Group Critical Illness Health Screening Benefit Claim Form

United of Omaha Life Insurance Company • Mutual of Omaha Insurance Company

Group Critical Illness Claims • Mutual of Omaha Plaza • Omaha, NE 68175-0001

Phone (800)775-8805 (toll-free) • Fax (402)997-1835 • www.mutualofomaha.com/customer-service

Please print clearly in blue or black ink. **All applicable information should be completed to avoid delays in the processing of the claim. When complete, submit the form to the address or fax above.** This form is to be completed without expense to United of Omaha Life Insurance Company or Mutual of Omaha Insurance Company.

Section 1: Policyholder/Employer Information

POLICYHOLDER/EMPLOYER NAME			GROUP ID NUMBER G000 _ _ _ _
CITY	STATE	ZIP CODE	PHONE NUMBER

Section 2: Employee/Member Information

LAST NAME	FIRST NAME	MI	PHONE NUMBER
STREET ADDRESS	CITY	STATE	ZIP CODE

DATE OF BIRTH (MM/DD/YYYY)	GENDER ☐ Male ☐ Female	SSN OR ID NUMBER	MARITAL STATUS ☐ Single ☐ Married/Partnered ☐ Widowed ☐ Divorced

DURING THE PAST 12 MONTHS, HAS THE EMPLOYEE/MEMBER USED TOBACCO IN ANY FORM? ☐ Yes ☐ No	IS THE EMPLOYEE/MEMBER ELIGIBLE FOR OR RECEIVING BENEFITS FROM MEDICAID? ☐ Yes ☐ No	DOES THE EMPLOYEE/MEMBER PARTICIPATE IN AN HSA? ☐ Yes ☐ No

DOES THE EMPLOYEE/MEMBER HAVE MAJOR MEDICAL INSURANCE, OR A COMBINATION OF BASIC HOSPITAL AND BASIC MEDICAL INSURANCE? ☐ Yes* ☐ No	*If YES, PROVIDE NAME OF INSURANCE CARRIER & POLICY NUMBER:

IF THE POLICYHOLDER IS YOUR EMPLOYER, ARE YOU CURRENTLY ACTIVELY WORKING? ☐ Yes ☐ No†	†IF NO, PROVIDE DATE LAST WORKED (MM/DD/YYYY):	AVERAGE HOURS WORKED PER WEEK

Section 3: Patient Information

WHO IS THE PATIENT (THE PERSON THAT HAD THE HEALTH SCREENING TEST/PROCEDURE)? ☐ Employee/Member ☐ Spouse/Partner ☐ Child

COMPLETE THE REMAINDER OF SECTION 3 ONLY IF THE PATIENT IS NOT THE EMPLOYEE/MEMBER.

LAST NAME	FIRST NAME	MI
STREET ADDRESS	CITY	STATE	ZIP CODE

DATE OF BIRTH (MM/DD/YYYY)	GENDER ☐ Male ☐ Female	SSN OR ID NUMBER	RELATIONSHIP TO EMPLOYEE/MEMBER

DURING THE PAST 12 MONTHS, HAS THE PATIENT USED TOBACCO ANY FORM? ☐ Yes ☐ No	IS THE PATIENT ELIGIBLE FOR OR RECEIVING BENEFITS FROM MEDICAID? ☐ Yes ☐ No	DOES THE PATIENT PARTICIPATE IN AN HSA? ☐ Yes ☐ No

DOES THE PATIENT HAVE MAJOR MEDICAL INSURANCE, OR A COMBINATION OF BASIC HOSPITAL AND BASIC MEDICAL INSURANCE? ☐ Yes ☐ No	IF THE PATIENT IS THE CHILD OF THE EMPLOYEE/MEMBER, IS THE CHILD MARRIED, IN A PARTNERSHIP OR IN A CIVIL UNION? ☐ Yes ☐ No

IF THE PATIENT IS THE CHILD OF THE EMPLOYEE/MEMBER, IF OVER AGE 18, IS THE CHILD A FULL-TIME STUDENT? ☐ Yes* ☐ No	*IF YES, PROVIDE THE NAME, CITY, STATE & PHONE NUMBER OF THE SCHOOL:

Section 4: Claimant Information

WHO IS THE CLAIMANT (THE PERSON FILING THIS CLAIM)? ☐ Employee/Member ☐ Spouse/Partner ☐ Beneficiary ☐ Other** (ex. Power of Attorney, Conservator)

COMPLETE THE REMAINDER OF SECTION 4 ONLY IF THE CLAIMANT IS NOT THE EMPLOYEE/MEMBER.

LAST NAME	FIRST NAME	MI	PHONE NUMBER
STREET ADDRESS	CITY	STATE	ZIP CODE

DATE OF BIRTH (MM/DD/YYYY)	SSN OR ID NUMBER	RELATIONSHIP TO EMPLOYEE/MEMBER

IF OTHER, SUCH AS POWER OF ATTORNEY OR CONSERVATOR, A COPY OF THE DOCUMENT GRANTING AUTHORITY MUST BE SUBMITTED WITH THIS FORM

Section 5: Health Screening Test/Procedure Information

PLEASE CHECK THE HEALTH SCREENING TEST/PROCEDURE FOR WHICH THIS CLAIM IS BEING FILED:

☐ Abdominal aortic aneurysm ultrasound	☐ CA 125 (blood test for ovarian cancer)	☐ EKG (electrocardiogram)	☐ Pap smear
☐ Blood test for triglycerides	☐ Carotid ultrasound	☐ Double contrast barium enema	☐ PSA (blood test for prostate cancer)
☐ Bone marrow testing	☐ CEA (blood test for colon cancer)	☐ Fasting blood glucose test	☐ Serum cholesterol test (HDL & LDL)
☐ Bone density screening	☐ Chest X-ray	☐ Flexible sigmoidoscopy	☐ SPEP (blood test for myeloma)
☐ Breast ultrasound	☐ Colonoscopy	☐ Hemoccult stool analysis	☐ Stress test (on a bicycle or treadmill)
☐ CA 15-3 (blood test for breast cancer)	☐ CT angiography	☐ Mammography	☐ Thermography

DATE THE TEST/PROCEDURE WAS PERFORMED (MM/DD/YYYY)	PHYSICIAN NAME	PHYSICIAN PHONE NUMBER

A COPY OF THE TEST/PROCEDURE RESULTS, PROVIDER INVOICE OR OTHER PROOF OF THE TEST/PROCEDURE MUST BE SUBMITTED WITH THIS FORM.

Section 6: Acknowledgement & Signature

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. *(Note: This fraud warning does not apply to residents of AL, AR, CA, CO, DC, FL, KS, KY, LA, MA, ME, MD, NJ, NM, NY, OH, OR, PR, RI, TN, VT, VA and WA. Please read the specific fraud warning for your state of residence included with this form or available online at www.mutualofomaha.com.)*

By signing below, I certify that I have read and understand the fraud warning that applies to my state of residence, and that all information provided on this form is true and complete to the best of my knowledge and belief.

SIGNATURE OF CLAIMANT	DATE
SIGNATURE OF PATIENT, IF AGE 18 OR OLDER (AND NOT THE CLAIMANT) ☐ Check if Patient is deceased or incapable of signing	DATE