A Guide for Successfully Completing the Group Short-Term Disability Claim Form

Mutual of Omaha appreciates the opportunity to provide you with valuable income protection. We rely on the information you provide on this form to effectively determine if you qualify for group short-term disability benefits.

This guide provides information and instruction to help you successfully complete and submit the claim form. Please consult your employer/benefits administrator if you need assistance in providing information for the form.

Important Tips for Paper Copy Submission

- Prior to submission, make sure you have provided all required information and answered all questions completely and accurately. If information is missing or cannot be read, the processing of your form will be delayed.
- The following guidelines provide valuable information to help you successfully complete the form.
- Please make a copy of the completed form for your records before submitting it to Mutual of Omaha/United of Omaha.

Section 1: Employee Statement

This section is to be completed by the Employee. Dates should include the month, date and year. In order to be considered complete, the form must be signed by you.

- Group ID Number for your Employer will consist of eight characters, beginning with "G000" and followed by four additional letters or numbers specific to your Employer.
- Job Title is the title of your position held with the Employer.
- The Hours Worked per Week is the number of hours you worked per week for the Employer.
- Height should be provided in feet and inches.
- Weight should be provided in pounds.
- Dominant Hand indicates whether you are primarily right- or left-handed.
- Date of Disability is the first day you were absent from work because of the disabling condition.
- Date First Treated is the date you first sought medical care because of the disabling condition.
- Other Income means money you are currently receiving or have applied to receive from any source in addition to your claim for disability benefits with Mutual of Omaha/ United of Omaha.

Authorization to Disclose Personal Information & Authorization to Disclose Health Information to my Employer

Both authorizations are to be completed by the Employee. Dates should include the month, date and year. In order to be considered complete, the form must be signed by you or your legal representative.

- By signing the authorization, you are applying for short-term disability benefits with Mutual of Omaha/United of Omaha and are agreeing to allow disclosure of personal information to the necessary parties for the purpose of claim processing.
- If the name associated with any of your medical records differs from the name provided on the form, provide any alternate names. This might occur in the event of a name change due to marriage or adoption.

Guidelines for Section 2: Employer's Statement

This section is to be completed by the Employer. Dates should include the month, date and year. In order to be considered complete, the form must be signed by the Employer.

- Group ID Number consists of eight characters, beginning with "G000" and followed by four additional letters or numbers.
- Date Covered Under This Plan indicates the date in which the Employee's coverage became effective.
- If the Employee is eligible for salary continuation/sick leave, this does not include Mutual of Omaha/United of Omaha short-term disability benefits, paid time off or vacation compensation.
- If claim is paid, indicate whether or not Mutual of Omaha is to withhold income tax from the benefit payment, and if so, how much. Minimum is **$88** per month.

Guidelines for Section 3: Attending Physician's Statement

This section is to be completed by the Attending Physician. Dates should include the month, date and year. In order to be considered complete, the form must be signed by the Attending Physician.

Required Fraud Warnings

Before completing the claim form, please read the Required Fraud Warnings listed on the following page.

Please read – State specific warnings apply to the resident of such state

- **Fraud Warning:** 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.

- **Arkansas/Kentucky/Louisiana/Maine/New Mexico/ Ohio/Tennessee:** Any person who, with intent to defraud or knowing that he/she 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.

- **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.

- **District of Columbia:** It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the 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.

- **Kansas:** 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 as determined by a court of law.

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

- **New Jersey:** Any person who includes any false or misleading information on an application for insurance is subject to criminal and civil penalties.

- **Oregon:** 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 may be a crime and may subject such person to criminal and civil penalties.

- **Puerto Rico:** Any person who knowingly, and with intent to defraud or deceive any insurance company includes false information in an application for insurance or files, assists, or abets in the filing of a fraudulent claim to obtain payment of a loss or other benefits, or files more than one claim for the same loss or damage, may be guilty of a felony. Upon conviction, that person will be fined between $5,000 and $10,000, imprisoned for three (3) years or both. Aggravating or attenuating circumstances may result in the prison term being increased to five (5) years or reduced to two (2) years.

- **Vermont:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claims containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto may be committing a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties.

- **Virginia:** Any person who, with the 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 may have violated state law.

Short-Term Disability Claim Form

Mutual of Omaha Insurance Company
United of Omaha Life Insurance Company
Group Insurance Claims Management
Mutual of Omaha Plaza
Omaha, NE 68175-0001
Phone 800-877-5176 Fax 402-997-1865

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	$ _____	_____	_____

Important Notice: If you are age 60 or over, please contact your Employer within 31 days of disability to preserve your group life insurance conversion privileges.

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:** _____

Oklahoma 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)

   Such release may include information, which may indicate the presence of communicable or venereal disease which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea, Human Immunodeficiency Virus (HIV) Infection, and Acquired Immune Deficiency Syndrome (AIDS).

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
   Mutual of Omaha Plaza
   Omaha, NE 68175-0001

   or

   Fax 402-997-1865

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 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 disclose 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

Oklahoma 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.

Such release may include information, which may indicate the presence of communicable or venereal disease which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea, Human Immunodeficiency Virus (HIV) Infection, and Acquired Immune Deficiency Syndrome (AIDS).

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 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
Mutual of Omaha Plaza
Omaha, NE 68175-0001

or

Fax 402-997-1865

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

MUG6893_OK_1110

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:

Weekly earnings as defined by the Plan: _____
(Please note: Benefits will be calculated based on premium received.)

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? _____% Pre-tax _____ Post-tax _____?

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

How was the Employee paid?

Is this Employee eligible for salary continuation/sick leave? ☐ Yes ☐ No If yes, what is the weekly amount? $_____
When do benefits begin? _____ End? _____

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.

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.

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
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	
_____ Bending	_____ Outside	_____ R: Above Shoulders	
_____ Squatting	_____ Working with Others	_____ L: Above Shoulders	
_____ Stooping	_____ Other (explain)_____		

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

Mental Limitations – Abilities

	Excellent	Good	Fair	Guarded
Judgment/Decision making	_____	_____	_____	_____
Deal with work stresses	_____	_____	_____	_____
Function independently	_____	_____	_____	_____
Concentration/Attention span	_____	_____	_____	_____
Emotional lability	_____	_____	_____	_____
Caring for self/family	_____	_____	_____	_____
Estimate overall prognosis	_____	_____	_____	_____

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.