Short-Term Disability Claim Form

Mutual of Omaha Insurance Company
United of Omaha Life Insurance Company
Group Insurance Claims Management
3300 Mutual of Omaha Plaza
Omaha, NE 68175-0001
Phone 800-877-5176 Fax 402-997-1865 Email newdisabilityclaim@mutualofomaha.com

Section 1 – Employee Statement (Answer all questions to avoid delay)

Current Employer's Name	Group ID Number	Job Title	Hours Worked per Week

Name

Address	City	State	ZIP

(Area Code) Home Telephone Number	(Area Code) Cellular Telephone Number	Social Security Number

Email Address

Date of Birth	Height	Weight	Dominant Hand: ☐ Right ☐ Left	☐ Male ☐ Female	☐ Single ☐ Married	☐ Widowed ☐ Divorced

Date of Disability (1st Day Absent)	Date First Treated	Estimated Return to Work Date

Nature of illness and when symptoms first appeared, or describe how and where accident occurred.

Was the disability work related? ☐ Yes ☐ No Have you filed a Workers' Compensation claim? ☐ Yes ☐ No

Was disability related to a motor vehicle accident or is another third party liable? ☐ Yes ☐ No

Physician's Name

Other income you have filed for, are receiving, or are eligible for:

	Amount	Date Claim Filed	Date Benefits Began
Workers' Compensation	$ ______	______	______
State Disability	$ ______	______	______
Other	$ ______	______	______

Overpayment Notice: Should you become overpaid at anytime during the duration of this claim we, Mutual of Omaha Insurance Company (Mutual) or United of Omaha Life Insurance Company (United), will request reimbursement of the overpaid amount. This amount is equal to the net benefit you received and any Federal Income Tax paid on your behalf for any time prior to current tax year. Your signature on the claim form authorizes Mutual or United to recover any overpaid Medicare and/or Social Security Tax that was paid on your behalf and certifies you will not attempt to recover a refund or credit of the Medicare and/or Social Security Tax with any Form W-2C that is furnished to you based on recoveries received.

Important Notice: If you have group life insurance through your employer, please contact your benefits administrator as soon as possible to determine what options are available to you to continue your life insurance. Some options require action within 31 days of the date you stop working/insurance ends for life insurance to continue.

If your coverage is written in California, North Carolina or Michigan and includes Survivor Benefits, please check your policy to determine if you can elect a survivor benefit beneficiary. If so, you may obtain a Beneficiary Designation form on the Internet or from your employer.

Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing false, incomplete, or misleading information is guilty of a felony of the third degree.

Employee's Signature: ______________________ **Date:** ______________

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Authorization to Disclose Personal Information

1. I authorize any physician, medical or dental practitioner, hospital, clinic, pharmacy benefit manager, other medical care facility, health maintenance organization, insurer, employer, consumer reporting agency and any other provider of medical or dental services to release records containing the personal information of:

   Claimant/Patient Name: ____
   (Last) (First) (Middle)

   Date of Birth: _____/_____/_________

2. Personal information includes medical history, mental and physical condition, prescription drug records, alcohol or drug use, financial and occupational information.
3. You may release information to:

   Group Disability Management Services
   Mutual of Omaha Insurance Company/United of Omaha Life Insurance Company
   3300 Mutual of Omaha Plaza
   Omaha, NE 68175-0001
   Or
   Fax 402-997-1865
   Or
   Email newdisabilityclaim@mutualofomaha.com

4. I understand that the personal information that is disclosed will be used by Mutual of Omaha Insurance Company and United of Omaha Life Insurance Company to evaluate my claim for disability benefit plan reimbursement and that if I refuse to sign this authorization my claim for benefits may not be paid.
5. I understand that if the person or entity to whom information is disclosed is not a health care provider or health plan subject to federal privacy regulations, the personal information may be redisclosed without the protection of the federal privacy regulations.
6. This authorization will expire 24 contiguous months after the date signed.
7. I understand that I may revoke this authorization at any time by providing a written request to Mutual of Omaha Insurance Company and United of Omaha Life Insurance Company at the address above. If I revoke this authorization, it will not affect any use or disclosure of personal information that occurred prior to the receipt of my revocation.
8. I understand that I am entitled to receive a copy of this authorization and that a copy is as valid as the original.

RETAIN A SIGNED COPY FOR YOUR RECORDS

Name(s) used for records (if different than the name below): ______________________________

____

______________________________ ______________
Signature of Claimant Date

If Applicable: I am the legal representative of the claimant and I am authorized to grant permission on behalf of the claimant.

Printed Name of Legal Representative:______________________________

Signature of Legal Representative: ______________________________

Type of Legal Representative: ______________________________

THIS AUTHORIZATION COMPLIES WITH HIPAA AND OTHER FEDERAL AND STATE LAWS

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Authorization to Disclose Health Information to My Employer

I authorize Mutual of Omaha Insurance Company and United of Omaha Life Insurance Company to disclose health information about me to my employer, and to my employer's broker. I understand that this information will be used by my employer, and its broker, to monitor and manage the disability benefits program provided under my Group disability policy. I also understand that my employer and its broker will use the information solely for the purposes of auditing disability benefits paid, providing claims assistance, determining waiver or discontinuance of premium deductions, and coordinating with other subsidized salary continuance plans my employer may offer.

The health information which may be disclosed pursuant to this authorization includes such items as medical history, mental and physical condition, prescription drug records and alcohol or drug use.

I understand that I may refuse to sign this authorization. I realize that if I refuse to sign, my claim for benefits may not be paid.

This authorization will remain in effect for 24 contiguous months from the date I sign it. I understand that I may revoke this authorization at any time. If I would like to revoke this authorization, I should send my revocation request to:

ATTN: Group Disability Management Services
Mutual of Omaha Insurance Company/United of Omaha Life Insurance Company
3300 Mutual of Omaha Plaza
Omaha, NE 68175-0001

Or

Fax 402-997-1865

Or

Email newdisabilityclaim@mutualofomaha.com

I also understand that any revocation of this authorization will not affect any use or disclosure of health information that occurred prior to receipt of my revocation.

I understand that I am entitled to receive a copy of this authorization. A copy of this authorization is as effective as the original.

____

(Printed Name and Address)

___________________________________ ___________________

Signature Date

or

If Applicable: I am the legal representative of the person whose financial and health information is to be disclosed, but I am authorized to grant permission on behalf of that person.

Printed Name of Legal Representative: ___________________________________

Signature of Legal Representative: ___________________________________

Type of Legal Representative: ___________________________________

Date: _______________

RETAIN A SIGNED COPY FOR YOUR RECORDS

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HS-Manager

FAX (402) 997-1865 Email newdisabilityclaim@mutualofomaha.com Form must be completed in full at no expense to Mutual of Omaha

Section 2 – Employer's Statement (Answer all questions to avoid delay)

Company Name	Group ID Number	Master Policy Number

Class No. or Description	Division/Location No. or Description

Address	City	State	ZIP

Email Address

Employee's Name	Employee's Phone Number

Employee Address	Employee City	Employee State	Employee ZIP

Weekly earnings as defined by the Plan: ______________
(Please note: Benefits will be calculated based on premium received.)
Salary Effective Date: ____

Number of weekly hours worked: ________

Was disability caused by employment? ☐ Yes ☐ No Has workers' compensation claim been filed? ☐ Yes ☐ No

Does the Employee contribute toward the premium? ☐ Yes ☐ No

If yes, what percent is paid by the Employee? _____% Is it Pre-tax or Post-tax? ______________

Employee's payroll classification ☐ Exempt ☐ Non-Exempt ☐ Salaried ☐ Hourly ☐ Union ☐ Non-Union ☐ Other

How was the Employee paid? ________________________

Is the Employee continuing to receive compensation or pay since their last day of work? ☐ Yes ☐ No

If yes, what is the weekly amount of the type of compensation being received and the period payable?

Amount _________ Salary Continuation Start _________ End _________ Amount _________ Vacation Start _________ End _________

Amount _________ Sick Leave Start _________ End _________ Amount _________ PTO Start _________ End _________

Amount _________ Severance Start _________ End _________ Amount _________ Other Start _________ End _________

If other is marked, please describe ____

Date of Hire:	Date Covered Under This Plan:

Does Mutual of Omaha cover the Employee for group long-term disability? ☐ Yes ☐ No

Does United of Omaha Life Insurance Company cover the Employee for group life? ☐ Yes ☐ No If so, please complete the following.

Name of Employee's beneficiary according to your records:__________________________ Relationship to Employee:________________

Important Notice: For Employees age 60 or over, refer to the policy provisions regarding group life continuation and conversion rights.

Does Mutual of Omaha cover the employee under an additional short-term disability policy? ☐ Yes ______________ (policy number) ☐ No

Please contact Employee's direct supervisor and then circle the strength demand below which best describes the Employee's job:

Circle One

- S – Sedentary: 10 lbs. Maximum lifting, occasional lift/carry of small articles. Some occasional walking or standing may be required.
- L – Light: 20 lbs. Maximum lifting with frequent lift/carry up to 10 lbs. A job is light if less lifting is involved but significant walking/standing is done or if done mostly sitting but requires push/pull on arm or leg controls.
- M – Medium: 50 lbs. Maximum lifting with frequent lift/carry up to 25 lbs.
- H – Heavy: 100 lbs. Maximum lifting with frequent lift/carry up to 50 lbs.
- V – Very Heavy: Over 100 lbs. Lifting with frequent lift/carry over 50 lbs.

Employee's Job Title	Last Day at Work

What was the Employee's employment status on the first day absent?

Description of major job duties – Please attach job description

Has the Employee returned to work? ☐ Yes ☐ No
a) If yes, when?
b) If not, what is the estimated return to work date?

Can the Employee's job be modified? ☐ Yes ☐ No

Signature of Person Completing Claim Form	Title of Person Completing Claim Form

Date Signed	(Area Code) Phone Number	(Area Code) Fax Number	Email Address

Please notify us if the Employee returns to work after the submission of this form.

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FAX (402) 997-1865 **Email newdisabilityclaim@mutualofomaha.com** **Form must be completed in full at no expense to Mutual of Omaha**

Section 3 – Attending Physician's Statement (Answer all questions to avoid delay)

Employer Name			Group ID Number
Name of Patient (Last, First, MI) – Please Print		Date of Birth	Employee's Phone Number

Employee Address	Employee City	Employee State	Employee ZIP

Diagnoses	ICD-9 Code(s)
Symptoms	Date symptom first appeared

Initial date of treatment:	Last date of treatment:	Next date of treatment/office visit:

Is disability due to: ☐ Accident/Injury ☐ Sickness	Is the disability work related? ☐ Yes ☐ No

If applicable, list the surgical procedure(s) – Describe fully and provide dates if any.

If disability is due to Pregnancy, please provide the information below:

Date of Last Monthly Period	Expected Date of Delivery	Expected Type of Delivery ☐ Vaginal ☐ Cesarean Section

Actual Date of Delivery	Actual Type of Delivery ☐ Vaginal ☐ Cesarean Section

If any of the following questions are answered "Yes," then please provide the information to the right of that question.

Was the patient treated in an Emergency Room? ☐ Yes ☐ No	Date treated	Name of Hospital	Name of Physician
Did another physician treat or will be treating the patient? ☐ Yes ☐ No	Date treated	Physician's Name and Address	
Was the patient hospital confined? ☐ Yes ☐ No	Date Confined In Hospital: From________ To________	Name of Hospital	
Did patient have outpatient surgery in a hospital or ambulatory surgical center? ☐ Yes ☐ No	Date of Surgery	Name of Facility	

Functional Limitations – Abilities

Indicate frequency per day the listed activity can be performed.

(n = never, o = occasional, f = frequent, c = constant)

Lifting	**Carrying**
_____ 1-5 lbs.	_____ 1-5 lbs.
_____ 6-10 lbs.	_____ 6-10 lbs.
_____ 11-25 lbs.	_____ 11-25 lbs.
_____ 26-50 lbs.	_____ 26-50 lbs.
_____ 51-100 lbs.	_____ 51-100 lbs.
_____ Over 100 lbs.	_____ Over 100 lbs.

Indicate longest single time duration each activity can be performed.

_____ Sitting	_____ Kneeling	_____ R: Finger Dexterity
_____ Total time on feet		_____ L: Finger Dexterity
_____ Standing	_____ Inside	_____ R: Below Shoulder (Reaching)
_____ Walking		_____ L: Below Shoulder (Reaching)
_____ Bending	_____ Outside	_____ R: Above Shoulders (Reaching)
_____ Squatting	_____ Working with Others	_____ L: Above Shoulders (Reaching)
_____ Stooping	_____ Other (explain)________	

Please notify us if the Employee returns to work after the submission of this form.

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Mental Limitations – Abilities

Please check off the appropriate response of the person's ability to adapt to these specific job situations at this time.

	Unlimited	Somewhat Limited	Markedly Limited	Unable to Perform
Follow work rules	☐	☐	☐	☐
Perform repetitive, or short cycle work	☐	☐	☐	☐
Perform at a constant pace	☐	☐	☐	☐
Maintain attention and concentration	☐	☐	☐	☐
Perform a variety of duties	☐	☐	☐	☐
Understand, remember and carry out complex job instructions	☐	☐	☐	☐
Attain set limits and standards	☐	☐	☐	☐
Relate to co-workers	☐	☐	☐	☐
Interact with supervisors	☐	☐	☐	☐
Interact with the public/customers	☐	☐	☐	☐
Use judgment and make decisions	☐	☐	☐	☐
Direct, control or plan activities of others	☐	☐	☐	☐
Influence people in their opinions, attitudes and judgments	☐	☐	☐	☐
Expressing personal feelings	☐	☐	☐	☐
Work alone or apart in physical isolation from others	☐	☐	☐	☐

What functions of the person's own/usual occupation is the person unable to perform? (Please provide rationale here, if not already provided.)

What functional restrictions have been placed on this person?

The patient has been continuously disabled (unable to work) from ____________ to ____________

Is the patient able to work with job modifications? ☐ Yes ☐ No

The patient should be able to work ☐ Full-time ☐ Part-time on ____________ or a specific date is unavailable, in
☐ 1 month ☐ 1-3 months ☐ 3-6 months ☐ Other (please specify)

Remarks and/or treatment plan

Name of the Attending Physician – Please Print	Specialty/Degree(s)	Tax Identification Number
Address (No., Street, City, State, ZIP)	(Area Code) Telephone Number	(Area Code) Fax Number

If necessary, whom can we contact at the attending physician's office for additional information?

Name: (Area Code) Telephone Number:

Signature of Attending Physician Date

Please notify us if the Employee returns to work after the submission of this form.

UNITED OF OMAHA LIFE INSURANCE COMPANY
A MUTUAL *of* OMAHA COMPANY

Group Claim Fraud Statements

The following fraud language is attached to, and made part of this claim form. Please read and do not remove these pages from this claim form.

** **Alabama:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

** **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 and Louisiana:** 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 to appear on this form. Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

** **Colorado:** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

** **Delaware:** Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

** **District of Columbia:** WARNING: It is a crime to provide false or misleading information to an insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

** **Florida:** Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

** **Idaho:** Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement containing any false, incomplete, or misleading information is guilty of a felony.

** **Indiana:** A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

** **Kentucky:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

** **Maine:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

** **Maryland:** Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

** **Minnesota:** A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

** **New Hampshire:** Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment of insurance fraud, as provided in RSA 638:20.

** **New Jersey:** Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

** **New Mexico:** ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

** **Ohio:** Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

** **Oklahoma:** WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

** **Pennsylvania:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

** **Puerto Rico:** Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances [be] present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

** **Rhode Island:** 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.

** **Tennessee, Virginia, and Washington:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

** **Texas:** Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

** **If you live in a state other than mentioned above, the following statement applies to you:** Any person who knowingly, and with intent to injure, defraud or deceive any insurer or insurance company, files a statement of claim containing any materially false, incomplete, or misleading information or conceals any fact material thereto, may be guilty of a fraudulent act, may be prosecuted under state law and may be subject to civil and criminal penalties. In addition, any insurer or insurance company may deny benefits if false information is related to a claim by the claimant.