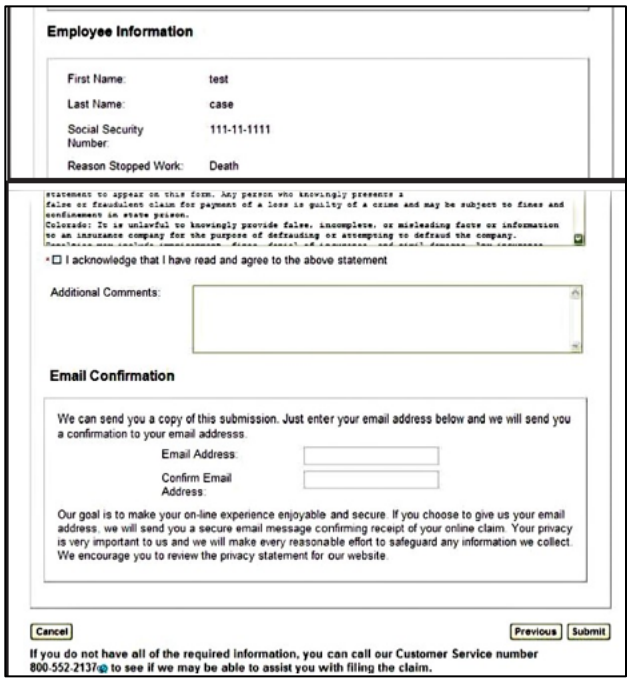
On the *Employee Information* screen, provide the information we need to begin processing the claim. Click *Next*.



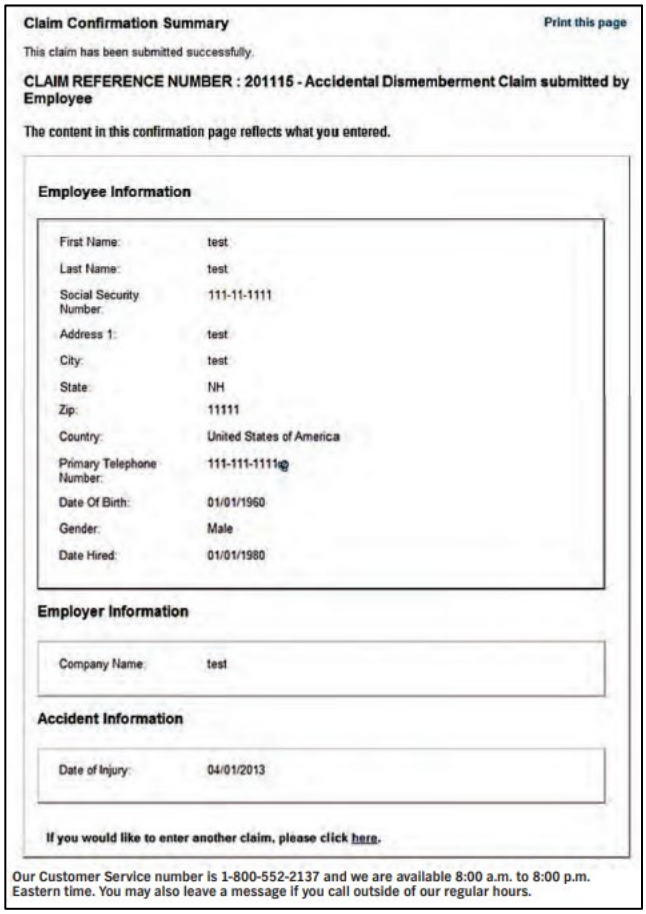
If you already have completed forms, you can scan and upload them on this screen. For example, if you have the *Employee's Statement* or *Attending Physician's Statement*, you can scan and attach them here. Click *Next*.



Next, you'll get confirmation of the information you entered and you'll agree to the legal statement so we can beginprocessing the claim. You can also enter your email address and we'll send you confirmation of all the information you entered. Click *Submit*.



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:	111-111-1111
Date Of Birth:	01/01/1960
Gender:	Male
Date Hired:	01/01/1980

Employer Information

Company Name:	test

Accident Information

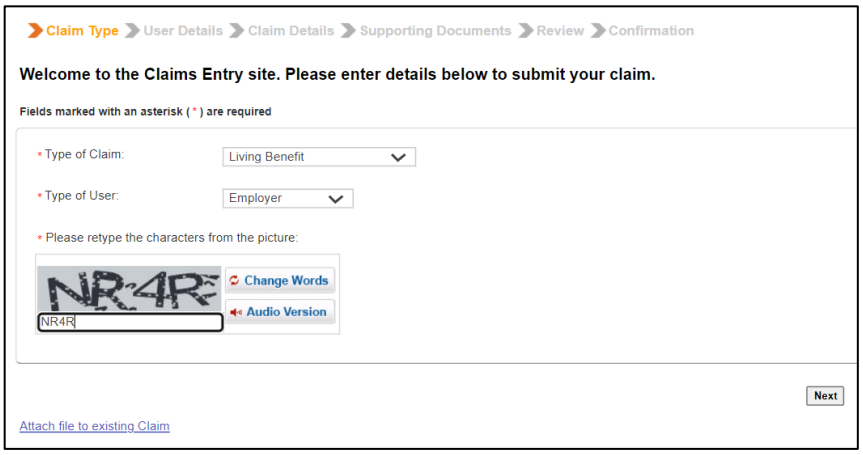
Date of Injury:	04/01/2013

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

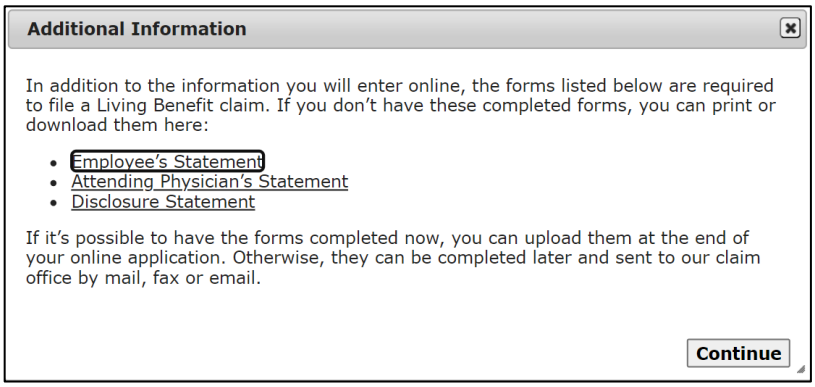
Select Living Benefit in the *Type of Claim* field and select Employee in the *Type of User* field. Then, enter the characters you see in the box and click *Next*.



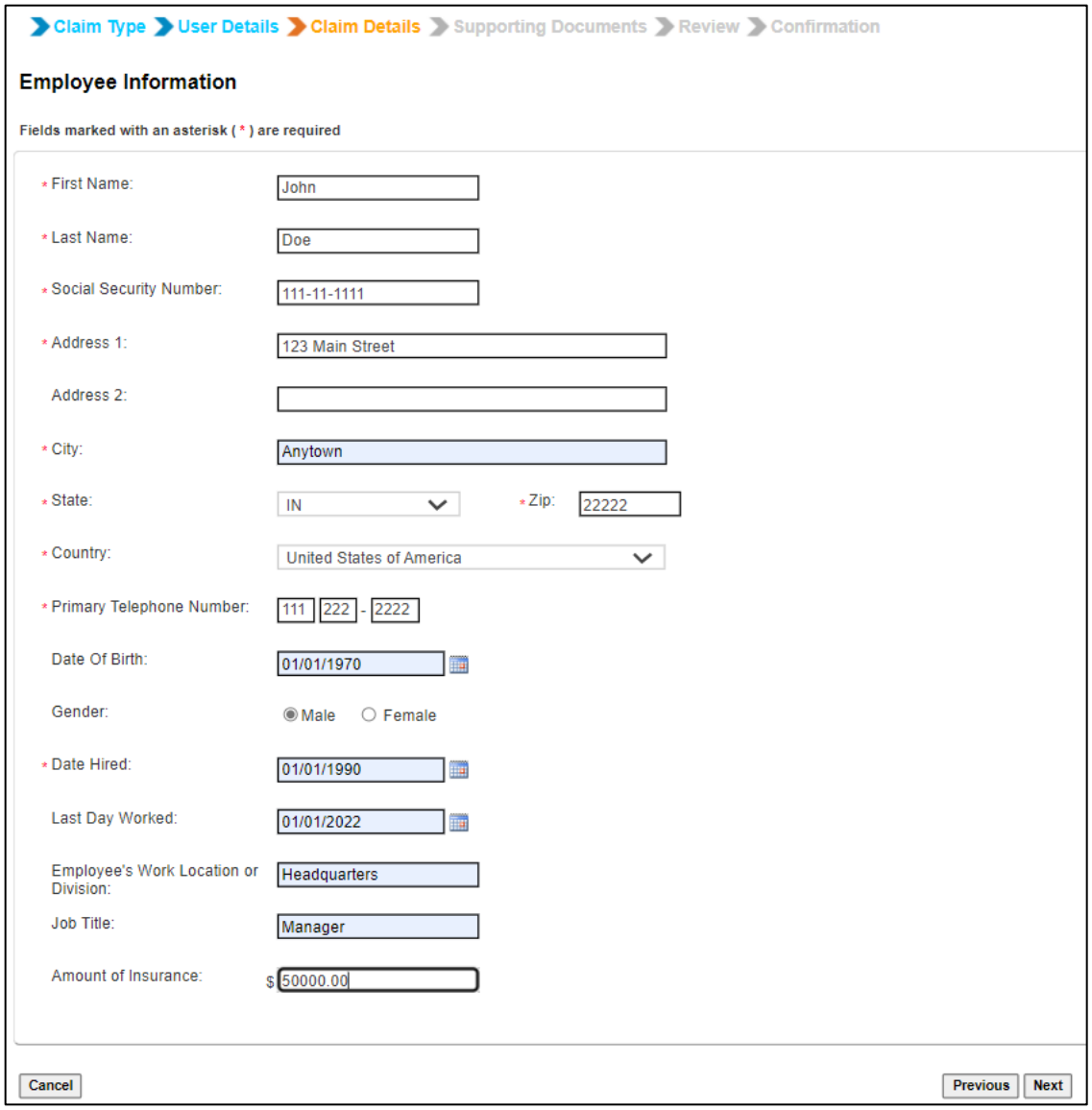
You can print the forms we need to process the living benefit claim from this screen. Select the links to get fillable PDFs of the forms:

- *Employee's Statement*
- *Attending Physician's Statement*
- *Disclosure Statement*

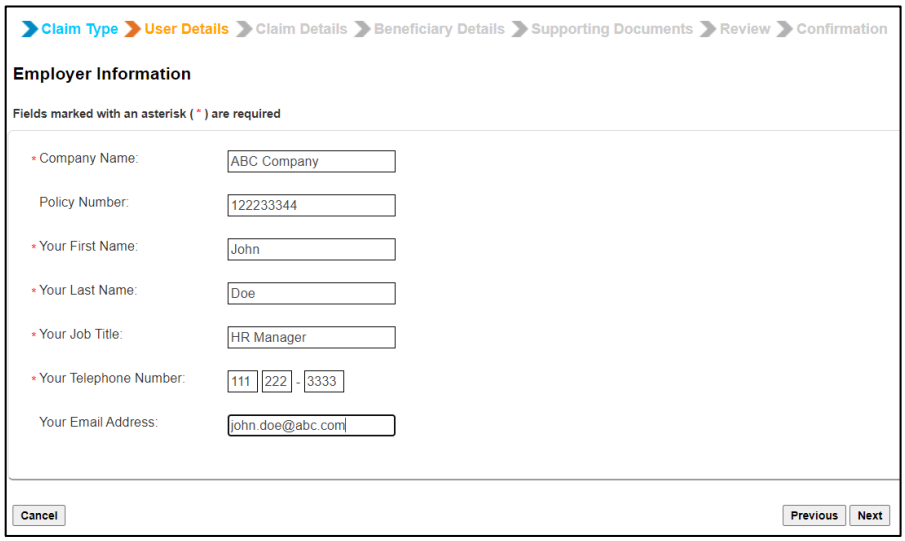
Click *Continue*.



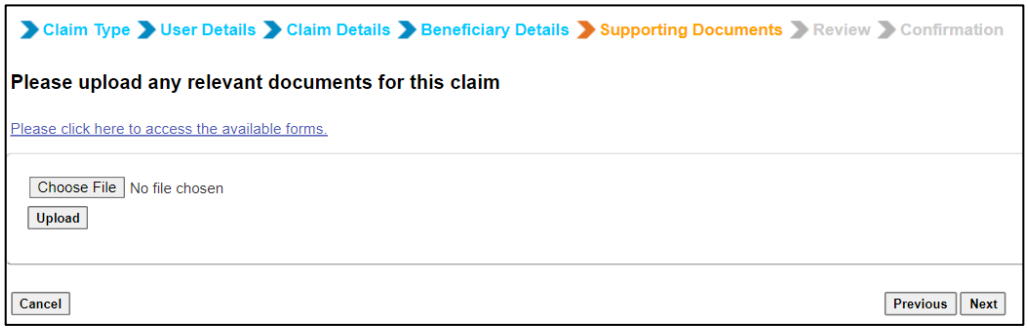
On the *Employee Information* screen, provide the information we need to begin processing the claim. Click *Next*.



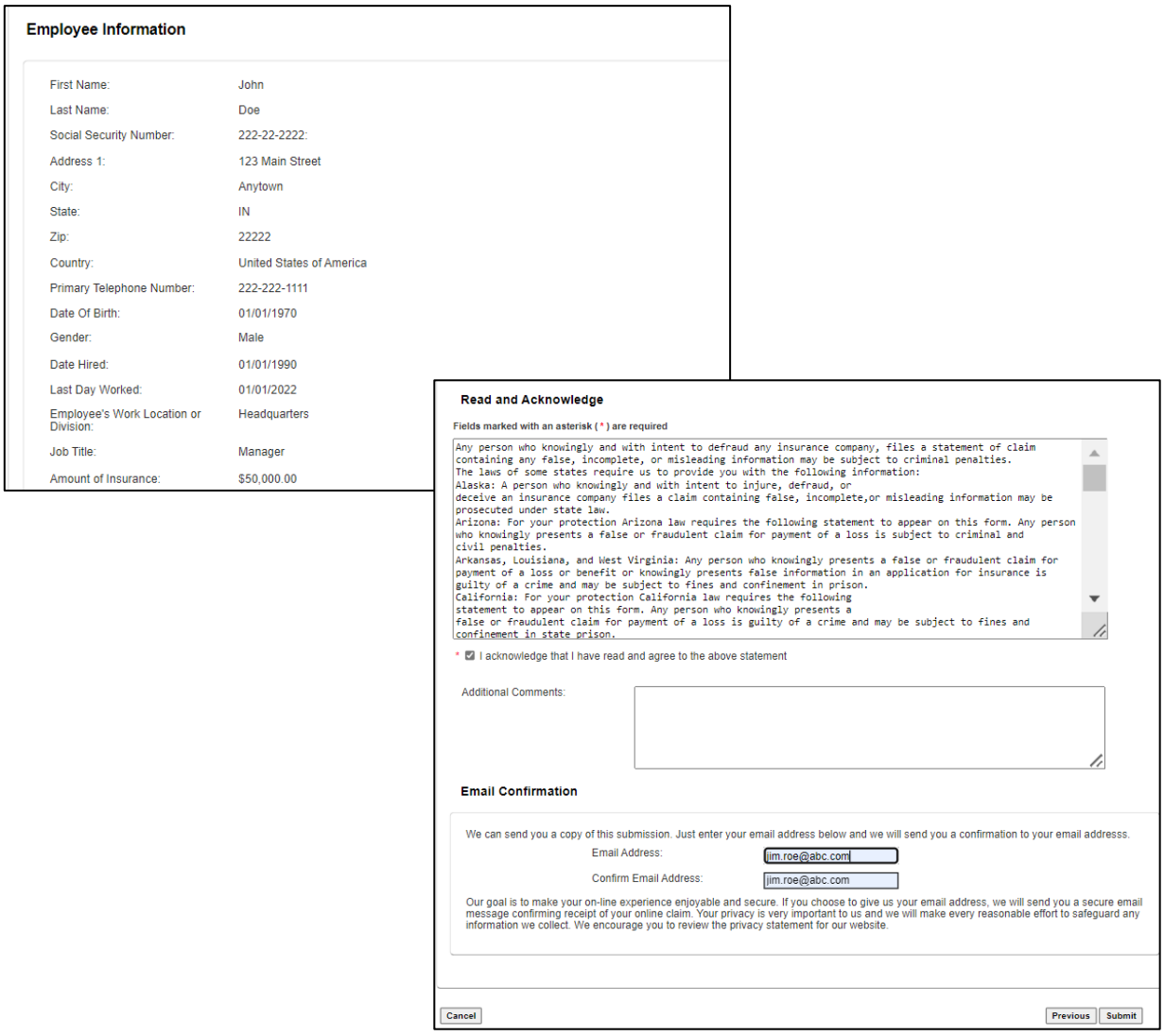
Enter your Employer's contact information on the *Employer Information* screen. Click *Next*.



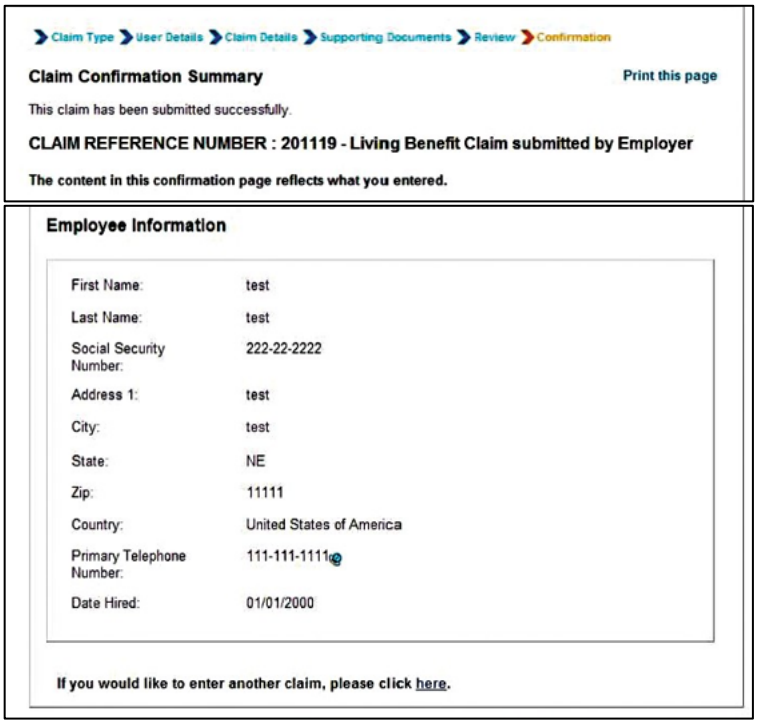
If you have completed forms, you can scan them and upload them on this screen.For example, if you have the *Employee's Statement*, the *Attending Physician's Statement* and/or the *Disclosure Statement*, you can scan and attach them here. Click *Next*.



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*.



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.

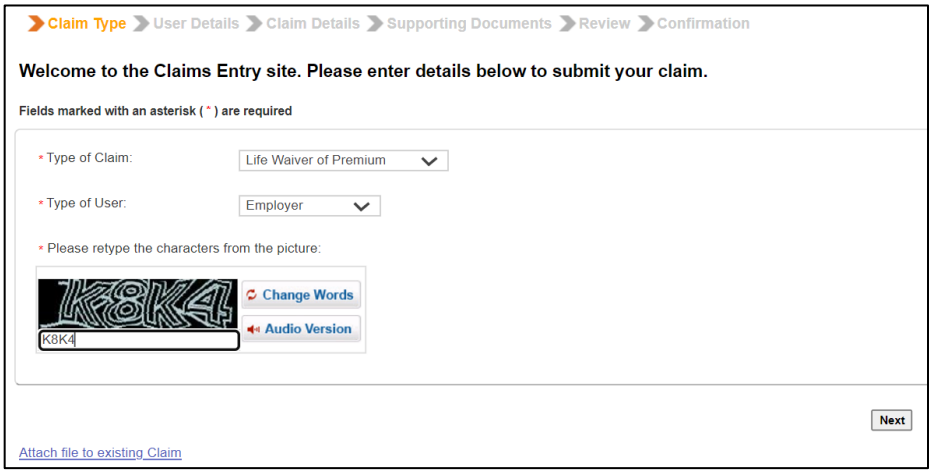
Employee Information

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

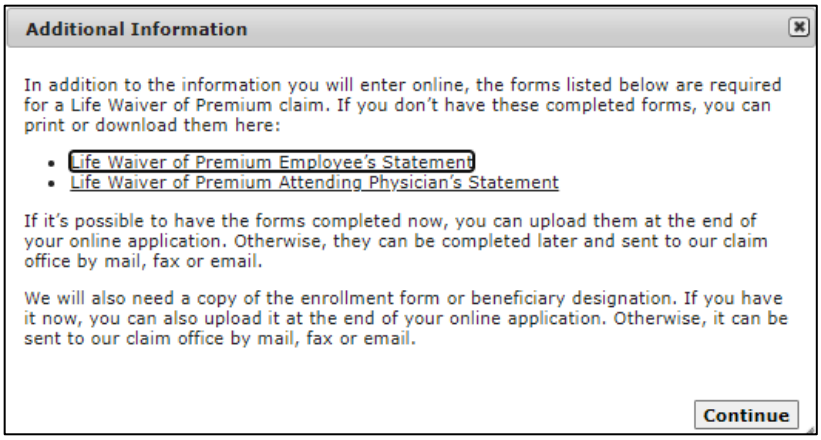
If you would like to enter another claim, please click here.

Submitting a life waiver of premium claim

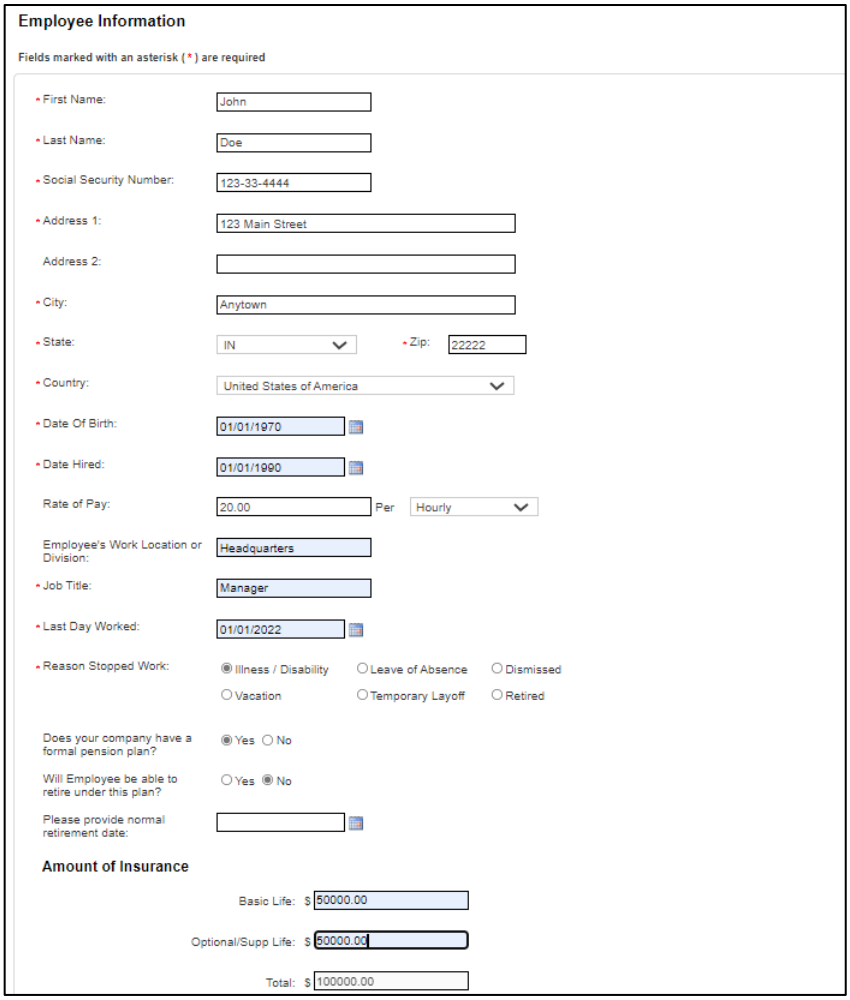
Select Life Waiver of Premium in the *Type of Claim* field and Employee in the *Type of User* field. Enter the characters you see in the bottom box, then click *Next*.



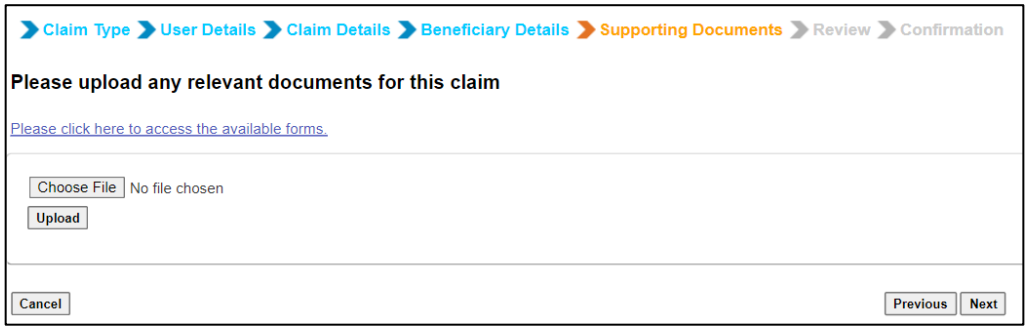
You can print the forms we need to process the life waiver of premium claim from this screen. Select the links to get fillable PDFs of the *Life Waiver of Premium Employee's Statement* and the *Life Waiver of Premium Attending Physician's Statement*. Click *Continue*.



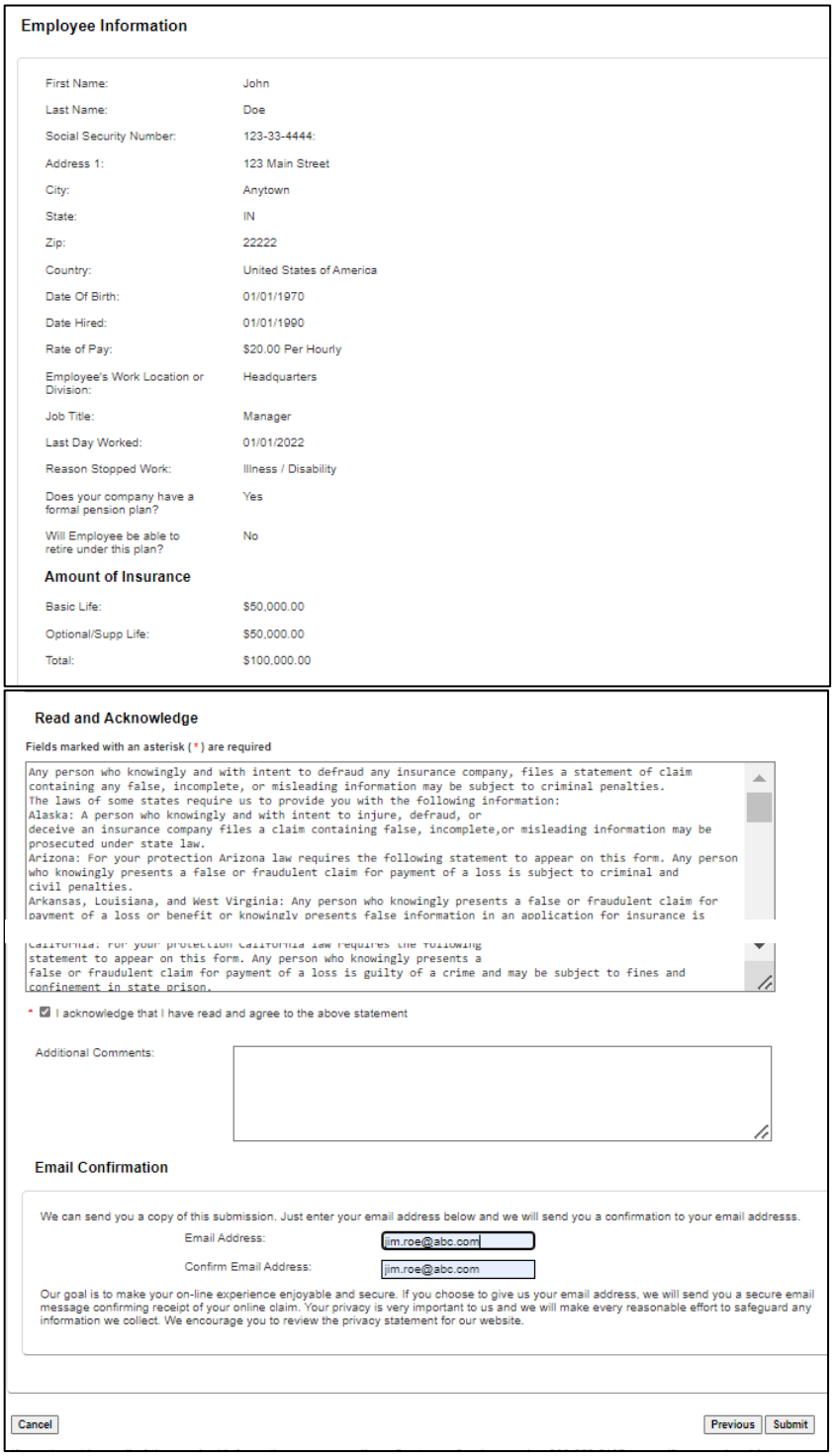
On the *Employee Information* screen, provide the information we need to begin processing the life waiver of premium claim. Click *Next.*



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.*



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

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

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 addresss.

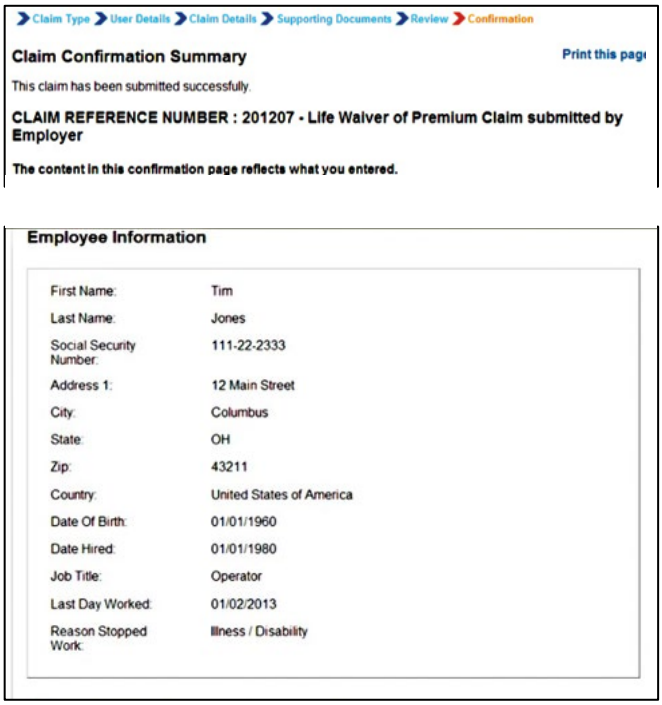
Email Address: jim.roe@abc.com

Confirm Email Address: 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.

Cancel | Previous | 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

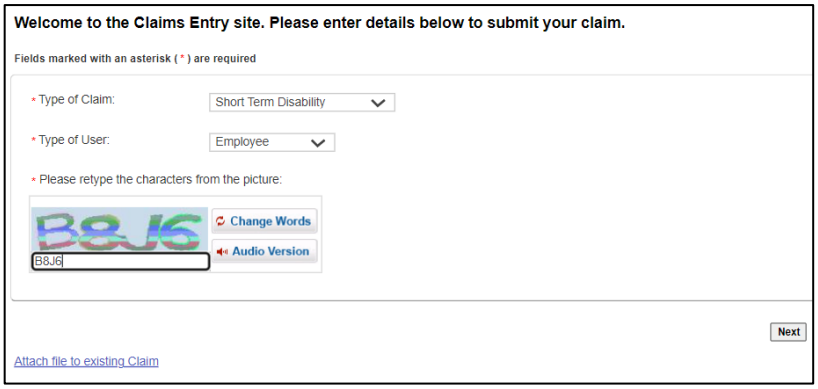
The content in this confirmation page reflects what you entered.

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

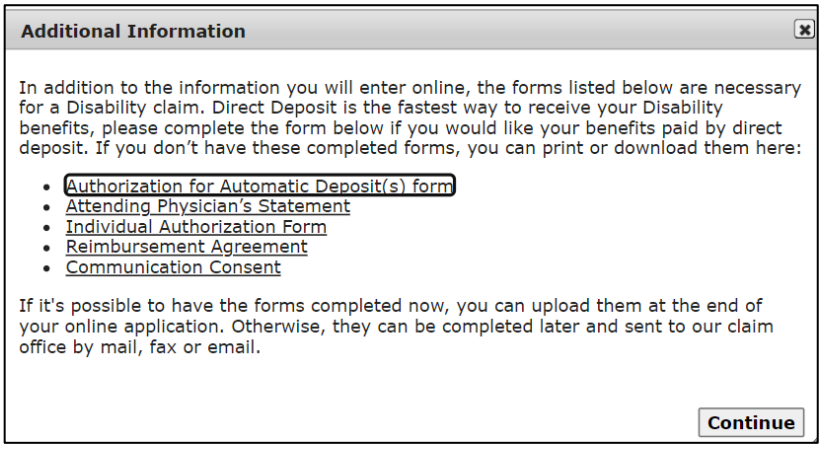
Select Short-Term Disability in the *Type of Claim* field and Employee in the *Type of User* field. Enter the characters you see in the bottom box, then click *Next*.



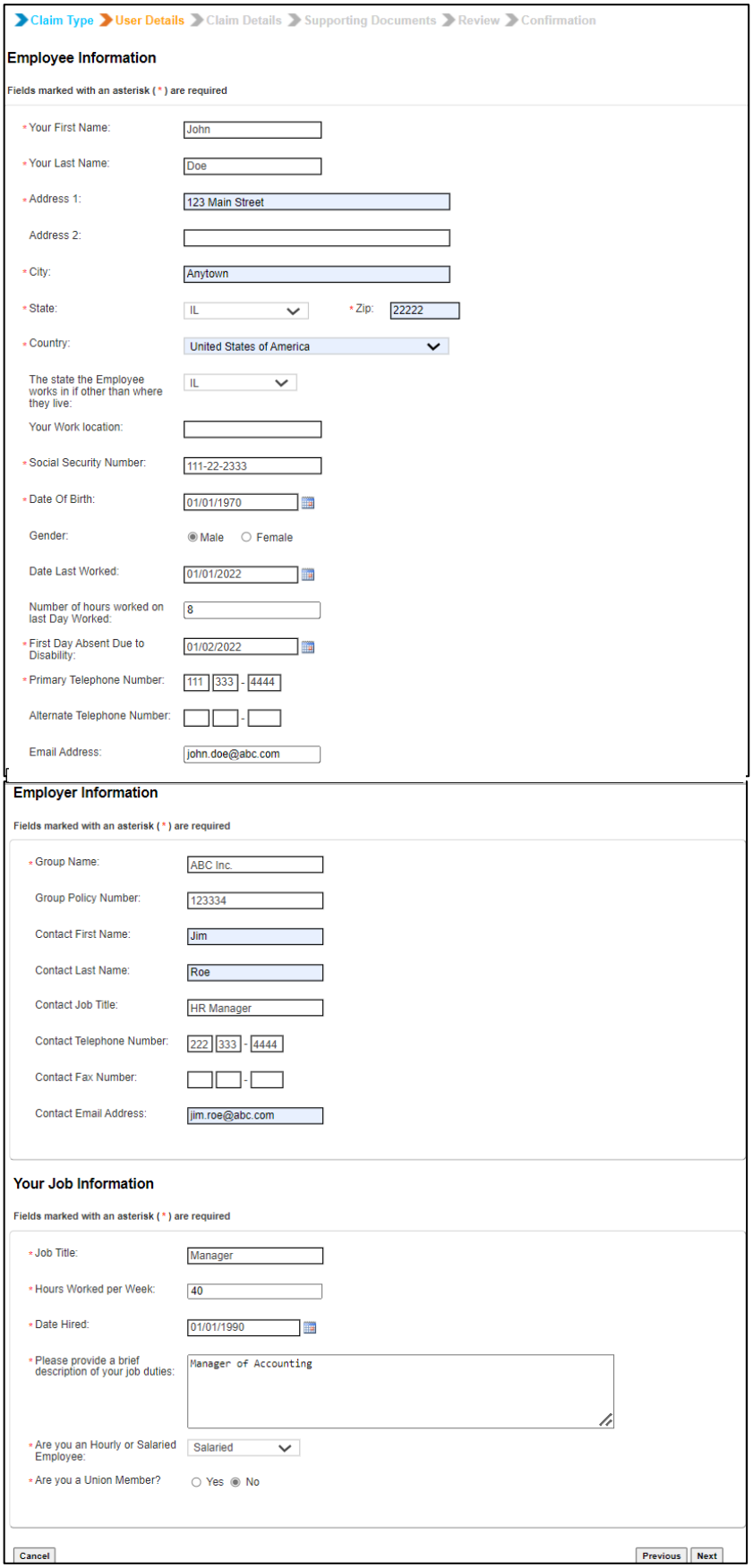
You can print the forms we need to process the short-term disability claim from this screen. Select the links to get fillable PDFs of the forms:

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

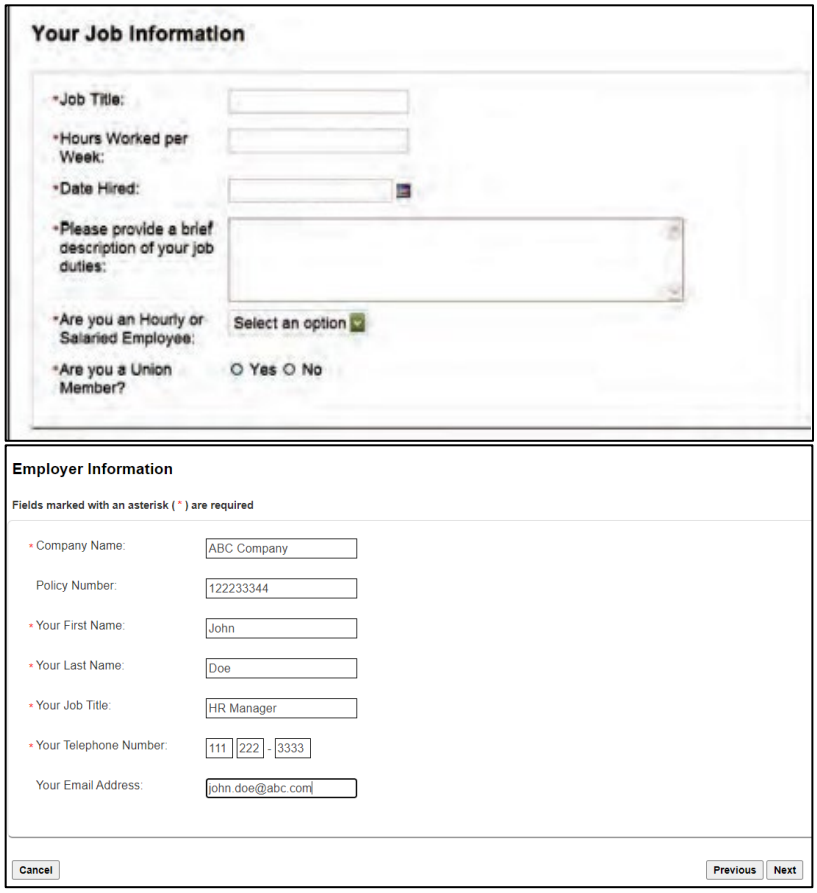
Click *Continue*.



On the *Employee Information* screen, enter as much information as you have about the employee. Click *Next*.



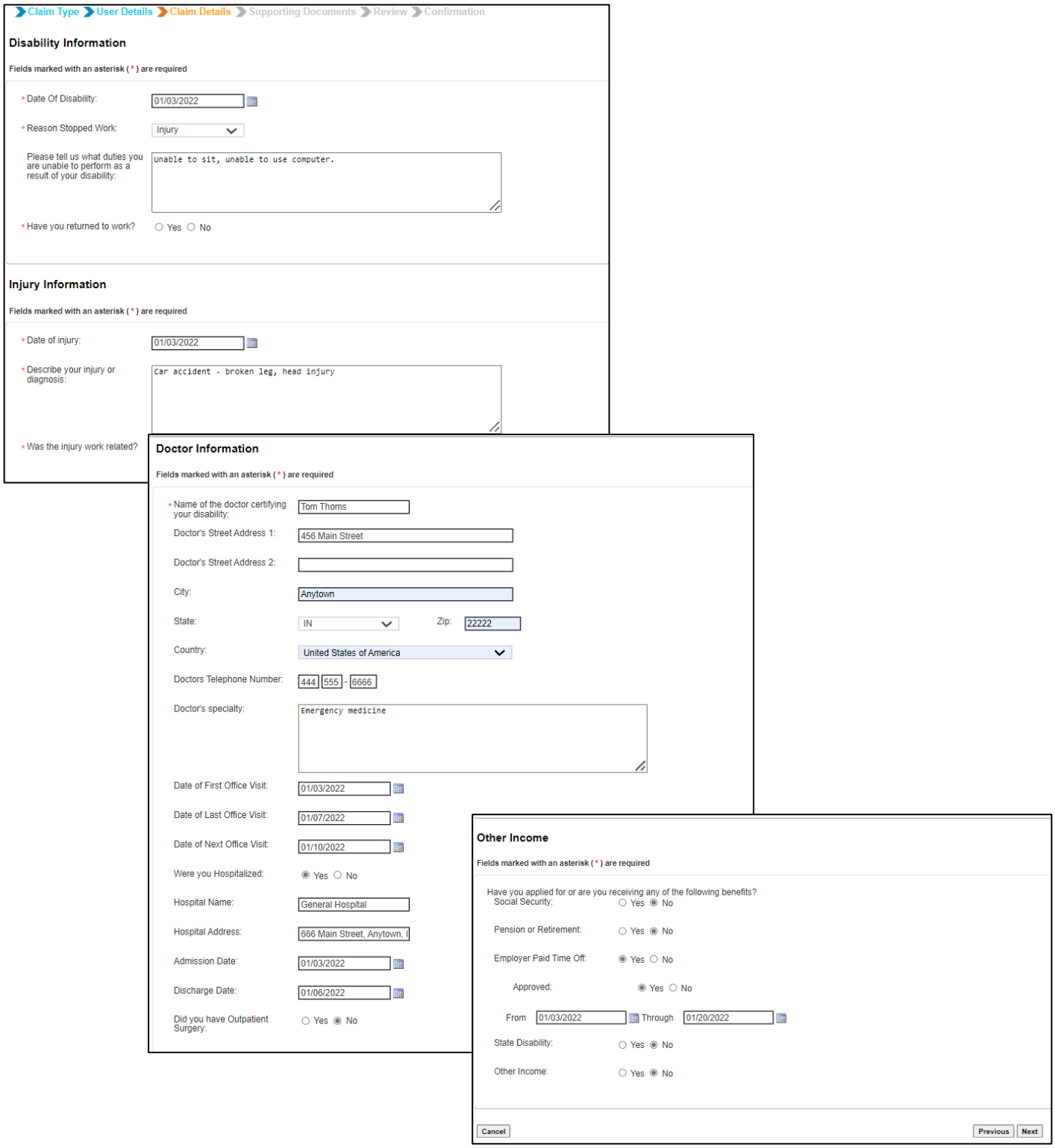
Enter your employer's contact information and information about your job. Click *Next*.



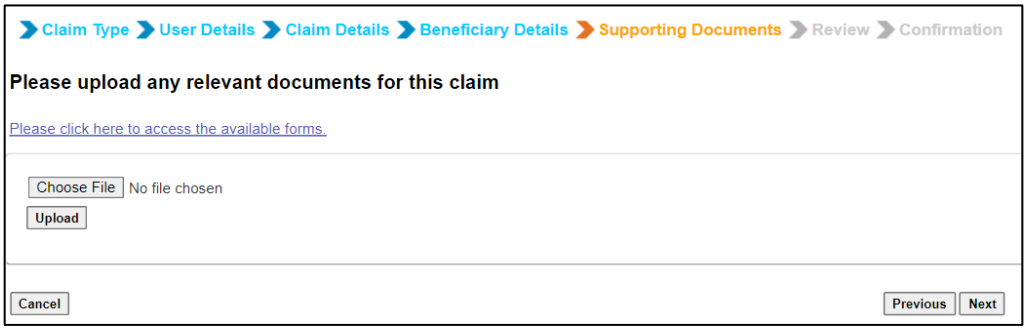
On the *Disability Information* screen, enter as much information as you can about the disabling condition. The questions will vary based on the reason you stopped work:

- Illness
- Injury
- Maternity
- Unknown

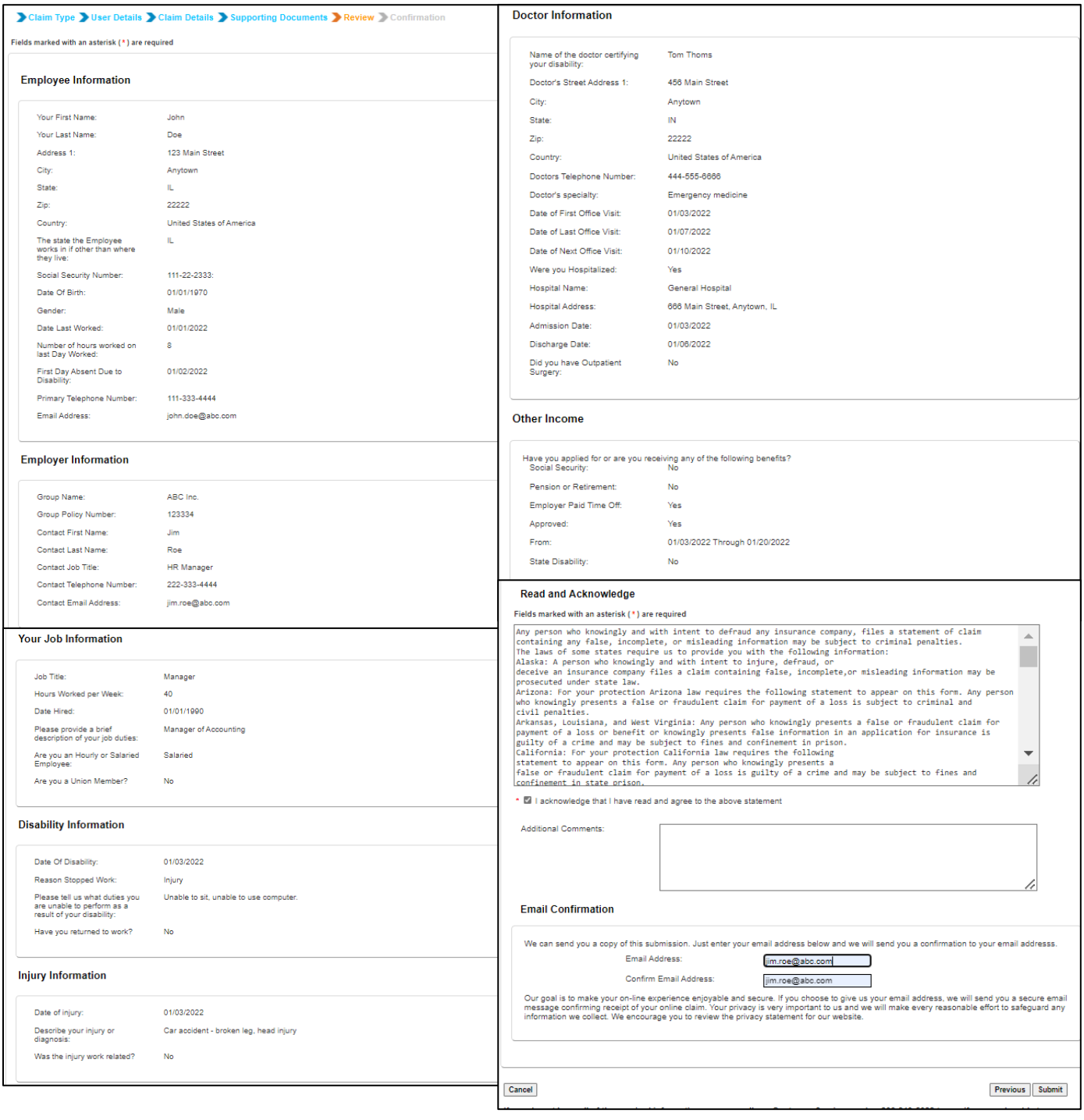
Click *Next*.



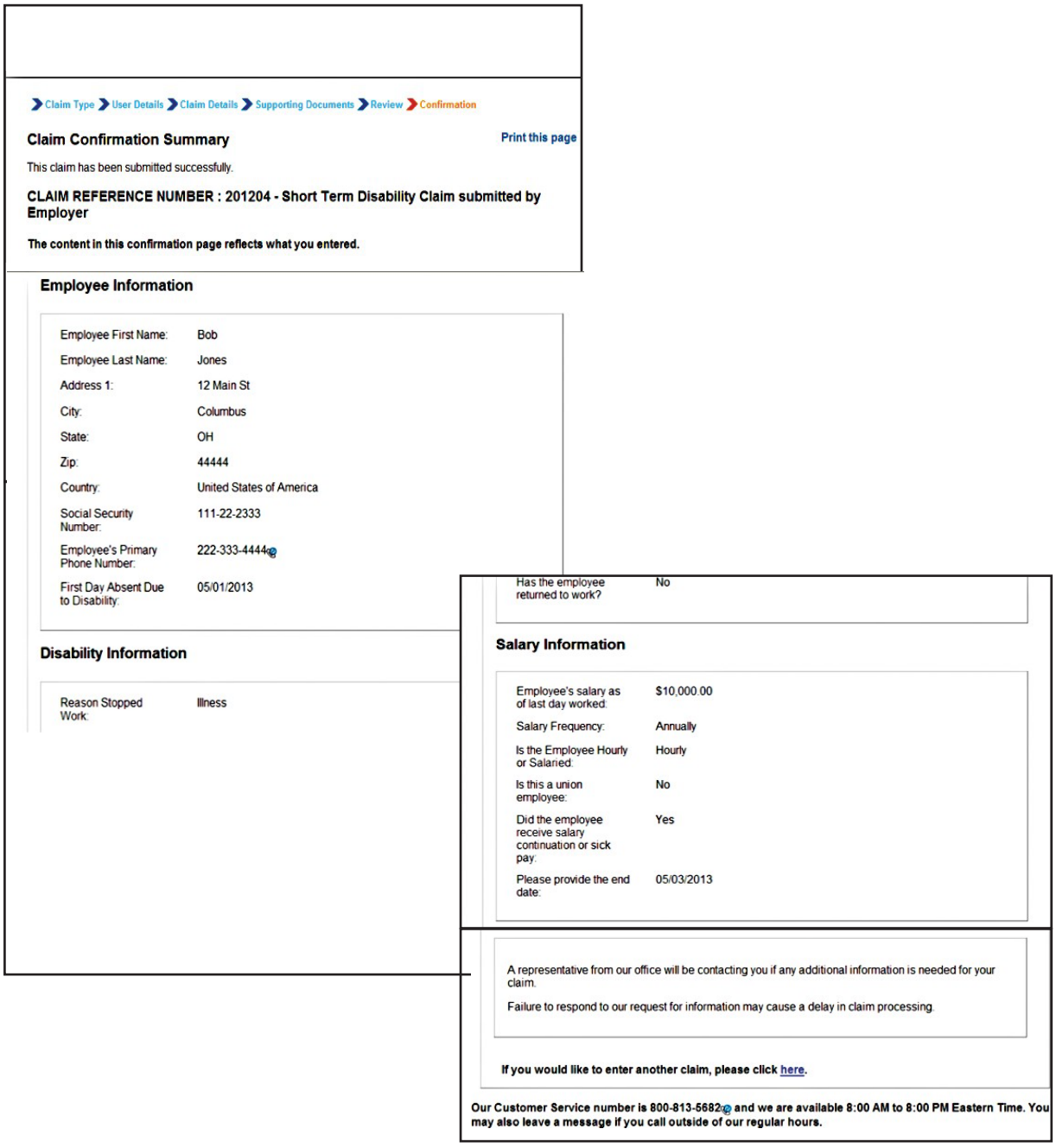
If you have completed forms at the time you enter the claim, such as the *Authorization for Automatic Deposit(s) form*, *Attending Physician's Statement*, the *Individual Authorization Form* and/or the *Reimbursement Agreement and Communication Consent*, you can scan and attach them here. Click *Next*.



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.*



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 - Short 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
Has the employee returned to work?	No

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.

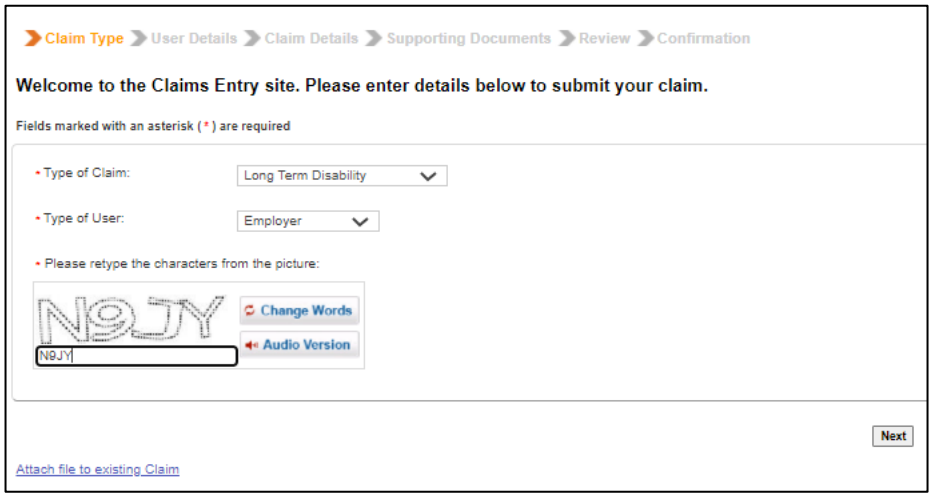
Failure to respond to our request for information may cause a delay in claim processing.

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.

Submitting a long-term disability claim

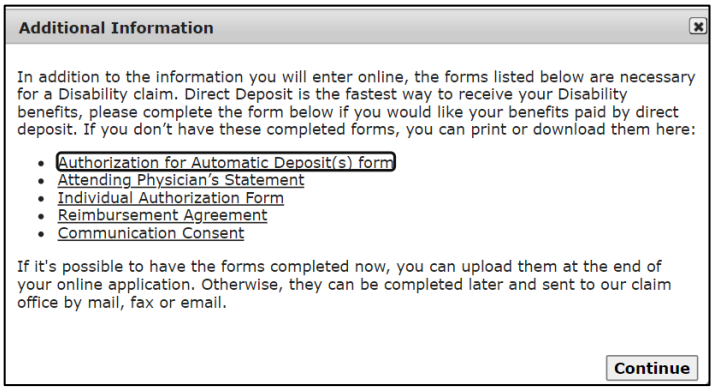
Select Long-Term Disability in the *Type of Claim* field and Employee in the *Type of User* field. Enter the characters you see in the bottom box, then click *Next*.



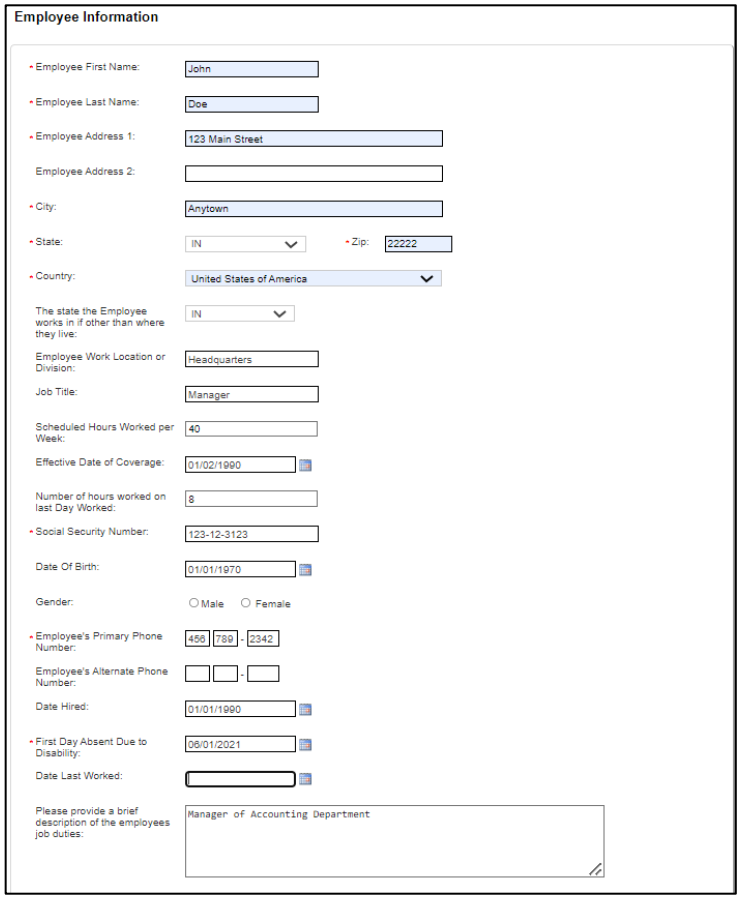
You can print the forms we need to process the long-term disability claim from this screen. Select the links to get fillable PDFs of the forms:

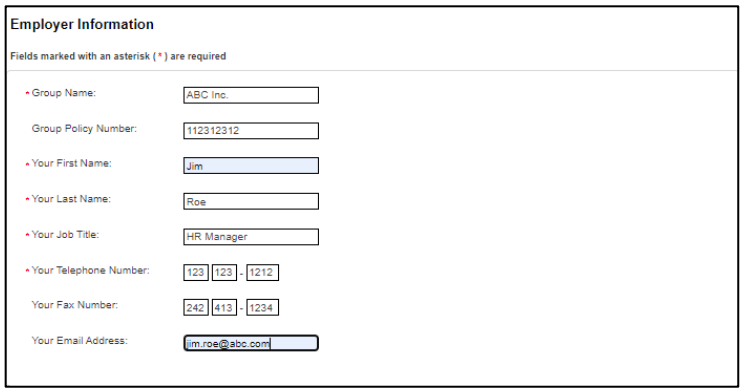
- *Authorization for Automatic Deposit(s) form*
- *Attending Physician's Statement*
- *Individual Authorization Form*
- *Reimbursement Agreement*
- *Communication Consent*

Click *Continue.*

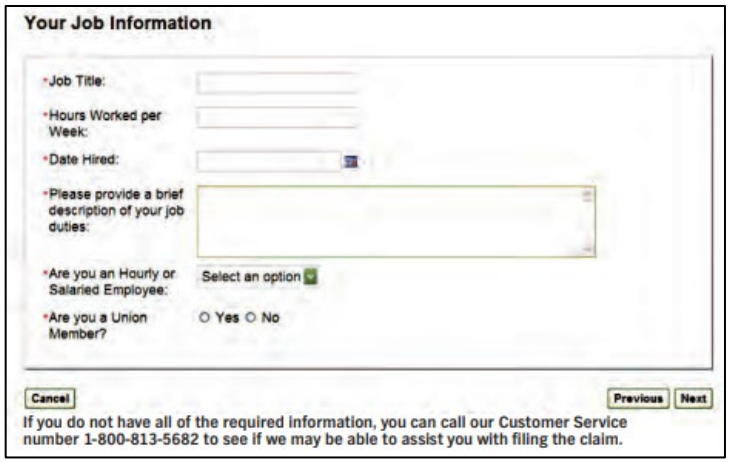


Enter your contact information and your Employer's contact information. Click *Next*.





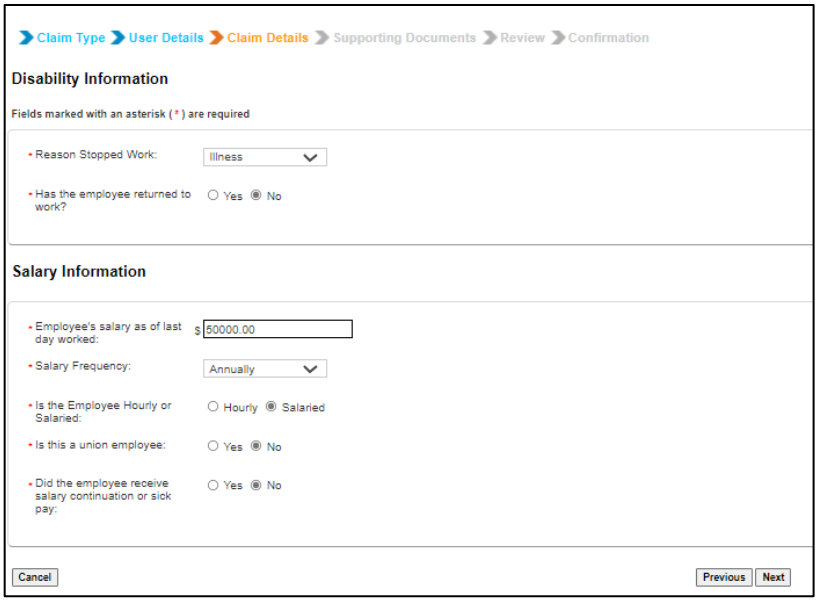
Give us as much information about your job as you can. Click *Next*.



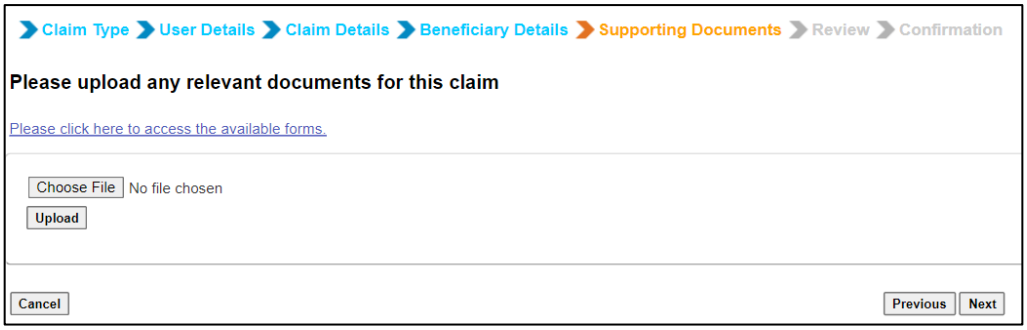
On the *Disability Information* screen, enter as much information as you can about the disabling condition. The questions will vary based on the reason you stopped work:

- Illness
- Injury
- Maternity
- Unknown

Click *Next*.



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 *IndividualAuthorization Form* and/or the *Reimbursement Agreement and Communication Consent*, you can scan and attach them here. Click *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 addresss.

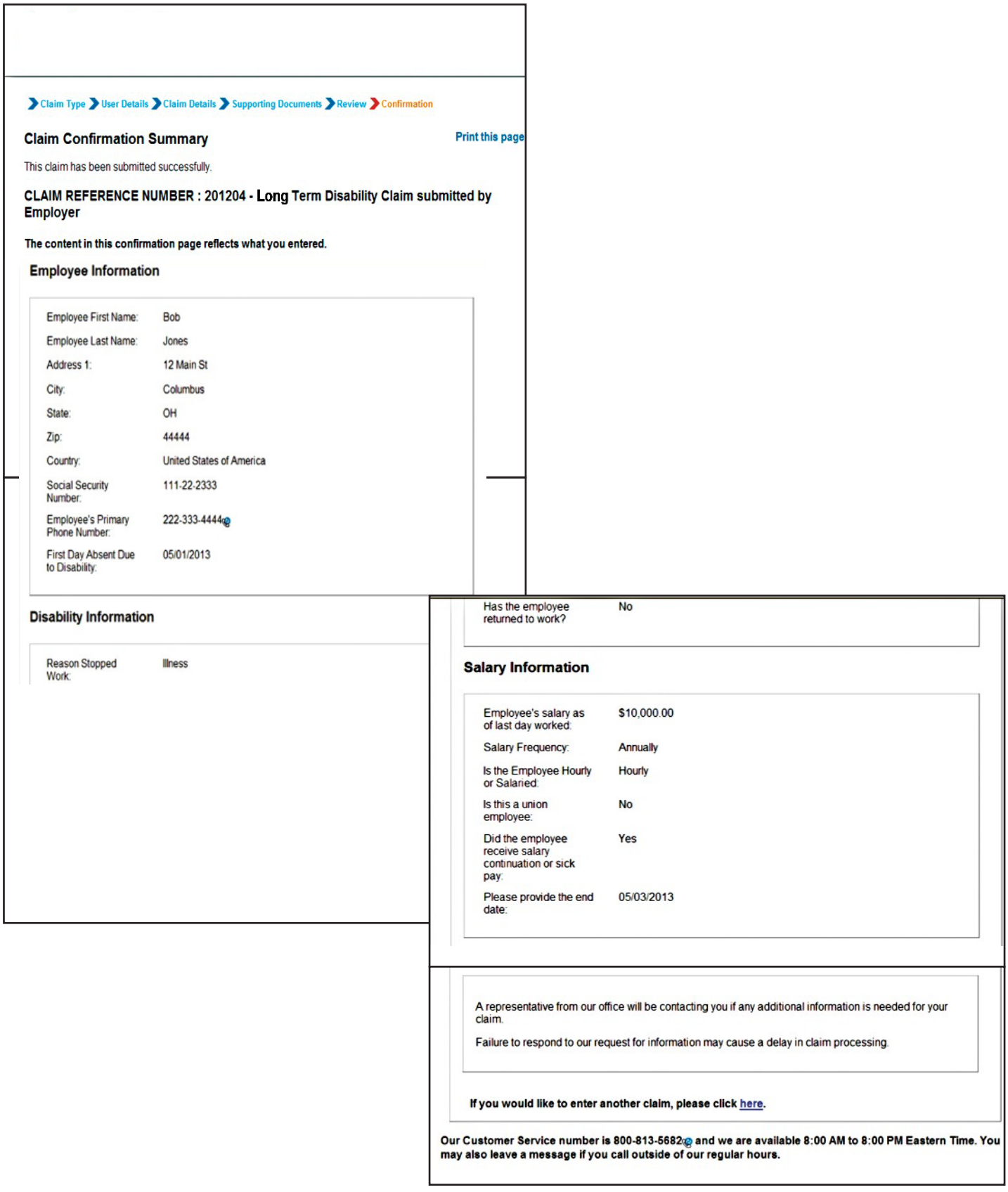
Email Address: jim.roe@abc.com

Confirm Email Address: 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.

Cancel | Previous | Submit

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
Has the employee returned to work?	No

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.

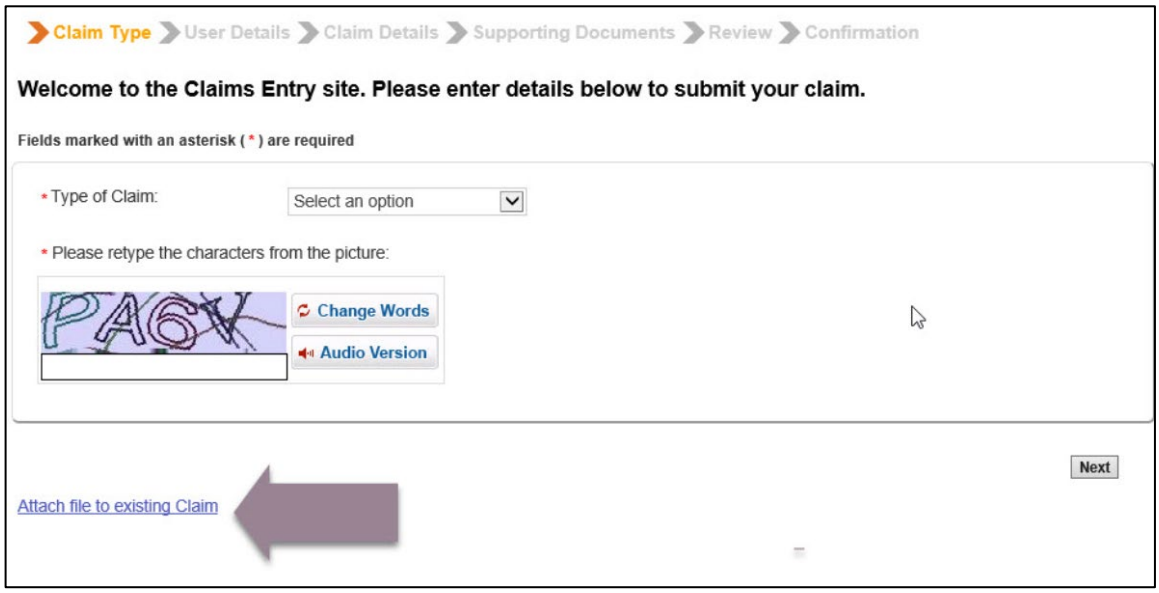
Failure to respond to our request for information may cause a delay in claim processing.

If you would like to enter another claim, please click here.

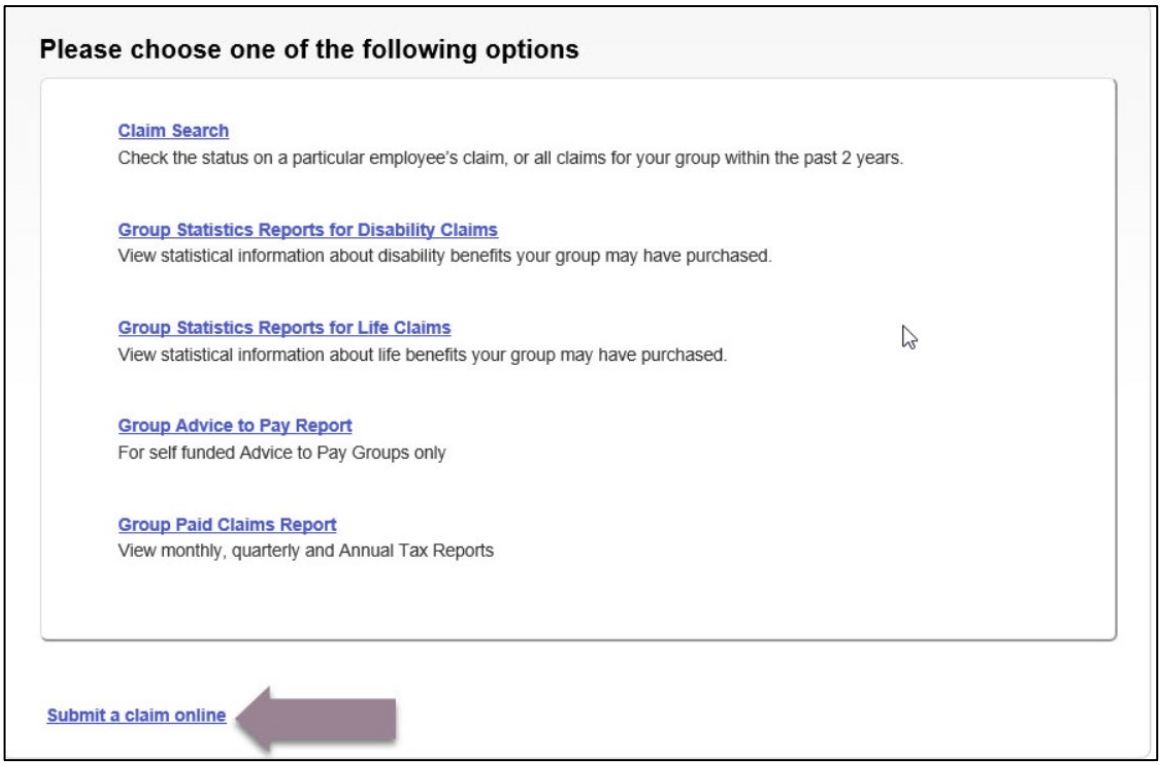
Our Customer Service number is 800-813-5682 and we are available 8:00 AM to 8:00 PM Eastern Time. You may also leave a message if you call outside of our regular hours.

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.*

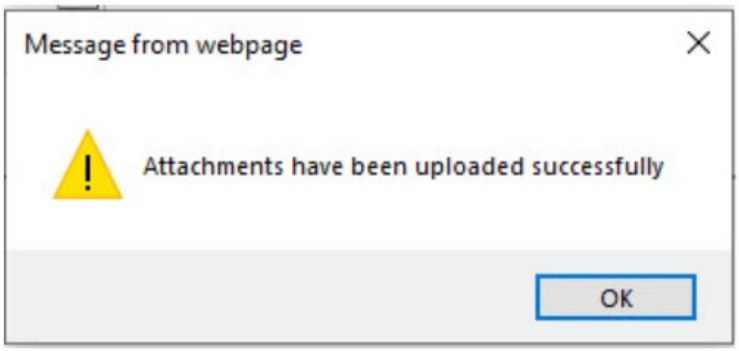


You can also access the screen to add additional information to an existing claim on the **Please choose one of the following options** screen. Select Submit a Claim online, then click on *Attach file to existing Claim.*



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*.

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



Life and Disability products underwritten by UniCare Life & Health Insurance Company.

www.unicare.com/lifeanddisability

3/2022