Anthem Blue Cross

Accelerated Death Benefit
Attending Physician's Statement

PATIENT'S NAME (please print)	DATE OF BIRTH
PRESENT ADDRESS (Number & Street)	SOCIAL SECURITY NUMBER
(CITY, STATE, ZIP)	
NAME OF PATIENT'S EMPLOYER	GROUP POLICY NUMBER

Attending Physician's Statement of Disability

The patient is responsible for completion of this form without expense to the Company. Space is available on the reverse side if you wish to amplify your answers. If #5 is not completed in full, claim processing will be delayed.

		Mo.	Day	Yr.
1	HISTORY When did symptoms first appear?			

2 PRESENT CONDITION
A. Subjective symptoms
B. Objective findings
Include results of current x-rays, EKGs or any other special tests relevant to your judgement of prognosis.
C. Is patient ❑ Ambulatory? ❑ Bed confined? ❑ House Confined? ❑ Hospital Confined?

3 DIAGNOSIS

		Mo.	Day	Yr.
4	TREATMENT A. Date of first visit for above condition B. Date of most recent visit			

5 PROGNOSIS
"In my best medical judgement, the above patient's life expectancy is _____ months or less, or not more than _____ months."

6 MENTAL CONDITION
Is the patient competent to endorse checks and direct the proceeds thereof? ❑ Yes ❑ No

REMARKS

ATTENDING PHYSICIAN'S NAME (please print)	DEGREE
ADDRESS (Number & Street)	
(City, State, Zip)	TELEPHONE
ATTENDING PHYSICIAN'S SIGNATURE	DATE

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

To the Attending Physician: Please mail this report directly to the address shown below.

Anthem Blue Cross Life and Health Insurance Co.
Life Claims Service Center
P.O. Box 105448
Atlanta, GA 30348-5448

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