Mutual of Omaha Insurance Company
United of Omaha Life Insurance Company
Group Insurance Claims Management

3300 Mutual of Omaha Plaza
Omaha, NE 68175-0001
Toll Free (800) 877-5176
Fax (402) 997-1865
Email newdisabilityclaim@mutualofomaha.com

A Guide for Successfully Completing the Group 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 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 all required information is provided and all questions have been answered completely and accurately. If information is missing or is illegible (unreadable), the processing of your form will be delayed.
- Refer to the guidelines for each section below, which provide valuable information to help you successfully complete the form.
- Make a copy of the completed form for your records before submitting it to Mutual of Omaha/United of Omaha.

Required Fraud Warnings

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

Guidelines for Section 1: Employee's Statement

This section is to be completed by the Employee. Please answer all questions in order to avoid possible delays. All dates should indicate the month, date and year.

A. Information About You

- The Group Policy Number will have eight characters, beginning with "G000" followed by four additional letters or numbers specific to your employer.
- Provide weight in pounds, and height in feet and inches.
- Your Occupation/Job Title is the title of your position held with the employer.
- Indicate any other Mutual of Omaha/United of Omaha plans in which you are currently insured.

C. Information About Your Disabling Condition

- The Date First Treated is the date you first sought out medical care because of the disabling condition.

D. Information About Work

- The Last Day Worked is the day before you were first absent from work because of the disabling condition.

E. Information About Care and Treatment

- Provide the name, specialty, phone and address for each doctor or hospital that treated you for the disabling condition.

F. Information About Other Income Benefits

- 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.
- Check all sources of other income that apply.

G. Information for Tax Withholding

- If your claim is paid, indicate whether or not you would like Mutual of Omaha to withhold income tax from your benefit payment, and if so, how much. Minimum is **$88** per month.

H. Signature

- Your signature is required.

Education, Training and Work Experience

- This form is to be completed by the employee. Please make sure all questions have been answered completely and accurately. If information is missing or is illegible (unreadable), the processing of your form will be delayed.
- Vocational rehabilitation services include, but are not limited to (a) job modification; (b) job placement; (c) retraining; and (d) other activities reasonably necessary to help you return to work.

Authorization to Disclose Personal Information

This authorization is to be completed by the employee.

- Please read this section in its entirety. By signing the authorization, you are applying for long-term disability benefits with Mutual of Omaha/ United of Omaha, and are agreeing to allow disclosure of personal information to the necessary parties for purposes 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, for example.
- **IMPORTANT:** To be complete, the form must be signed by you.

Guidelines for Section 2: Employer's Statement

This section is to be completed by the employer. Please answer all questions in order to avoid possible delays. All dates should indicate the month, date and year.

A. Information About the Employer

- The Group Policy Number will have eight characters, beginning with "G000" followed by four additional letters or numbers.

B. Information About the Employee

- The Date Employee Became Insured Under This Plan indicates the date in which the employee's coverage became effective.
- The Date Employee Became Insured Under Prior Plan indicates the date in which the employee's coverage was in effect under a plan prior to the Mutual of Omaha plan.
- The No. of Hours Employee Regularly Works is the number of hours the employee is typically at work per day/per week for the employer.

C. Information for Tax Withholding

- If this section is not completed, Mutual of Omaha will assume that premium paid by the employee is with pre-tax dollars.
- If this is not true, indicate otherwise and provide the percentage amount.

E. Information for Life Waiver

- Date Life Insurance Terminated means the first day the coverage is no longer in force.
- If applicable, the Paid-To-Date for group life insurance is the date on which the next premium is due.

F. Information About Your Pension Plan

- This section is not applicable if the disabling condition is maternity.

H. Information About Employee's Salary

- Indicate the method in which the employee is paid.
- If hourly, also indicate the hourly rate in which the employee is paid.
- Please attach supporting payroll documentation.

Guidelines for Section 3: Job Analysis

This section is to be completed by the employer if a formal job description is not available. If a formal job description is not available, please answer all questions in order to avoid possible delays. All dates should indicate the month, date and year.

A. Information About the Employee's Job

- Occasionally means the employee does this activity up to 33 percent of the time.
- Frequently means the employee does the activity 34 percent to 66 percent of the time.
- Continuously means the employee does the activity 67 percent to 100 percent of the time.

B. Physical Aspects of the Job

- Check all the activities that apply to the employee's job.
- Indicate the frequency with which the employee performs the activity using the guidelines in Section A, Information About the Employee's Job.

Guidelines for Section 4: Signature and Attachments

- Attach a copy of the employee's job description to the claim application.
- Attach any additional documentation that may be helpful when reviewing the application, including further explanation of any question(s) on the application.
- Your signature is required.

Guidelines for Section 5: Attending Physician's Statement

This section is to be completed by the attending physician. Please answer all questions in order to avoid possible delays. All dates should indicate the month, date and year.

Fraud Warnings

Required Fraud Warnings (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.

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.

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: WARNING: 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: 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.

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 York: 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

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 furnishes information verbally or in writing, or offers any testimony on improper or illegal actions which, due to their nature constitute fraudulent acts in the insurance business, knowing that the facts are false shall incur a felony and, upon conviction, shall be punished by a fine of not less than five thousand (5,000) dollars, nor more than ten thousand (10,000) dollars for each violation or by imprisonment for a fixed term of three (3) years, or both penalties. Should aggravating circumstances be present, the fixed 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 on an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

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.

Virgin Islands: 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 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.

Disability Claim Form

What type of disability coverage do you have?
❑ Short-Term Disability ❑ Long-Term Disability ❑ Both

3300 Mutual of Omaha Plaza | Omaha, NE 68175-0001
Phone (800) 877-5176 (toll-free) | Fax (402) 997-1865
Email newdisabilityclaim@mutualofomaha.com

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

A. Information About You

Employee Last Name | Employee First Name | Employee Middle Initial | Group Policy Number

Employee Address | Employee City | Employee State/Province | Employee ZIP

Employee Telephone ( ) | Employee Email Address | Employee Social Security Number

Employee Date of Birth | Height | Weight | ❑ Male ❑ Female | ❑ Right Handed ❑ Left Handed | ❑ Single ❑ Married | ❑ Widowed ❑ Divorced

Name of Your Employer (include Division/Location, if applicable) | Your Occupation/Job Title

Under what other Mutual of Omaha/United of Omaha policies are you currently covered?

Did you have disability coverage prior to being effective with Mutual of Omaha? ❑ Yes ❑ No

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.

B. Information About Your Family (Required to determine your eligibility for Social Security benefits.)

Spouse's Name | Spouse's Social Security Number | Spouse's Date of Birth | Is your spouse employed? ❑ Yes ❑ No

First and Last Name of any children under the age of 25	Date of Birth	Social Security Number

C. Information About Your Disabling Condition

1. If your disability is due to an injury, answer the following questions and then proceed to #3 below.

When did the injury occur?

Where and how did the injury occur?

What is the date you were first treated by a physician?

2. If your disability is due to a pregnancy or an illness, answer the following questions. If <u>not</u> pregnancy-related, proceed to #3 below.

What were your first symptoms?

When did you notice these symptoms?

What is the date you were first treated by a physician?

3. If your disability is due to an injury or an illness, but not pregnancy, answer the following questions.

Why are you unable to work?

Before you stopped working, did your condition require you to change your job or the way you did your job? ❑ Yes ❑ No If **Yes**, please explain below.

Is your condition related to your occupation? ❑ Yes ❑ No If **Yes**, please explain below.

Have you filed, or do you intend to file a Workers' Compensation claim? ❑ Yes ❑ No

D. Information About Work

What is the date of your last day worked before the disability?

On your last day worked, did you work a full day? ❑ Yes ❑ No
If **No**, please explain.

What is the date you were first unable to work?

Have you returned to work? ❑ Yes, Part-Time ❑ Yes, Full-Time ❑ No
What date did you return to work?

If you haven't yet returned to work, do you expect to? ❑ Yes, Part-Time ❑ Yes, Full-Time ❑ No
What date do you expect to be able to return to work?

Are you currently self-employed or working for another employer? ❑ Yes ❑ No If **Yes**, provide details.

E. Information About Care and Treatment (If additional space is needed, please provide details on a separate page.)

Doctor who **first** provided medical attention to you for your current disability. | Doctor's Specialty | Telephone ( ) Fax ( )

Doctor's Address | Date(s) you were seen by this doctor From _____ To _____

List all other physicians and/or hospitals you have visited for this condition below.

Doctor's Name | Doctor's Specialty | Telephone ( ) Fax ( )

Doctor's Address | Date(s) you were seen by this doctor From _____ To _____

Doctor's Name | Doctor's Specialty | Telephone ( ) Fax ( )

Doctor's Address | Date(s) you were seen by this doctor From _____ To _____

Doctor's Name | Doctor's Specialty | Telephone ( ) Fax ( )

Doctor's Address | Date(s) you were seen by this doctor From _____ To _____

Name of Hospital | Department of Treatment | Telephone ( ) Fax ( )

Hospital's Address | Date(s) you were treated at the hospital From _____ To _____

Name of Hospital | Department of Treatment | Telephone ( ) Fax ( )

Hospital's Address | Date(s) you were treated at the hospital From _____ To _____

F. Information About Other Income Benefits (Check all benefits you are receiving or are eligible to receive.)

Source of Income	Amount	Weekly/Monthly	Date claim was filed	Date payments began	Date payments ended
Social Security Retirement					
Social Security Disability					
Canadian Pension Plan					
Workers' Compensation					
State Disability					
Pension Retirement					
Pension Disability					
Short-Term Disability					
Unemployment					
No-Fault Insurance					
Other (include Individual or Group benefits)					

G. Information For Tax Withholding

If your request for benefits is approved, should Mutual of Omaha/United of Omaha withhold income taxes from your benefit checks? ☐ Yes ☐ No

If **Yes**, how much should be withheld from each check (the minimum is **$88.00** per month). $_____.00

Overpayment Notice: Should you become overpaid at any time 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.

H. Signature (Required for all claims.)

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.

The above statements are true and complete to the best of my knowledge and belief.

X _____ _____

Signature of Employee | Date

Education, Training and Work Experience

Name _____

Policy Number _____ Claim Number _____

Educational Background

High School Graduate: ❑ Yes ❑ No If **No**, what was the last grade completed? _____ Last Date Attended _____

GED: ❑ Yes ❑ No Field of Study: ❑ General ❑ Business ❑ Vocational ❑ Other

Did you attend college? ❑ Yes ❑ No Last Date Attended _____

Name and Address of College _____

_____

Major(s) _____

Final Status: ❑ Freshman ❑ Sophomore ❑ Junior ❑ Senior ❑ Undergraduate Degree ❑ Graduate School

Degree(s) earned _____

Other formal training _____

Certification(s) _____

Computer Skills _____

Military Service: ❑ Yes ❑ No If **Yes**, in which branch did you serve? _____

Rank _____

Specialty _____

What computer programs are you able to use? _____

List all languages spoken fluently _____

Work Experience

Please fill out completely. Start with your most recent employment and list chronologically.

Dates: From _____ To _____

Employer _____

Job Title _____

List job duties _____

List physical requirements of job _____

Product/Service produced _____

Did you supervise others? ❑ Yes ❑ No

Reason for leaving? _____

Dates: From _____ To _____

Employer _____

Job Title _____

List job duties _____

List physical requirements of job _____

Product/Service produced _____

Did you supervise others? ❑ Yes ❑ No

Reason for leaving? _____

Dates: From _____ To _____

Employer _____

Job Title _____

List job duties _____

List physical requirements of job _____

Product/Service produced _____

Did you supervise others? ❑ Yes ❑ No

Reason for leaving? _____

Dates: From _____ To _____

Employer _____

Job Title _____

List job duties _____

List physical requirements of job _____

Product/Service produced _____

Did you supervise others? ❑ Yes ❑ No

Reason for leaving? _____

Dates: From _____ To _____

Employer _____

Job Title _____

List job duties _____

List physical requirements of job _____

Product/Service produced _____

Did you supervise others? ❑ Yes ❑ No

Reason for leaving? _____

Additional courses taken, hobbies and special skills. Please be specific such as computer skills either personal or professional, sales, carpentry, auto repair, etc.

_____

_____

_____

Are you currently involved in a vocational rehabilitation program? ❑ Yes ❑ No

If **Yes**, please provide the name, address and phone number of the rehabilitation case worker _____

_____

_____

Are you interested in learning about our vocational rehabilitation program? ❑ Yes ❑ No

What is your employment goal or other work that you would be interested in doing? _____

Date _____ **Signature** _____

Authorization to Release Personal Information

1. I (the undersigned) authorize any physician, medical or dental practitioner, pharmacist, other health care provider, hospital, clinic, or medical facility, insurer, reinsurer, insurance services support organization, employer, government agency, consumer reporting agency, or insurance policy or benefit plan administrator to release records containing the Personal Information of:

   Name of Claimant _____
   (Last) (First) (Middle)

   Date of Birth_____/_____/_____ Social Security Number_____-_____-_____

2. **Personal Information to be released:**
   - data or records regarding my medical history, treatment, prescriptions, consultations (including medical and psychological reports, records, charts, notes (excluding psychotherapy notes), X-rays, films or correspondence, and any medical condition I may now have or have had;
   - any information regarding insurance or benefit plan coverage, claims or benefits; and/or
   - any information, data or records regarding my activities (including records relating to my Social Security, Workers' Compensation, retirement income, financial information, earnings and employment history)

3. **You may release my Personal 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 my Personal Information will be used by Mutual to evaluate my claim for benefits, or as required or permitted by law, and that if I refuse to sign this Authorization, my claim for benefits may not be paid. I also authorize Mutual to release my Personal Information as follows:**
   - to its reinsurer, or other persons or organizations performing business, legal or insurance support services in connection with my claim(s); or
   - to a vendor specializing in the application for Social Security Disability Benefits; or
   - to vendors/consultants providing me with wellness, disability or leave related services as part of an employer sponsored benefit plan; or
   - for self-insured disability plans only, to my employer; or
   - for fully insured plans to my employer for use in discussions with Mutual regarding my functional capacity, and any related restrictions and limitations, in order to facilitate my return to work; or
   - as otherwise required or permitted by law or as I further authorize

5. I understand my Personal Information may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

6. I understand that I may revoke this Authorization at any time by providing a written request to Mutual at the address above. If I revoke this Authorization, it will not affect any use or disclosure of Personal Information that occurred prior to Mutual's receipt of my revocation. If written revocation is not received, this Authorization will remain valid until 24 months after the date signed.

7. 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

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