

Group Long Term Disability Claim Application

S-1 Group Disability Management Services
Mutual of Omaha Insurance Company
Mutual of Omaha Plaza, Omaha, NE 68175
Fax ~~(402) 351-2167~~



Employee — form completion information

Application for Group LTD — Instructions

- A. **Complete and sign the authorization.** This will allow our insurance carrier or their representative to secure additional information (if necessary) to make a decision on your request for benefit payments (do not detach).
- B. **Complete employee claim statement in full.**
Attach: ● a copy of Social Security and other income entitlement awards (or forward when received)
- C. **Give this authorization and attached claim application to the physician treating you** (if more than one, obtain other forms for completion from employer). Instruct your attending physician to send his statement along with yours to the insurance carrier.
- D. When those forms are received by the Insurance Company, they will advise you of your eligibility for benefits or of any additional information that may be needed.

Long Term Disability Claim Employee's Statement

Please Complete in Full

To Be Completed By The Employee

Policy Number _____

A. Information about you

Last Name _____ First _____ Middle Initial _____

Address _____ City _____ State/Province _____ Zip _____

Telephone () _____ Social Security Number _____

Date of Birth (Month, Day, Year) _____ Height _____ Weight _____
 Rt Handed Male Single Widowed
 Lt Handed Female Married Divorced

Your Employer (include division if applicable) _____

Occupation _____

B. Information about your family (required to determine your eligibility for Social Security benefits)

Spouse's Name (Last, First) _____

Spouse's Social Security Number _____ Date of Birth (Month, Day, Year) _____ Is your spouse employed?
 Yes No

Children under age 25: Name (Last, First) _____ Date of Birth (Month, Day, Year) _____

C. Information about the condition causing your disability

1 For pregnancy or illness, answer the following questions:

What were your first symptoms? _____

When did you first notice them? _____ Date you were first treated by a physician (Month, Day, Year) _____

2 For an injury, answer the following questions:

Where and how did the injury occur? _____

Date the injury occurred (Month, Day, Year) _____ Date you were first treated by a physician (Month, Day, Year) _____

3 For illness or injury, 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, explain _____

Is your condition related to your occupation?
 Yes No If yes, explain _____

Have you filed, or do you intend filing a Workers' Compensation claim?
 Yes No

D. Information about the disability

Last day you worked before the disability (Month, Day, Year) _____ Did you work a full day?
 Yes No If no, explain _____ Date you were first unable to work (Month, Day, Year) _____

Have you returned to work?
 Yes Part time (date) _____ Full time (date) _____
 No If you have not returned to work, do you expect to?
 Yes Part time (date) _____ Full time (date) _____
 No

Are you currently self-employed or working for another employer?
 Yes No If so, give details. _____

(Continued on next page)

Please Complete in Full

E. Information about physicians and hospitals

First medical attention for the current disability was given by (complete below):

Doctor's Name	Telephone: () Fax: ()	Specialty
Address (Street, City, State, Zip)		Dates Seen To

List all other physicians and hospitals you have seen for this condition:

Doctor's Name	Telephone: () Fax: ()	Specialty
Address (Street, City, State, Zip)		Dates Seen To

Doctor's Name	Telephone: () Fax: ()	Specialty
Address (Street, City, State, Zip)		Dates Seen To

Doctor's Name	Telephone: () Fax: ()	Specialty
Address (Street, City, State, Zip)		Dates Seen To

Hospital

Address (Street, City, State, Zip)	Dates of Confinement To
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Have you ever had the same or a similar condition in the past?

Yes No If yes, complete the following concerning your past treatment:

Doctor's Name	Telephone: () Fax: ()	Specialty
Address (Street, City, State, Zip)		Dates Seen To

Hospital

Address (Street, City, State, Zip)	Dates of Confinement To
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F. Information about other income benefits

(Check the other income benefits you are receiving or are eligible to receive.)

Source of Income	Amount / (week, month)	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 about income 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. Federal taxes (minimum is \$87.00 per month) \$ _____ . 00

H. Signature (Required for all claims)

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

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

X _____ Date _____
Signature of Employee

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.

- ** **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 or 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 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.
- ** **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 of claim 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 a 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.
- ** **Maine, Tennessee or Virginia:** 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 a denial of insurance benefits.
- ** **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 for 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 AN 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.
- ** **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, except for New York 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 materially related to a claim is provided by the claimant.

Authorization To Disclose Personal Information

To physicians, medical or dental practitioners, hospitals, clinics, pharmacies, pharmacy benefit managers, other medical care facilities, health maintenance organizations, insurers, employers, consumer reporting agencies and all other providers of medical or dental services.

I authorize you to release to representatives of Mutual of Omaha Insurance Company, personal information about me including: medical history, mental and physical condition, prescription drug records, alcohol or drug use, financial and occupational information in order to evaluate my claim for disability benefit plan reimbursement.

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 information may be redisclosed without the protection of the federal privacy regulations.

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 expire 24 months after the date signed. I may revoke this authorization at any time by written notice to; ATTN: Group Disability Management Services, Mutual of Omaha Insurance Company, Mutual of Omaha Plaza, Omaha, NE 68175-0001. Any revocation of this authorization will not affect any use or disclosure of Personal Information that occurred prior to the receipt of my revocation.

I understand that I am entitled to receive a copy of the authorization and that a copy is as valid as the original.

Name(s) used for medical 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: _____

Date: _____

Authorization To Provide Financial and Health Information To My Employer

I, _____, authorize Mutual of Omaha Insurance Company and United of Omaha
Printed Name

Life Insurance Company to disclose or furnish certain financial and health information about me to my employer. I understand that the release of this information is necessary for my employer to monitor and manage the disability benefits program provided under my Group disability policy. I also understand that the information will be used by my employer solely for the purposes of auditing disability benefits paid, meeting mandated tax reporting obligations, determining waiver or discontinuance of premium deductions, and coordinating with other subsidized salary continuance plans my employer may offer.

To financial and health information which may be disclosed pursuant to this authorization includes such items as disability payment information for tax reporting purposes, copies of explanation of benefits (excluding medical information), and letters and other communications to me from the named insurance companies regarding the status of my claims for disability benefits.

I understand that my authorization will remain in effect for 24 months after I sign this form, unless earlier revoked, and I understand that I may revoke my authorization at any time by either:

Calling Toll Free:

or

Writing:

800-877-5176

Mutual of Omaha Insurance Company
S-1 Group Disability Management Services
Mutual of Omaha Plaza
Omaha, NE 68175-0001

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

I understand that I am entitled to receive a copy of this authorization

Signature

Date

If Applicable: I am not the person whose health information is to be disclosed to the named insurance companies, but I am legally authorized to grant permission on behalf of that person.

Printed Name of Legal Representative: _____

Signature of Legal Representative: _____

Type of Legal Representative: _____

Date: _____

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Long Term Disability Claim Physician's Statement

Please Complete in Full

S-1 Group Disability Management Services
 Mutual of Omaha Insurance Company
 Mutual of Omaha Plaza, Omaha, NE 68175
 Fax (402) 351-2167

This form should be completed by the physician who was treating the claimant when he or she last worked.

To Be Completed By The Attending Physician

A. General Information

This claim is for (Patient's Name)

Patient's Social Security Number	Height	Weight	Blood Pressure	Date of Birth (Month, Day, Year)
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B. Complete this section for normal pregnancy, then go to section E.

What was the date of the last menstrual period?	What is the expected date of delivery?	
What is the expected length of postpartum recovery?	What was the first date of treatment?	What was the last date of treatment?

C. Complete this section for all conditions except normal pregnancy.

Primary Diagnosis including ICD 9 or DSM code

Symptoms

Objective Findings

What diagnostic testings have been done?

Are there secondary conditions contributing to the disability?
 Yes No If yes, what are they? (Please include ICD 9 or DSM code.)

If this is a cardiac condition, what is the functional capacity?
 (American Heart Association) Class 1 - No limitation Class 2 - Slight limitation Class 3 - Marked limitation Class 4 - Complete limitation

When did symptoms first appear?	Date of the patient's first visit (Month, Day, Year)	Date you believe the patient was first unable to work (Month, Day, Year)
Date of the patient's last visit (Month, Day, Year)	How often do you see the patient?	

Is the patient's condition work related?
 Yes No If yes, explain:

Has the patient undergone surgery?
 Yes No If yes, give date, procedure and result.

If no, do you expect surgery to be performed in the future?
 Yes No If yes, give date and type of surgery.

What medication is the patient currently taking or has been prescribed?

Please indicate other types and frequencies of treatment.

Has the patient been referred to a medical rehabilitation or therapy program?
 Yes No If yes, give details.

Have you referred the patient for other types of consultations?
 Yes No If yes, give details.

Has the patient been hospital confined?
 Yes No If yes, complete the following:

Name of Hospital

Address	Dates of Confinement through
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