Reimbursement Agreement

Anthem Life

Anthem Life
Disability Claims Service Center
P.O. Box 105426
Atlanta, GA 30348-5426
Phone: 1-800-813-5682 Fax: 1-800-850-0017
Email: lifeanddisabilityclaims@anthem.com

Employee last name: _____ First: _____ M.I. ____

Social Security no.: |_ _ _|_ _|_ _ _ _|

First date absent: |_ _|_ _|_ _ _ _| (MM/DD/YYYY)

Employer: _____ Group no.: _____

I acknowledge that I am eligible for benefits under the disability plan sponsored by the above named employer whose claims for plan benefits are either insured by or administered on an employer self-funded basis by Anthem Life Insurance Company (hereinafter referred to as Anthem Life). I agree to reimburse Anthem Life 100% of the amount of benefits I receive, have received, or shall receive from any person or entity for loss wages incurred as a result of the occurrence which gave rise to my claim for payment of benefits from the disability plan. In the event that the 100% reimbursement provided in the preceding sentence is greater than the amount of my recovery, less attorney fees and other legal expenses I incurred in obtaining such recovery (my net recovery), I agree to reimburse Anthem Life the entire amount of my net recovery.

I agree to keep Anthem Life fully informed as to the status of my payment recovery so that Anthem Life may take whatever action it deems necessary to protect its interest. I also agree to authorize any person including, but not limited to, any insurance company, attorney, hospital, physician, surgeon or pharmacist to release to Anthem Life any information pertaining to this occurrence, or claim.

I also acknowledge that Anthem Life will have the right to recover any overpayment of benefits, either directly from me or by deduction of the amount of the overpayment from my future benefits payable under the disability plan, which are the result of error caused by or misinformation provided to Anthem Life.

Your signature: **X** _____

Date signed: |_ _|_ _|_ _ _ _| (MM/DD/YYYY)

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