AnthemLife

Disability Service Center P.O. Box 105426 Atlanta, GA 30348-5426 Tel 800-813-5682 Fax 800-850-0017 Email: disability@anthem.com

REIMBURSEMENT AGREEMENT

Employee's Name:				
	Last	First	M	liddle
Employee's last 4 di Social Security Num	•		First Day Absent	
Employer			Group #	
whose claims for platified Insurance Combenefits I receive, he the occurrence which 100% reimbursement fees and other legal Anthem the entire and I agree to keep Anthaction it deems necessary insurance compertaining to this occurrence in the second I also acknowledge by deduction of the	an benefits a pany (herei ave received th gave rise at provided i al expenses mount of my nem fully infessary to pro pany, attorned currence, or that Anthem amount of the	formed as to the status of my payment otect its interest. I also agree to authory, hospital, physician, surgeon or pha	on an employer self-funde e to reimburse Anthem 100 entity for loss of wages incompleted in the disability plan. In the amount of my recovery (my net recovery), I and the amount of my recovery (my net recovery), I are recovery so that Anthem norize any person including armacist to release to Anthem repayment of benefits, either its payable under the disab	d basis by Anthem % of the amount of urred as a result of the event that the very, less attorney agree to reimburse may take whatever but not limited to em any information directly from me of
 Signature			Date	