Accelerated death benefit claim form for Blue Shield of California Life & Health Insurance Company (Blue Shield Life)

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

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

For your protection, California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Section 1 – Employer to complete this section

Name of the insured employee			Job title – occupation of employee	
Address of insured employee				Birth date (MM/DD/YYYY)
Group number	Employee's Social Security number	Basic annual earnings $		Amount of insurance $
Date employed	Is employee still working? ☐ Yes ☐ No If not, date last worked:		Was employee terminated? ☐ Yes ☐ No Date of termination:	
Reason ☐ Illness ☐ Discharged ☐ Retired ☐ Resigned ☐ Other (specify)				
Employer name		Completed by Signature		
Address		Title		
City	State	ZIP	Telephone number	Date

Section 2 – Employee to complete this section

Name	Birth date (MM/DD/YYYY)	Gender ☐ M ☐ F
Address	Telephone number	
Condition contributing to your need for living benefits	Date condition first identified	
What important daily duties are you unable to perform?		
When do you expect to resume the majority of your duties?		

If you are currently in a location other than your own home, please provide complete address Type of place (relative's home, hospital, etc.)			Telephone number
Address	City	State	ZIP

Authorization to obtain and release medical information

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

Insured/patient _____ _____ _____

Print name | Signature | Date

(reverse side to be completed by physician)

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

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

Name of patient	Birth date (MM/DD/YYYY)

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

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

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

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

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

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

Hospital name and address, if applicable	Dates of hospitalization

Names and addresses of other treating physicians

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

If in hospital/health center, please provide
Name: Admission date: Anticipated discharge date:

Address	City	State	ZIP

Remarks

Name of attending physician (please print)	Degree		
Address	**City**	**State**	**ZIP**
Signature	**Telephone number**	**Date**	