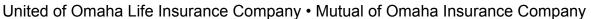
Part A – Employee/Member, Patient & Claimant Statement





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

Phone (800)775-8805 (toll-free) • Fax (402)997-1898 • www.mutualofomaha.com/customer-service • submitgrpacc@mutualofomaha.com
Please print clearly in blue or black ink. All applicable information should be completed to avoid delays in the processing of the claim. When Part A is complete,
submit with any proof requirements to the address or fax above. Provide Part C to all attending physicians/medical professionals and Part D to the
policyholder for completion. All parts of this form are to be completed without expense to the underwriting company. Please use the Group Accident Express Benefit
Claim Form for all accident express benefit claims. Please use the Group Health Screening Benefit Claim Form for all health screening benefit claims.

Section 1: Policyholder/Employ		the Group ricular of	breening benefit oldin	1 Offit for all fleath 30	coming benefit of	uiiiio.
POLICYHOLDER/EMPLOYER NAME						GROUP ID NUMBER
						G000
CITY				STATE	ZIP CODE	
Section 2: Employee/Member In	formation					
LAST NAME			FIRST NAME			MI
STREET ADDRESS		CITY		OTATE	ZIP CODE	
STREET ADDRESS		CITY		STATE	ZIP CODE	
EMAIL ADDRESS			HOME PHONE NUM	MBER	CELL PHONE	NUMBER
					02221110112	
DATE OF BIRTH (MM/DD/YYYY)	GENDER	SSN OR ID NUI	MBER	MARITAL STATUS		
	☐ Male ☐ Female			☐ Single ☐ Marrie	d/Partnered 🔲 W	/idowed Divorced
DOES THE EMPLOYEE/MEMBER HA	AVE MAJOR MEDICAL INSU	JRANCE, OR A	*If YES, PRO	OVIDE NAME OF INSU	RANCE CARRIE	R & POLICY NUMBER:
COMBINATION OF BASIC HOSPITAL	AND BASIC MEDICAL INS	SURANCE? Yes*	□No			
IF THE POLICYHOLDER IS YOUR EN	MPLOYER, ARE YOU TIF	NO, PROVIDE DAT	E LAST WORKED (MM/D	DD/YYYY): AVERAGE	HOURS WORKE	D PER WEEK
CURRENTLY ACTIVELY WORKING?	□Yes □No <sup>†</sup>					
Section 3: Patient Information						
WHO IS THE PATIENT (THE PERSOI	N THAT WAS IN THE ACCI	DENT)? 🗌 Employe	ee/Member	Partner		
	IPLETE THE REMAINDER	OF SECTION 3 ONL		NOT THE EMPLOYEE	MEMBER.	
LAST NAME			FIRST NAME			MI
STREET ADDRESS		CITY		STATE	ZIP CODE	
STREET ADDRESS		CITY		STATE	ZIP CODE	
DATE OF BIRTH (MM/DD/YYYY)	GENDER	SSN OR ID NUM	BER	RELATIONSHIP TO	EMPLOYEE/MEI	MRFR
BATE OF BITCH (MINISBATT)	☐ Male ☐ Female	CON ON ID NOM	DER	TREEXTIONORM TO	Livii LOTEL/IVILI	NDLI (
DOES THE PATIENT HAVE MAJOR N		A COMBINATION	*If YES_PROVIDE N	L NAME OF INSURANCE	CARRIER & PO	ICY NUMBER:
OF BASIC HOSPITAL AND BASIC ME	,		11 120,111011021	TAME OF MOOIT WOL	o, ii	LIOT HOMBER.
			IF THE DATIENT IS	THE CHILD OF THE E	MDI OVEE/MEM	RED IS THE CHILD
IF THE PATIENT IS THE CHILD OF THE EMPLOYEE/MEMBER AND OVER AGE 18, IS THE CHILD A FULL-TIME STUDENT? ☐ Yes¹ ☐ No				PARTNERSHIP?		DEIX, IO THE OHIED
†IF YES, PROVIDE THE NAME, CITY,				FARTNERSHIP!	es 🗌 NO	
TES, FROVIDE THE NAME, CITT,	, STATE & FITONE NOWIDE	K OF THE SCHOOL	•			
Section 4: Accident Information						
DATE OF ACCIDENT (MM/DD/YYYY)	TIME OF ACCIDENT (HH:	мм) WHERE DI	D THE ACCIDENT HAP	PPEN (LOCATION)?	DID ANY LAW	AGENCY INVESTIGATE
	ПАМ Г	¬PM			THE ACCIDEN	T? ☐ Yes** ☐ No
FOR THIS ACCIDENT AND THE PAT	IENT DESCRIBED IN SECT	TION 3, WHAT CLAIN	// TYPE IS THIS? ☐ Fi	rst Claim	l/Subsequent Clai	m
	E REMAINDER OF SECTION					
DID THE ACCIDENT HAPPEN	*IF YES, HAS A WORKER	RS' COMP CLAIM	DID THE ACCIDENT I	NVOLVE A MOTOR	*	H WAS THE PATIENT?
WHILE WORKING? ☐ Yes* ☐ No			VEHICLE/AUTOMOBI			
PROVIDE A DETAILED EXPLANATION				F INJURIES SUSTAINE	ED BY THE PATIE	ENT (IF MORE SPACE IS
REQUIRED, PROVIDE ON A SEPARA	ATE SHEET OF PAPER AN	D SUBMIT WITH TH	IS CLAIM):			
**IF ANY LAW ENFORCEMENT A	GENCY INVESTIGATED TH	HIS ACCIDENT, A CO	OPY OF THE AGENCY/	POLICE REPORT MUS	T BE SUBMITTE	D WITH THIS CLAIM.**
Section 5: Claim & Benefit Infor		,				
CHECK EACH INJURY, TREATMENT						
NOT ALL BENEFITS ARE INCLUDED ANY PREVIOUS CLAIMS HAVE BEE						
Initial Care & Emergency	Specified Injury	ACCIDENT AND I A	Surgical	TIE BEREITIS ITIAT I	Catastrophic	L TO THIS NEW CLAIM.
Emergency Room (ER)	Fracture		Exploratory/Arthr	oscopic Surgery	☐ Basic Accide	ental Death
Urgent Care Center (UC)	Dislocation			al/Thoracic Surgery		arrier Accidental Death
Initial Physician Office Visit (IPO)	Laceration		Herniated Disc S			on of Remains
Ground Ambulance	Second or Third D	Degree Burns	Torn Knee Cartila		Dismemberr	nent
Air Ambulance	☐ Skin Graft ☐ Dental Extraction,	Crown or Filling		n/Rotator Cuff Surgery	☐ Paralysis	Modifications
Follow-Up Care		Crown or Filling	☐ Eye Procedure ☐ Blood Products		☐ Reasonable	Modifications
Physician Follow-Up Visit	Hospital		Pain Managemer	nt	_	6:4-
☐ Therapy Services ☐ Medical Device	☐ Admission ☐ Daily Confinemen	ŧ	Diagnostic	•	Additional Bei	
☐ Prosthetic Device(s)	☐ ICU Confinement	ı	X-Ray or Other D	iagnostic Exam	Lodging	UII
	Rehabilitation Fac	cility Confinement	Brain Injury Diagr		Childcare	
PROOF REQUIREMENTS						

- Documentation must be submitted to support the benefits claimed, which in addition to Part C Attending Physician/Medical Professional Statement may include medical records, physician notes, ER/UC/IPO discharge papers, radiology reports, hospital/physician/ambulance bills, toxicology reports or other proof. Documentation must provide: 1) the date of service; 2) the specific procedure/service received; and 3) the diagnosis; for all benefits claimed, as applicable.
- · A copy of the hospital bill or admission/discharge summary showing the number of days the Patient was hospitalized must be submitted with this claim.

• If death was a result of this accident, a certified copy of the death certificate for the Patient must be submitted with this claim.

Section 6: Physician/Medical Profes PROVIDE INFORMATION FOR THE PATIS PHYSICIAN NAME			AL PROFESS		EX. FAMILY DOCTOR	OR PEDIATRICIAN):	
STREET ADDRESS		CITY	THONE NO	MIDER	STATE	ZIP CODE	
PROVIDE INFORMATION FOR THE PATIE		AN/MED. PR	OF./SPE				
PHYSICIAN NAME			PHONE NU			FAX NUMBER	
STREET ADDRESS		CITY			STATE	ZIP CODE	
IF THE PATIENT WAS HOSPITALIZED FO HOSPITAL NAME	OR THE TREATMENT	OF INJURIES SUSTAI	PHONE NU		NT, PROVIDE HOSPIT	AL INFORMATION: FAX NUMBER	
STREET ADDRESS		CITY			STATE	ZIP CODE	
DATE OF ADMISSION (MM/DD/YYYY)	DATE OF DISCHAR	GE (MM/DD/YYYY)	REASON F	OR VISIT	/CARE		
**IF THE PATIENT WAS TREATED BY MO INFORMATION REQUIRED ABOVE FOR E							
Section 7: Authorization and Signat	ure						
Fraud Warning: Any person who insurance or statement of claim concerning any fact material there penalties. (Note: This fraud warning does Please read the specific fraud warning for your lauthorize any physician, medical care or other medical care facility.	ontaining any mate to commits a fraud is not apply to residents our state of residence it or dental practitio	erially false inform dulent insurance a of AL, AR, CA, CO, DO ncluded with this form oner, hospital, clini	ation or co act, which i C, FL, KS, KY or available or c, pharmad	nceals to a crime, LA, MA, and	for the purpose of ne and subjects su ME, MD, NJ, NM, NY, ww.mutualofomaha.cor macy benefit man	misleading, information uch person to criminal and civil NC, OH, OR, PR, RI, TN, VT, VA and WA. m.)	
Security Administration, law enforce Patient named above to United of information includes all health info	care or other medical care facility, health maintenance organization, insurer, reinsurer, employer, consumer reporting agency, Social Security Administration, law enforcement agency and governmental agency to disclose records containing the personal information of the Patient named above to United of Omaha Life Insurance Company and Mutual of Omaha Insurance Company (the "Company"). Personal information includes all health information, mental and physical condition, prescription drug records, alcohol and drug use, financial information and occupational information.						
I understand that the personal information that is disclosed will be used by the Company to evaluate a claim for accident insurance benefits. I understand that the personal information may be redisclosed to reinsurance companies or other persons or organizations performing services in connection with this claim, as is lawfully required or permitted. If the person or entity to whom personal 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 if I refuse to sign, revoke, or alter the contents of this form, the processing of this claim may be affected. This may include denial of benefits. Unless revoked earlier, this authorization will remain in effect for 12 months from the date this form is signed. I may revoke this authorization at any time by providing written notice to the address listed at the beginning of this form. I understand that my right to revoke this authorization is limited to the extent that the Company has taken action in reliance on the authorization. I understand that I, or my authorized representative, may receive a copy of this form upon request. A copy of this form is as effective as the original.							
Name(s) used for records for the Patient (if different than the name provided in Section 3 of this form):							
I understand that should this claim be overpaid for any reason, it is the obligation of the recipient of the benefit payment to repay any such overpayment in accordance with the terms of the policy. I understand that benefit payments may be considered taxable income, to the degree that premiums for the insurance were not included in my income/the income of the employee/member, or if the insurance premiums were paid on a pre-tax basis. I understand that such benefit payments will be reported as required by the IRS on form 1099-MISC, and that I should consult independent tax counsel for additional information and guidance regarding the taxability of any benefit payment.							
I acknowledge that incomplete information on this form may delay processing of the claim. If the Company requests additional information to complete processing of this claim, I understand that any delay in response may delay processing of the claim.							
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 and statements provided on this form are true and complete to the best of my knowledge and belief. <b>If applicable</b> : I am not the person whose personal information is to be disclosed, but I am legally authorized to grant permission on behalf of that person and have completed Section 7: Claimant Information (below).							
SIGNATURE OF CLAIMANT DATE						DATE	
SIGNATURE OF PATIENT, IF AGE 18 OR OLDER (AND NOT THE CLAIMANT)  DATE  Check if Patient is decreased or incarable of signing.							
Check if Patient is deceased or incapable of signing  Section 8: 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 8 ONLY IF THE CLAIMANT IS NOT THE EMPLOYEE/MEMBER.							
LAST NAME	FIRST NAME	T = 1=1	MI	EMAIL	ADDRESS		
STREET ADDRESS		CITY			STATE	ZIP CODE	
DATE OF BIRTH (MM/DD/YYYY)	SSN OR ID NUMBEI	R 	HOME PHO			CELL PHONE NUMBER	
IF APPLICABLE, RELATIONSHIP TO EMPLOYEE/MEMBER     IF APPLICABLE, TYPE OF LEGAL REPRESENTATIVE							
**IF OTHER, SUCH AS POWER OF ATTO	RNEY OR CONSERV	ATOR, A COPY OF TH	IE DOCUME	NT GRAN	TING AUTHORITY MU	JST BE SUBMITTED WITH THIS CLAIM.**	

Part B – Optional Authorization to Disclose Information to Third Parties
United of Omaha Life Insurance Company • Mutual of Omaha Insurance Company

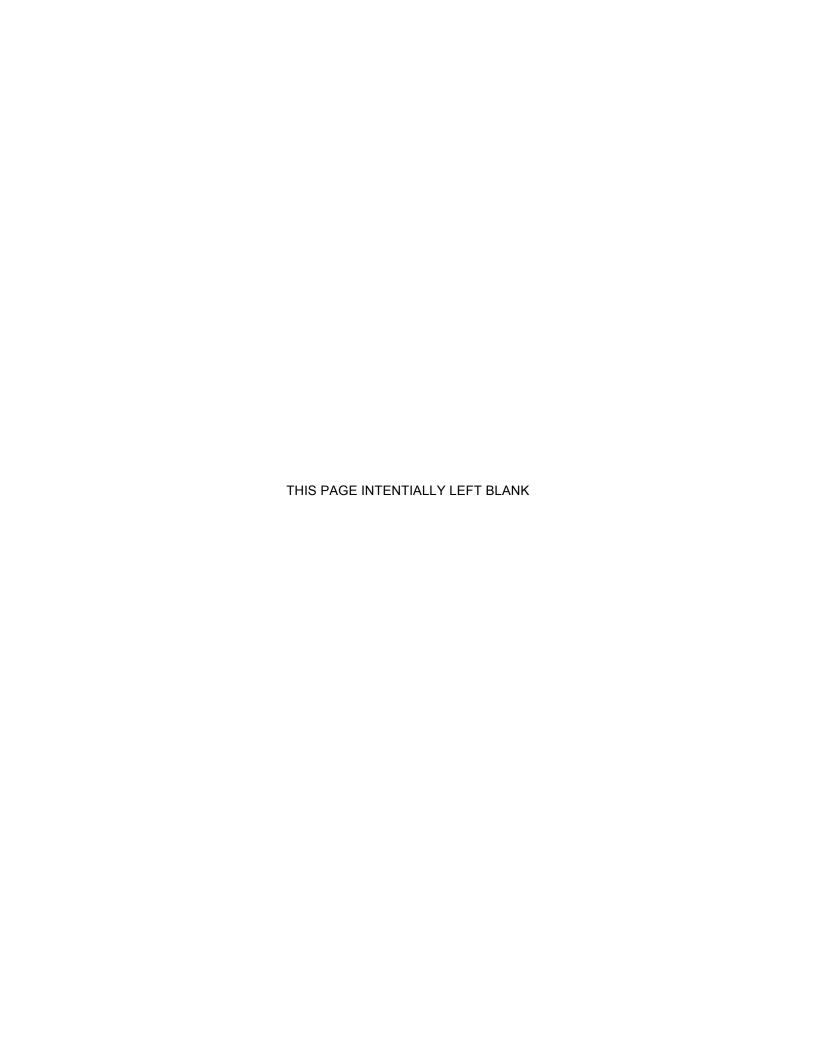


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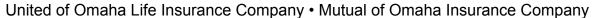
Phone (800)775-8805 (toll-free) • Fax (402)997-1898 • www.mutualofomaha.com/customer-service • submitgrpacc@mutualofomaha.com
Please print clearly in blue or black ink. Part B is optional, and is to be completed if the Claimant or Patient would like to allow
United of Omaha Life Insurance Company or Mutual of Omaha Insurance Company to communicate with a third party about this
claim. A third party includes a family member, friend, or other person identified. If Part B is completed, submit with Part A to the address or
fax above

tax above.								
Section 1: Employee/Member	er & Patient Information		<u> </u>	<u></u>				
EMPLOYEE/MEMBER NAME			EMPLOYEE/MEMBER SSN OR ID NUMBER GROUP ID NUMBER G000					
PATIENT NAME (IF NOT THE EMPLOYEE/MEMBER)			PATIENT SSN OR ID N	PATIENT SSN OR ID NUMBER (IF NOT THE EMPLOYEE/MEMBER)				
PATIENT DATE OF BIRTH (MM/DD/	YYYY) PATIENT GENDER	RELATIONSHIP TO EMP	LOYEE/MEMBER (WRITE "SEI	LF" IF PATIENT IS THE EMPLOYEE/MEMBER				
	☐ Male ☐ Female	•						
DATE OF ACCIDENT (MM/DD/YYYY)	BRIEF DESCRIPTION OF A	CCIDENT						
Section 2: Third Party Inform								
	The state of the s	AMILY MEMBER, FRIEND OF	R OTHER PERSON) YOU WOL	JLD LIKE TO ALLOW US TO COMMUNICATE				
SPOUSE/PARTNER NAME				PHONE NUMBER				
OTHER FAMILY MEMBER/PERS	ON NAME	RELA'	TIONSHIP TO PATIENT	PHONE NUMBER				
OTHER FAMILY MEMBER/PERS	ON NAME	RELA	TIONSHIP TO PATIENT	PHONE NUMBER				
OTHER FAMILY MEMBER/PERS	ON NAME	RELA	TIONSHIP TO PATIENT	PHONE NUMBER				
OTHER FAMILY MEMBER/PERS	ON NAME	RELA <sup>-</sup>	TIONSHIP TO PATIENT	PHONE NUMBER				
OTHER FAMILY MEMBER/PERS	ON NAME	RELA	TIONSHIP TO PATIENT	PHONE NUMBER				
Section 3: Authorization & S	ianoturo							
personal information of the party(ies) named above. Unless otherwise indicated	Employee/Member or Pa	atient (if the Patient is no tion includes medical cal	it the Employee/Member re and history, mental an	"Company") to receive and disclose ) related to this claim with the third  d physical condition, prescription dru e needed to determine the insurance				
benefits payable.								
I do not authorize the foll	owing information relev	ant to this claim to be	shared:					
insurance benefits. I under organizations performing s	stand that the personal in ervices in connection with not a health care provider	formation may be redisc this claim, as is lawfully or health plan subject to	closed to reinsurance cor required or permitted. If	pany to evaluate my claim for acciden mpanies or other persons or f the person or entity to whom person ons, the information may be				
	y providing written notice it is received by the Com	to the address listed at t pany. I understand that I	the beginning of this form , or my authorized repres	n. I understand the revocation may no sentative, may receive a copy of this				
SIGNATURE OF CLAIMANT	2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	Ga	2 2 3 2 2 2 2 2 7 3 1 1 1	DATE				
CIONATUDE OF DATIENT IS AC	E 40 OD OLDED (AND NOT TH	T CLAIMANT)		DATE				
SIGNATURE OF PATIENT, IF AG  Check here if Patient is decease	,	E CLAIMANT)		DATE				
			,					

MUGC9668 PAGE 1 OF 1



Part C – Attending Physician/Medical Professional Statement





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Please print clearly in blue or black ink. All applicable information should be completed to avoid delays in the processing of the

claim. Section 1 should be completed by the claimant. All other sections are to be completed by the attending physician/medical

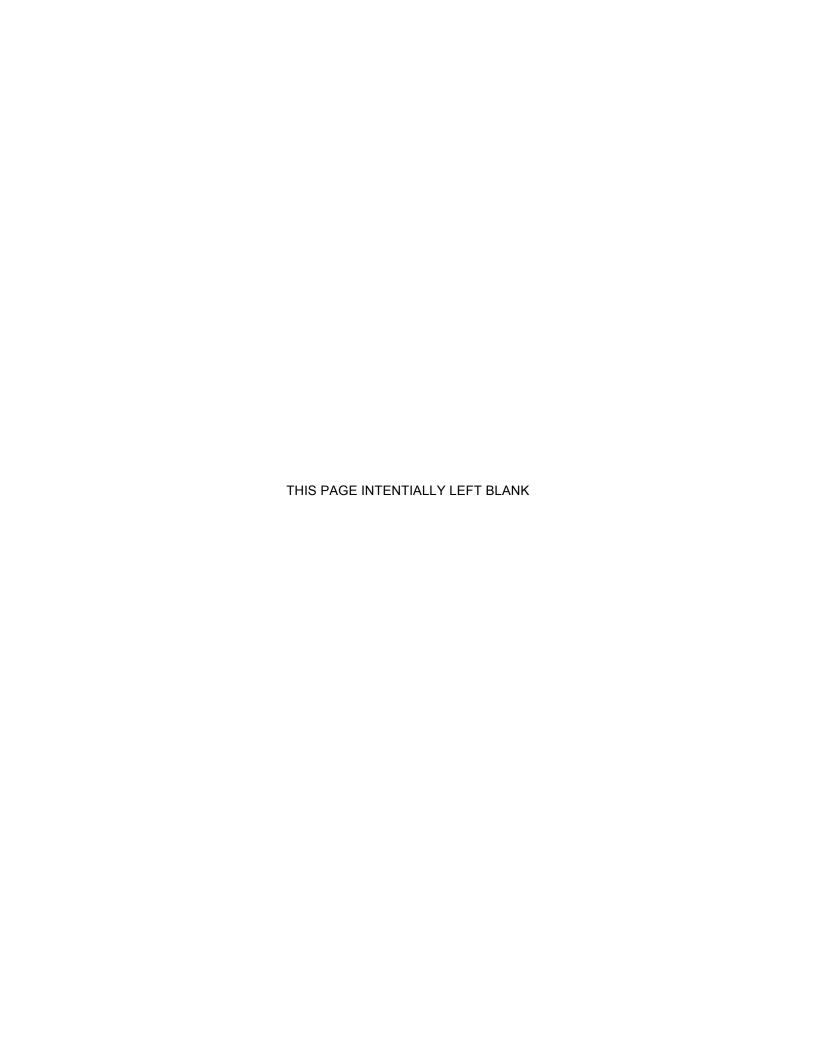
professional. When complete, submit with any supporting documentation (reports, office notes, medical records or statements,

consultations, test results, etc.) to the address or fax above. Any fee charged for the completion of this form is the Claimant's responsibility.

EMPLOYEE/MEMBER NAME	Patient Information		EMPLOY	EE/MEMBER SSN	OR ID NUMBER	GROUP ID NUMBER
PATIENT NAME (IF NOT THE EMPLOY	YEE/MEMBER)		PATIENT	SSN OR ID NUMI	BER (IF NOT THE E	EMPLOYEE/MEMBER)
PATIENT DATE OF BIRTH (MM/DD/YYYY)	PATIENT GENDER  Male Female	RELATIONSHIP TO EMPLO	YEE/MEMBE	R (OR "SELF")	DATE OF ACCID	DENT (MM/DD/YYYY)
Section 2: Accident Information						
DESCRIPTION OF ACCIDENT AND PR	RIMARY DIAGNOSIS					
WAS THE PATIENT HOSPITALIZED?	IS/ WAS A MEDICAL	DEVICE (FOR LOCOMOTION/	MOBILITY)	IS/WAS ONE OR	MORE PROSTHET	TIC DEVICES REQUIRED
Yes (Complete Section 10) No		O THE PATIENT? ☐ Yes ☐ No	*		「? □ One □ Two	
ARE ALL INJURY/TREATMENTS/SERV						
IS THERE ANY OTHER ILLNESS OR II	NFIRMITY AFFECTING TH	E PATIENT'S CONDITION OR I	NJURIES SUS	STAINED IN THE A	CCIDENT? Tyes	☐ No - Explain:
Section 3: Injury, Treatment & Section 3: Injury, Treatment & Section 3: Submit any relevant test result information below. Each in	OR SERVICE FOR WHICH JLTS, HOSPITAL DISCHAF	RGE SUMMARY AND/OR YOUR SERVICE MUST BE INDEPEND	R MEDICAL S ENT OF BOD	TATEMENTS/REC	ORDS WITH THIS CKNESS AND ALL	FORM, IN ADDITION TO . OTHER CAUSES.
INJURY/TREATMENT/SERVICE	DATE(S) OF SERVICE	DIAGNOSIS/PROCEDURE CODE(S) (ICD-9/10, CPT4, ETC)	DIAGNOSIS INFORMAT		DESCRIPTION & A	ADDITIONAL
Initial Care & Emergency	I					
Emergency Room						
Urgent Care Center						
☐ Initial Physician Office Visit						
Follow-Up Care	1	T				
Physician Follow-Up Visit						
Therapy Services (OT, PT, speech, chiropractic care)						
Specified Injury						
☐ Fracture(s) and/or Dislocations(s)	SEE SECTION 4 FOR FE	RACTURE(S) AND SECTION 5 F		• • •		
Laceration(s) (Repair incl. sutures, adhesives, staples or closure strips)			•	of all lacerations retion required repair,		inches
Second or Third Degree Burn(s)				•	for Second Degree I for Third Degree Bu	
Skin Graft (Incl. stem cells or skin substitute)			76 OF TOTAL L	Body Surface Area	or Tilla Degree Ba	
☐ Dental Crown, Filling and/or Extraction						
Surgical						
Exploratory or Arthroscopic Surgery						
Abdominal, Cranial or Thoracic Surgery						
Herniated Disc Surgery						
☐ Torn Knee Cartilage Surgery						
☐ Ligament/Tendon/Rotator Cuff Surgery						
Eye Procedure (Removal of object or surgery, other than eyelid)						
Blood Products (Blood, red cells, plasma, platelets or granulocytes)						
Epidural Anesthesia						
Diagnostic						
X-ray and/or Diagnostic Exam						
☐ Brain Injury Diagnosis (TBI or MTBI, incl. concussions)						
Catastrophic						
☐ Dismemberment, Paralysis and/or Coma	SEE SECTION 6 FOR DI	SMEMBERMENT, SECTION 7 F	OR PARALY	SIS AND SECTION	9 FOR COMA	
Loss of Sight, Hearing and/or Speech	SEE SECTION 8 FOR LO	OSS OF SIGHT, HEARING AND	OR SPEECH			
**IFMORE SPACE IS NEEDED, PROVI	IDE ADDITIONAL INFORMA	ATION BELOW IN SECTION 12	OR ON A SEI	PARATE SHEET O	F PAPER SUBMIT	TED WITH THIS CLAIM.**

If MORE THAN DIVER PRACTICE WAS SUSTAINED BY THE PATENT AS A REQUIRY OF THE CODEST.	Section 4: Fracture		AC CHCTAINE	D DV THE DAT	TIENT AC A	DECILI T.O	E THE ACCIDENT D	ECONDE EACH	EDACTURE	
DATE OF CORRECTION   DATE OF CARACHOUSE SUPERVISION   DATE OF CARACHOUSE SUPERVISION COLOR			IAS SUSTAINEL						FRACTURE.	
MAGING?   Yes   TNE   DIAGNOSSIDESCRIPTION (1994), LOCATION \$1994, LOCATION							•	•		
CAUSE OF PRACTURE   DATE OF DIAGNOSS DESCRIPTION APPLICATION FOR CONTROL FOR	ICD-9/10 CODE			DATE OF DIA	AGNOSIS (MI	M/DD/YYYY)	*DATE SURGERY	PERFORMED (N	IM/DD/YYYY)	*CPT 4 CODE(S)
Part   Control   Closed Reaution   Open Reduction   Display   DATE OF DIAGNOSIS (NUMBER)   DATE OF DI	#2 - TYPE OF FRACTU		_ Yes No		DIAGNOSIS	S/DESCRIP	TION (BONE LOCATION FI	(C)		
Any Fig.   Constitution   Open Reduction   Open Reducti	Avulsion (Chip)	Closed Reduc	tion							
Author Code				DATE OF DIA	AGNOSIS (MI	M/DD/YYYY)	*DATE SURGERY	PERFORMED (M	IM/DD/YYYY)	*CPT 4 CODE(S)
Addition Chip   Closed Reduction   Open Reduction*   TOATE SURGERY PERFORMED AWASSETTY)   TOPT 4 CODE(S)			_YesNo		DIAGNOSIS	S/DESCRIP	TION (BONE, LOCATION, ET	ΓC)		
Section S. DISCORTION  ■ MORE THAN ONE DISLOCATION  □ Incomplete □ Closed Reduction □ Open Reduction*  □ DATE OF DIAGNOSIS BARROWYN*  □ DATE SURGERY PERFORMED DIAGNOSIS*  □ DATE OF DIAGNOSIS BARROWYN*  □ TATE SURGERY PERFORMED DIAGNOSIS*  □ DATE OF DIAGNOSIS BARROWYN*  □ DATE SURGERY PERFORMED DIAGNOSIS*  □ DATE OF DIAGNOSIS BARROWYN*  □ DATE SURGERY PERFORMED DIAGNOSIS*  □ DATE OF DIAGNOSIS BARROWYN*  □ DATE SURGERY PERFORMED DIAGNOSIS*  □ DATE OF DIAGNOSIS BARROWYN*  □ DATE SURGERY PERFORMED DIAGNOSIS*  □ DATE OF DIAGNOSIS BARROWYN*  □ DATE SURGERY PERFORMED DIAGNOSIS*  □ DATE OF DIAGNOSIS BARROWYN*  □ DATE SURGERY PERFORMED DIAGNOSIS*  □ DATE OF DIAGNOSIS BARROWYN*  □ DATE SURGERY PERFORMED DIAGNOSIS*  □ DATE OF DIAGNOSIS BARROWYN*  □ DATE SURGERY PERFORMED DIAGNOSIS*  □ DATE OF SURGERY PERFORMED DIAGNOSIS*  □ DATE OF DIAGNOSIS BARROWYN*  □ DATE OF DIAGNOSIS BARROWYN	Avulsion (Chip)	Closed Reduc								
Section 6: Dislocation(c)   DISLOCATION WAS SUSTAINED BY THE PATIENT AS A RESULT OF THE ACCIDENT, DESCRIBE EACH DISLOCATION.	ICD-9/10 CODE			DATE OF DIA	AGNOSIS (MI	M/DD/YYYY)	*DATE SURGERY	PERFORMED (M	IM/DD/YYYY)	*CPT 4 CODE(S)
If MORE THAN ONE DISLOCATION WAS SUSTAINED BY THE PATHENT AS A RESULT OF THE ACCIDENT, DESCRIPE EACH DISLOCATION.   Interpret   Closed Reduction   Open Reduction*   DATE OF DIAGNOSIS (MULLIPYYY)   TO ATE SURGERY PERFORMED (MARGANYYY)   TO ATE SURGERY	Section 5: Dislocati		Yes No							
COS-910 CODE   COS-	IF MORE THAN ONE	DISLOCATION	N WAS SUSTAIN						CH DISLOCA	TION.
ID-919 CODE   DATE OF DIAGNOSIS ####DEPTYPY  TO ATE SURGERY PERFORMED ####################################			□ On an Dadus		DIAGNOSIS	S/DESCRIP	TION (JOINT, LOCATION, ET	FC)		
Close   Closed Reduction   Close   C		ea Reduction			(MM/DD/YYYY)	*DATI	E SURGERY PERFOR	RMED (MM/DD/YYYY)	*CPT 4	CODE(S)
Close   Closed Reduction   Close   C	#2 TYPE 05 BIOLOG	47.011			D14 0110 010	(D.E.O.D.I.D.	TION			
DATE OF DISLOCATION   DIAGNOSIS, MARGORYTY)   "OATE SURGERY PERFORMED MARGORYTY)   "CPT 4 CODE(S)			□ Open Bedue		DIAGNOSIS	S/DESCRIP	IION (JOINT, LOCATION, ET	rc)		
DATE OF DIAGNOSIS (NAMOOTYYY)   "DATE SURGERY PERFORMED (NAMOOTYYY)   "CPT 4 CODE(S)		ed Reduction			(MM/DD/YYYY)	*DATI	E SURGERY PERFOR	RMED (MM/DD/YYYY)	*CPT 4	CODE(S)
DATE OF DIAGNOSIS (NAMOOTYYY)   "DATE SURGERY PERFORMED (NAMOOTYYY)   "CPT 4 CODE(S)	#0 TYPE OF BIOLOG	ATION			DIAGNIGGI	/DECODIE	TION			
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Section 8: Loss of Sight, Hearing and/or Speech  Loss of Sight Means Total and Permanent Loss of Sight Which cannot be corrected by any Means, or severance of an eye. Loss of Hearing Means Total and Permanent Loss of Hearing in Both Ears Which cannot be corrected by any Means, loss of Speech Means Total and Permanent Loss of Audible Voice Communication Which Cannot be corrected by any Means, loss of Speech Means Total and Permanent Loss of Audible Voice Communication Which Cannot be corrected by any Means, loss of Speech Means Total and Permanent Loss of So Audible Voice Communication Which Cannot be corrected by any Means, loss of Speech Means Total and Permanent Loss of Sight Loss of Speech Means Total Loss of Sight Loss of Sight Loss of Sight Loss of Speech Loss of Hearing Loss of Sight Loss of Speech Loss of Hearing Loss of Sight Loss of Speech Loss of Hearing Loss of Sight Loss of Speech Loss of Hearing Loss of Hearing Loss of Speech Loss of Hearing Loss of Speech Loss of Hearing Loss of Speech Loss of Hearing Loss of Hearin			•	,	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	701411 11014				
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COMA MEANS A PROFOUND STUPOR OR STATE OF COMPLETE AND TOTAL UNCONSCIOUSNESS WITH NO REACTION TO EXTERNAL STIMUL, RESPONSE TO INTERNAL NEEDS, AND A GLASGOW COMA SCORE OF EIGHT (8) POINTS OR LESS, FOR WHICH INTUBATION IS REQUIRED FOR RESPIRATORY ASSISTANCE. A COMA DOES NOT INCLUDE A MEDICALLY INDUCED COMA OR A COMA THAT IS THE RESULT OF ANY ALCOHOL OR DRUG USE. DO NOT COMPLETE THIS SECTION IF A COMA DOES NOT INCLUDE A MEDICALLY INDUCED COMA OR A COMA THAT IS THE RESULT OF ANY ALCOHOL OR DRUG USE. DO NOT COMPLETE THIS SECTION IF A COMA DOES NOT MEET THIS DEFINITION.  ICD-9/10 CODE(S)  DATE COMA BEGAN (MINIDDYYYY)  DATE COMA ENDED (MINIDDYYYY) OR CURRENT DURATION OF COMA IN DAYS (IF CONTINUING)  CONFIRMED BY EEG?  GLASGOW SCORE ON DAY 1 OF COMA  GLASGOW SCORE ON DAY 14 OF COMA  TYPES  NO  SECTION 10: Hospital Confinement Information  IF THE PATIENT WAS HOSPITALIZED AS AN INPATIENT FOR ANY INJURY/PROCEDURE STATED ABOVE, PROVIDE HOSPITAL INFORMATION.  HOSPITAL NAME  DATE OF ADMISSION (MINIDDYYYY)  DATE OF DISCHARGE (MINIDDYYYY)  REASON FOR VISIT/CARE  DURING THIS CONFINEMENT, WAS THE PATIENT EVER  CONFINED TO THE ICU (OR EQUIVALENT)? Tyes* No START: END:  ""IF THE PATIENT WAS TREATED AT MORE THAN ONE HOSPITAL AS A RESULT OF THE ACCIDENT, PROVIDE THE INFORMATION REQUIRED ABOVE FOR EACH HOSPITAL EITHER BELOW IN SECTION 12 OR ON A SEPARATE SHEET OF PAPER SUBMITTED WITH THIS CLAIM.**  SECTION 11: Primary Care Physician/Medical Professional Information  PROVIDE INFORMATION FOR THE PATIENT'S PRIMARY CARE PHYSICIAN/MEDICAL PROFESSIONAL (EX. FAMILY DOCTOR OR PEDIATRICIAN).  PHYSICIAN NAME  STREET ADDRESS  CITY  STATE  ZIP CODE	ICD-9/10 CODE(S)				YYY) CA	USE OF LO	OSS(ES)			
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IF A COMA DOES NOT MEET THIS DEFINITION.  ICD-9/10 CODE(S)  DATE COMA BEGAN (MM/DD/YYYY)  DATE COMA ENDED (MM/DD/YYYY) OR CURRENT DURATION OF COMA IN DAYS (IF CONTINUING)  CONFIRMED BY EEG? GLASGOW SCORE ON DAY 1 OF COMA GLASGOW SCORE ON DAY 14 OF COMA Yes No Section 10: Hospital Confinement Information  IF THE PATIENT WAS HOSPITALIZED AS AN INPATIENT FOR ANY INJURY/PROCEDURE STATED ABOVE, PROVIDE HOSPITAL INFORMATION.  HOSPITAL NAME  DATE OF ADMISSION (MM/DD/YYYY)  DATE OF DISCHARGE (MM/DD/YYYY)  REASON FOR VISIT/CARE  DURING THIS CONFINEMENT, WAS THE PATIENT EVER  "IF YES, DATES OF ICU CONFINEMENT: "IF YES, PROVIDE NAME OF UNIT, IF SPECIALIZED: CONFINED TO THE ICU (OR EQUIVALENT)? Yes* No START: END:  ""IF THE PATIENT WAS TREATED AT MORE THAN ONE HOSPITAL AS A RESULT OF THE ACCIDENT, PROVIDE THE INFORMATION REQUIRED ABOVE FOR EACH HOSPITAL EITHER BELOW IN SECTION 12 OR ON A SEPARATE SHEET OF PAPER SUBMITTED WITH THIS CLAIM."  Section 11: Primary Gare Physician/Medical Professional Information PROVIDE INFORMATION FOR THE PATIENT'S PRIMARY CARE PHYSICIAN/MEDICAL PROFESSIONAL (EX. FAMILY DOCTOR OR PEDIATRICIAN).  PHONE NUMBER  STREET ADDRESS  CITY  STATE ZIP CODE										
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DURING THIS CONFINEMENT, WAS THE PATIENT EVER  *IF YES, DATES OF ICU CONFINEMENT:  *IF YES, PROVIDE NAME OF UNIT, IF SPECIALIZED:  CONFINED TO THE ICU (OR EQUIVALENT)?	DATE OF ADMISSION	(4444/DD 00000)	DATE OF DIS	CHADGE and	DDAAAAA	DEASON E	OD VISIT/CADE			
CONFINED TO THE ICU (OR EQUIVALENT)? Yes* No START: END:  **IF THE PATIENT WAS TREATED AT MORE THAN ONE HOSPITAL AS A RESULT OF THE ACCIDENT, PROVIDE THE INFORMATION REQUIRED ABOVE FOR EACH HOSPITAL EITHER BELOW IN SECTION 12 OR ON A SEPARATE SHEET OF PAPER SUBMITTED WITH THIS CLAIM.**  Section 11: Primary Care Physician/Medical Professional Information  PROVIDE INFORMATION FOR THE PATIENT'S PRIMARY CARE PHYSICIAN/MEDICAL PROFESSIONAL (EX. FAMILY DOCTOR OR PEDIATRICIAN).  PHYSICIAN NAME  PHONE NUMBER  STREET ADDRESS  CITY  STATE  ZIP CODE	DATE OF ADMISSION	(MM/DD/YYYY)	DATE OF DIS	CHARGE (MM/I	DD/YYYY)	KEASON F	OR VISIT/CARE			
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ABOVE FOR EACH HOSPITAL EITHER BELOW IN SECTION 12 OR ON A SEPARATE SHEET OF PAPER SUBMITTED WITH THIS CLAIM.**  Section 11: Primary Care Physician/Medical Professional Information  PROVIDE INFORMATION FOR THE PATIENT'S PRIMARY CARE PHYSICIAN/MEDICAL PROFESSIONAL (EX. FAMILY DOCTOR OR PEDIATRICIAN).  PHYSICIAN NAME  PHONE NUMBER  STREET ADDRESS  CITY  STATE  ZIP CODE	CONFINED TO THE IC	U (OR EQUIN	ALENT)? TEATED AT	es* No	START:	EI TAL AS A E	ND: PESTILT OF THE ACCU	DENT PROVIDE	THE INCOR	MATION REQUIRED
PROVIDE INFORMATION FOR THE PATIENT'S PRIMARY CARE PHYSICIAN/MEDICAL PROFESSIONAL (EX. FAMILY DOCTOR OR PEDIATRICIAN).       PHYSICIAN NAME     PHONE NUMBER     FAX NUMBER       STREET ADDRESS     CITY     STATE     ZIP CODE	ABOVI	E FOR EACH	HOSPITAL EITH	HER BELOW I	N SECTION	12 OR ON	A SEPARATE SHEET	OF PAPER SUB	MITTED WIT	H THIS CLAIM.**
PHYSICIAN NAME     PHONE NUMBER     FAX NUMBER       STREET ADDRESS     CITY     STATE     ZIP CODE	Section 11: Primary	Care Phys	ician/Medical	Profession	al Informa	tion	DROFESSIONAL /FY	EAMILY DOCT		(ATPICIAN)
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	MEDICAL SPECIALTY			DEGRE	EE	,		BOARD C	ERTIFICATI	ON(S)

Section 12: Attending Physician Remarks/Additi	onal information DRMATION RELATED TO TH	E ILLNESS/PROCEDU	IRE STA	TED ABOVE,	AS NEEDED:
Section 13: Attending Physician/Medical Profess ATTENDING PHYSICIAN/MEDICAL PROFESSIONAL NAI	sional Information	DUONE NUMBER			FAY NUMBER
ATTENDING PHYSICIAN/MEDICAL PROFESSIONAL NAI	WIE .	PHONE NUMBER			FAX NUMBER
STREET ADDRESS	CITY		STATE		ZIP CODE
MEDICAL SPECIALTY	DEGREE			BOARD CER	TIFICATION(S)
	ELATED TO OR FAMILIAR	*IF YES, EXPLAIN TH	HE RELA	TIONSHIP:	
Section 14: Acknowledgement & Signature	ATIENT? Yes* No				
Fraud Warning: Any person who knowingly a					
insurance or statement of claim containing any concerning any fact material thereto commits					
penalties. (Note: This fraud warning does not apply to re Please read the specific fraud warning for your state of resi					
By signing below, I certify that I have read and					esidence, and that all information
and statements provided on this form are true SIGNATURE OF ATTENDING PHYSICIAN	and complete to the be	st of my knowledg	je ano	DELIET. DATE	<u> </u>
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Part D – Policyholder/Employer Statement

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



Group Accident Claims • Mutual of Omaha Plaza • Omaha, NE 68175-0001 Phone (800)775-8805 (toll-free) • Fax (402)997-1898 • www.mutualofomaha.com/customer-service • submitgrpacc@mutualofomaha.com Please print clearly in blue or black ink. All applicable information should be completed to avoid delays in the processing of the claim. Section 1 should be completed by the claimant. All other sections are to be completed by the policyholder/employer. When Part D is complete, submit with a copy of the employee/member's enrollment form/record to the address or fax above. Section 1: Employee/Member (EE) & Patient Information EMPLOYEE/MEMBER SSN OR ID NUMBER **GROUP ID NUMBER** EMPLOYEE/MEMBER NAME G000 PATIENT SSN OR ID NUMBER (IF NOT THE EMPLOYEE/MEMBER) PATIENT NAME (IF NOT THE EMPLOYEE/MEMBER) PATIENT DATE OF BIRTH (MM/DD/YYYY) PATIENT GENDER RELATIONSHIP TO EMPLOYEE/MEMBER (WRITE "SELF" IF PATIENT IS THE EMPLOYEE/MEMBER) ☐ Male ☐ Female DATE OF ACCIDENT (MM/DD/YYYY) DESCRIPTION OF ACCIDENT DID THE ACCIDENT HAPPEN WHILE WORKING? ☐ Yes ☐ No Section 2: Policyholder/Employer Information POLICYHOLDER/EMPLOYER NAME GROUP ID NUMBER G000 STATE ZIP CODE EMAIL ADDRESS PHONE NUMBER FAX NUMBER **Section 3: Accident Insurance Information** EFFECTIVE DATE OF INSURANCE FOR EMPLOYEE/MEMBER (MM/DD/YYYY) EFFECTIVE DATE OF INSURANCE FOR PATIENT (MM/DD/YYYY) COVERAGE TIER (ELECTED/IN EFFECT) PREMIUM PAID THROUGH DATE (MM/DD/YYYY) ☐ EE Only/All Insured Persons ☐ EE + Spouse ☐ EE + Child(ren) ☐ EE + Family \*\*A COPY OF THE EMPLOYEE/MEMBER'S ENROLLMENT FORM/RECORD AND CURRENT BENEFICIARY DESIGNATION MUST BE SUBMITTED WITH THIS CLAIM.\*\* Section 4: Employee/Member Employment Information - To be completed only if the policyholder is the employer of the employee/member FULL-TIME EMPLOYMENT DATE (MM/DD/YYYY) AVERAGE HOURS WORKED/WEEK DATE LAST WORKED, IF APPLICABLE (MM/DD/YYYY) IF THE EMPLOYEE IS NOT WORKING THE MINIMUM HOURS REQUIRED UNDER THE POLICY, INDICATE WHY: ☐ Termination ☐ Layoff ☐ Personal Leave ☐ Medical/Protected Leave (e.g. FMLA) ☐ Other (Explain in Section 5) IF THE ACCIDENT HAPPENED WHILE WORKING, HAS A WORKERS' \*IF YES, PROVIDE NAME AND CONTACT INFORMATION FOR WORKERS' COMP CARRIER: COMP CLAIM BEEN FILED? ☐ Yes/To be Filed\* ☐ No ☐ NA ARE THE PREMIUMS FOR THIS INSURANCE GROSSED-UP (ADDED TO THE IS THIS INSURANCE OFFERED TO THE EMPLOYEE THROUGH A SECTION 125 EMPLOYEES INCOME/W-2)? ☐ Yes ☐ No PLAN? Yes No DOES THE EMPLOYEE PAY ANY PREMIUM FOR THIS INSURANCE? \*IF YES, WHAT % OF TOTAL PREMIUM IS PAID PRE-TAX BY THE EMPLOYEE? ☐ Yes\* ☐ No % Pre-tax Section 5: Policyholder/Employer Additional Information USE THIS SPACE TO PROVIDE ANY ADDITIONAL INFORMATION RELATED TO THE ACCIDENT OR INFORMATION STATED ABOVE, AS NEEDED: 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, NC, OH, OR, PR, RI, TN, VT, VA and WA.

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, NC, 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

and statements provided on this form are true and complete to the best of my knowledge and belief.

and statements provided on this form are true and complete to the best	of or my knowledge and belief.	
SIGNATURE OF POLICYHOLDER/EMPLOYER REPRESENTATIVE		DATE
PRINTED NAME	TITLE	
EMAIL ADDRESS	PHONE NUMBER	FAX NUMBER

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## **Fraud Warnings**

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

Mutual of Omaha Plaza • Omaha, NE 68175-0001 Phone (800) 948-9478 (toll-free) • www.mutualofomaha.com/customer-service



#### Please review the specific fraud warning for your place of residence prior to signing the attached form or application.

All Other States: 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/Maine/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.

**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.

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.

**Kentucky:** 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.

**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.

**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.

Massachusetts/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.

**New Jersey:** Any person who includes any false or misleading information on an application for insurance 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.

**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.

North Carolina/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, may have committed 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.

**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.

**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.

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