Group Accident Claim Form

Part A – Employee/Member, Patient & Claimant 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. 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/Employer Information

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

Section 2: Employee/Member Information

LAST NAME	FIRST NAME	MI
STREET ADDRESS	CITY	STATE / ZIP CODE
EMAIL ADDRESS	HOME PHONE NUMBER	CELL PHONE NUMBER

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

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 WAS IN THE ACCIDENT)? ☐ 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

DOES THE PATIENT 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 PATIENT IS THE CHILD OF THE EMPLOYEE/MEMBER AND OVER AGE 18, IS THE CHILD A FULL-TIME STUDENT? ☐ Yes† ☐ No	IF THE PATIENT IS THE CHILD OF THE EMPLOYEE/MEMBER, IS THE CHILD MARRIED OR IN A PARTNERSHIP? ☐ Yes ☐ No

†IF YES, PROVIDE THE NAME, CITY, STATE & PHONE NUMBER OF THE SCHOOL:

Section 4: Accident Information

DATE OF ACCIDENT (MM/DD/YYYY)	TIME OF ACCIDENT (HH:MM) ☐ AM ☐ PM	WHERE DID THE ACCIDENT HAPPEN (LOCATION)?	DID ANY LAW AGENCY INVESTIGATE THE ACCIDENT? ☐ Yes** ☐ No

FOR THIS ACCIDENT AND THE PATIENT DESCRIBED IN SECTION 3, WHAT CLAIM TYPE IS THIS? ☐ First Claim ☐ Additional/Subsequent Claim

COMPLETE THE REMAINDER OF SECTION 4 ONLY IF THIS CLAIM IS THE FIRST CLAIM FOR THIS ACCIDENT AND PATIENT.

DID THE ACCIDENT HAPPEN WHILE WORKING? ☐ Yes* ☐ No	*IF YES, HAS A WORKERS' COMP CLAIM BEEN FILED? ☐ Yes/To be Filed ☐ No	DID THE ACCIDENT INVOLVE A MOTOR VEHICLE/AUTOMOBILE? ☐ Yes* ☐ No	*IF YES, WHICH WAS THE PATIENT? ☐ Driver ☐ Passenger

PROVIDE A DETAILED EXPLANATION OF HOW THE ACCIDENT OCCURRED AND THE NATURE/TYPE OF INJURIES SUSTAINED BY THE PATIENT (IF MORE SPACE IS REQUIRED, PROVIDE ON A SEPARATE SHEET OF PAPER AND SUBMIT WITH THIS CLAIM):

IF ANY LAW ENFORCEMENT AGENCY INVESTIGATED THIS ACCIDENT, A COPY OF THE AGENCY/POLICE REPORT MUST BE SUBMITTED WITH THIS CLAIM.

Section 5: Claim & Benefit Information

CHECK EACH INJURY, TREATMENT OR SERVICE FOR WHICH A BENEFIT IS REQUESTED FOR THE PATIENT WITH THIS CLAIM AS A RESULT OF THE ACCIDENT. NOT ALL BENEFITS ARE INCLUDED IN ALL POLICIES. REFER TO THE APPLICABLE CERTIFICATE FOR AVAILABLE BENEFITS, LIMITATIONS AND EXCLUSIONS. IF ANY PREVIOUS CLAIMS HAVE BEEN SUBMITTED FOR THIS ACCIDENT AND PATIENT, ONLY CHECK THE BENEFITS THAT ARE APPLICABLE TO THIS NEW CLAIM.

Initial Care & Emergency
- ☐ Emergency Room (ER)
- ☐ Urgent Care Center (UC)
- ☐ Initial Physician Office Visit (IPO)
- ☐ Ground Ambulance
- ☐ Air Ambulance

Follow-Up Care
- ☐ Physician Follow-Up Visit
- ☐ Therapy Services
- ☐ Medical Device
- ☐ Prosthetic Device(s)

Specified Injury
- ☐ Fracture
- ☐ Dislocation
- ☐ Laceration
- ☐ Second or Third Degree Burns
- ☐ Skin Graft
- ☐ Dental Extraction, Crown or Filling

Hospital
- ☐ Admission
- ☐ Daily Confinement
- ☐ ICU Confinement
- ☐ Rehabilitation Facility Confinement

Surgical
- ☐ Exploratory/Arthroscopic Surgery
- ☐ Abdominal/Cranial/Thoracic Surgery
- ☐ Herniated Disc Surgery
- ☐ Torn Knee Cartilage Surgery
- ☐ Ligament/Tendon/Rotator Cuff Surgery
- ☐ Eye Procedure
- ☐ Blood Products
- ☐ Pain Management

Diagnostic
- ☐ X-Ray or Other Diagnostic Exam
- ☐ Brain Injury Diagnosis

Catastrophic
- ☐ Basic Accidental Death
- ☐ Common Carrier Accidental Death
- ☐ Transportation of Remains
- ☐ Dismemberment
- ☐ Paralysis
- ☐ Reasonable Modifications
- ☐ Coma

Additional Benefits
- ☐ Transportation
- ☐ Lodging
- ☐ 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.

EMPLOYEE/MEMBER NAME _____ EMPLOYEE/MEMBER SSN OR ID # _____ PATIENT NAME _____

Section 6: Physician/Medical Professional & Hospital Information

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

PROVIDE INFORMATION FOR THE PATIENT'S ATTENDING OR TREATING PHYSICIAN/MED. PROF./SPECIALIST FOR INJURIES SUSTAINED IN THE ACCIDENT:

PHYSICIAN NAME	PHONE NUMBER	FAX NUMBER

STREET ADDRESS	CITY	STATE	ZIP CODE

IF THE PATIENT WAS HOSPITALIZED FOR THE TREATMENT OF INJURIES SUSTAINED IN THE ACCIDENT, PROVIDE HOSPITAL INFORMATION:

HOSPITAL NAME	PHONE NUMBER	FAX NUMBER

STREET ADDRESS	CITY	STATE	ZIP CODE

DATE OF ADMISSION (MM/DD/YYYY)	DATE OF DISCHARGE (MM/DD/YYYY)	REASON FOR VISIT/CARE

IF THE PATIENT WAS TREATED BY MORE THAN TWO PHYSICIANS/MEDICAL PROFESSIONALS/SPECIALISTS OR AT MORE THAN ONE HOSPITAL, PROVIDE THE INFORMATION REQUIRED ABOVE FOR EACH ADDITIONAL REFERENCE ON A SEPARATE SHEET OF PAPER AND SUBMIT IT WITH THIS CLAIM.

Section 7: Authorization and 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. Please read the specific fraud warning for your state of residence included with this form or available online at www.mutualofomaha.com.)*

I authorize any physician, medical or dental practitioner, hospital, clinic, pharmacy, pharmacy benefit manager, any other provider of health 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. **If applicable:** 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

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

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	MI	EMAIL ADDRESS

STREET ADDRESS	CITY	STATE	ZIP CODE

DATE OF BIRTH (MM/DD/YYYY)	SSN OR ID NUMBER	HOME PHONE NUMBER	CELL PHONE NUMBER

IF APPLICABLE, RELATIONSHIP TO EMPLOYEE/MEMBER	IF APPLICABLE, TYPE OF LEGAL REPRESENTATIVE

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

Group Accident Claim Form

Part B – Optional Authorization to Disclose Information to Third Parties

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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.

Section 1: Employee/Member & Patient Information

EMPLOYEE/MEMBER NAME	EMPLOYEE/MEMBER SSN OR ID NUMBER	GROUP ID NUMBER G000 __ __ __ __
PATIENT NAME (IF NOT THE EMPLOYEE/MEMBER)	PATIENT SSN OR ID NUMBER (IF NOT THE EMPLOYEE/MEMBER)	

PATIENT DATE OF BIRTH (MM/DD/YYYY)	PATIENT GENDER ☐ Male ☐ Female	RELATIONSHIP TO EMPLOYEE/MEMBER (WRITE "SELF" IF PATIENT IS THE EMPLOYEE/MEMBER)

DATE OF ACCIDENT (MM/DD/YYYY)	BRIEF DESCRIPTION OF ACCIDENT

Section 2: Third Party Information

PROVIDE INFORMATION FOR ANY THIRD PARTY (SPOUSE, FAMILY MEMBER, FRIEND OR OTHER PERSON) YOU WOULD LIKE TO ALLOW US TO COMMUNICATE WITH REGARDING THIS CLAIM:

SPOUSE/PARTNER NAME		PHONE NUMBER
OTHER FAMILY MEMBER/PERSON NAME	RELATIONSHIP TO PATIENT	PHONE NUMBER
OTHER FAMILY MEMBER/PERSON NAME	RELATIONSHIP TO PATIENT	PHONE NUMBER
OTHER FAMILY MEMBER/PERSON NAME	RELATIONSHIP TO PATIENT	PHONE NUMBER
OTHER FAMILY MEMBER/PERSON NAME	RELATIONSHIP TO PATIENT	PHONE NUMBER
OTHER FAMILY MEMBER/PERSON NAME	RELATIONSHIP TO PATIENT	PHONE NUMBER

Section 3: Authorization & Signature

I authorize United of Omaha Life Insurance Company or Mutual of Omaha Insurance Company (the "Company") to receive and disclose personal information of the Employee/Member or Patient (if the Patient is not the Employee/Member) related to this claim with the third party(ies) named above.

Unless otherwise indicated below, personal information includes medical care and history, mental and physical condition, prescription drug records, alcohol or drug use, financial information, occupational information and information otherwise needed to determine the insurance benefits payable.

I do not authorize the following information relevant to this claim to be shared:

_____

_____

I understand that any personal information that is disclosed by a third party will be used by the Company to evaluate my 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.

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 the revocation may not take effect before the date it is received by the Company. 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. I may retain a signed copy of this form for my records.

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

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Group Accident Claim Form

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.

Section 1: Employee/Member & Patient Information

EMPLOYEE/MEMBER NAME	EMPLOYEE/MEMBER SSN OR ID NUMBER	GROUP ID NUMBER G000 __ __ __ __
PATIENT NAME (IF NOT THE EMPLOYEE/MEMBER)	PATIENT SSN OR ID NUMBER (IF NOT THE EMPLOYEE/MEMBER)	

PATIENT DATE OF BIRTH (MM/DD/YYYY)	PATIENT GENDER ☐ Male ☐ Female	RELATIONSHIP TO EMPLOYEE/MEMBER (OR "SELF")	DATE OF ACCIDENT (MM/DD/YYYY)

Section 2: Accident Information

DESCRIPTION OF ACCIDENT AND PRIMARY DIAGNOSIS

WAS THE PATIENT HOSPITALIZED? ☐ Yes (Complete Section 10) ☐ No	IS/ WAS A MEDICAL DEVICE (FOR LOCOMOTION/MOBILITY) RECOMMENDED TO THE PATIENT? ☐ Yes ☐ No	IS/WAS ONE OR MORE PROSTHETIC DEVICES REQUIRED BY THE PATIENT? ☐ One ☐ Two or More ☐ None

ARE ALL INJURY/TREATMENTS/SERVICES IDENTIFIED BELOW FOR THE PATIENT A DIRECT RESULT OF THE ACCIDENT? ☐ Yes ☐ No - Explain:

IS THERE ANY OTHER ILLNESS OR INFIRMITY AFFECTING THE PATIENT'S CONDITION OR INJURIES SUSTAINED IN THE ACCIDENT? ☐ Yes ☐ No - Explain:

Section 3: Injury, Treatment & Service Information

CHECK EACH INJURY, TREATMENT OR SERVICE FOR WHICH YOU ATTENDED TO THE PATIENT AS A DIRECT RESULT OF THE ACCIDENT STATED ABOVE, AND SUBMIT ANY RELEVANT TEST RESULTS, HOSPITAL DISCHARGE SUMMARY AND/OR YOUR MEDICAL STATEMENTS/RECORDS WITH THIS FORM, IN ADDITION TO THE INFORMATION BELOW. EACH INJURY, TREATMENT OR SERVICE MUST BE INDEPENDENT OF BODILY INFIRMITY, SICKNESS AND ALL OTHER CAUSES.

INJURY/TREATMENT/SERVICE	DATE(S) OF SERVICE	DIAGNOSIS/PROCEDURE CODE(S) (ICD-9/10, CPT4, ETC)	DIAGNOSIS/PROCEDURE(S) DESCRIPTION & ADDITIONAL INFORMATION
Initial Care & Emergency			
☐ Emergency Room			
☐ Urgent Care Center			
☐ Initial Physician Office Visit			
Follow-Up Care			
☐ Physician Follow-Up Visit			
☐ Therapy Services (OT, PT, speech, chiropractic care)			
Specified Injury			
☐ Fracture(s) and/or Dislocations(s)	SEE SECTION 4 FOR FRACTURE(S) AND SECTION 5 FOR DISLOCATION(S)		
☐ Laceration(s) (Repair incl. sutures, adhesives, staples or closure strips)			Total length of all lacerations requiring repair: _____ inches If no laceration required repair, check here: ☐
☐ Second or Third Degree Burn(s)			% of Total Body Surface Area for Second Degree Burns: _____ % of Total Body Surface Area for Third Degree Burns: _____
☐ Skin Graft (Incl. stem cells or skin substitute)			
☐ 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 DISMEMBERMENT, SECTION 7 FOR PARALYSIS AND SECTION 9 FOR COMA		
☐ Loss of Sight, Hearing and/or Speech	SEE SECTION 8 FOR LOSS OF SIGHT, HEARING AND/OR SPEECH		

IFMORE SPACE IS NEEDED, PROVIDE ADDITIONAL INFORMATION BELOW IN SECTION 12 OR ON A SEPARATE SHEET OF PAPER SUBMITTED WITH THIS CLAIM.

EMPLOYEE/MEMBER NAME _____ EMPLOYEE/MEMBER SSN OR ID # _____ PATIENT NAME _____

Section 4: Fracture(s)

IF MORE THAN ONE FRACTURE WAS SUSTAINED BY THE PATIENT AS A RESULT OF THE ACCIDENT, DESCRIBE EACH FRACTURE.

#1 - TYPE OF FRACTURE ☐ Avulsion (Chip) ☐ Closed Reduction ☐ Open Reduction*		DIAGNOSIS/DESCRIPTION (BONE, LOCATION, ETC)		
ICD-9/10 CODE	CONFIRMED BY IMAGING? ☐ Yes ☐ No	DATE OF DIAGNOSIS (MM/DD/YYYY)	*DATE SURGERY PERFORMED (MM/DD/YYYY)	*CPT 4 CODE(S)
#2 - TYPE OF FRACTURE ☐ Avulsion (Chip) ☐ Closed Reduction ☐ Open Reduction*		DIAGNOSIS/DESCRIPTION (BONE, LOCATION, ETC)		
ICD-9/10 CODE	CONFIRMED BY IMAGING? ☐ Yes ☐ No	DATE OF DIAGNOSIS (MM/DD/YYYY)	*DATE SURGERY PERFORMED (MM/DD/YYYY)	*CPT 4 CODE(S)
#3 - TYPE OF FRACTURE ☐ Avulsion (Chip) ☐ Closed Reduction ☐ Open Reduction*		DIAGNOSIS/DESCRIPTION (BONE, LOCATION, ETC)		
ICD-9/10 CODE	CONFIRMED BY IMAGING? ☐ Yes ☐ No	DATE OF DIAGNOSIS (MM/DD/YYYY)	*DATE SURGERY PERFORMED (MM/DD/YYYY)	*CPT 4 CODE(S)

Section 5: Dislocation(s)

IF MORE THAN ONE DISLOCATION WAS SUSTAINED BY THE PATIENT AS A RESULT OF THE ACCIDENT, DESCRIBE EACH DISLOCATION.

#1 - TYPE OF DISLOCATION ☐ Incomplete ☐ Closed Reduction ☐ Open Reduction*	DIAGNOSIS/DESCRIPTION (JOINT, LOCATION, ETC)		
ICD-9/10 CODE	DATE OF DIAGNOSIS (MM/DD/YYYY)	*DATE SURGERY PERFORMED (MM/DD/YYYY)	*CPT 4 CODE(S)
#2 - TYPE OF DISLOCATION ☐ Incomplete ☐ Closed Reduction ☐ Open Reduction*	DIAGNOSIS/DESCRIPTION (JOINT, LOCATION, ETC)		
ICD-9/10 CODE	DATE OF DIAGNOSIS (MM/DD/YYYY)	*DATE SURGERY PERFORMED (MM/DD/YYYY)	*CPT 4 CODE(S)
#3 - TYPE OF DISLOCATION ☐ Incomplete ☐ Closed Reduction ☐ Open Reduction*	DIAGNOSIS/DESCRIPTION (JOINT, LOCATION, ETC)		
ICD-9/10 CODE	DATE OF DIAGNOSIS (MM/DD/YYYY)	*DATE SURGERY PERFORMED (MM/DD/YYYY)	*CPT 4 CODE(S)

Section 6: Dismemberment

DIAGNOSIS/DESCRIPTION – STATE THE EXACT LOCATION AT WHICH THE SEVERANCE(S) OR AMPUTATION(S) OCCURRED FOR EACH LIMB OR DIGIT LOST (TO THE NEAREST, INTACT JOINT FOR LOSSES DISTAL TO THE WRIST OR ANKLE):

ICD-9/10 CODE(S)	DATE OF SEVERANCE/AMPUTATION (MM/DD/YYYY)	CAUSE OF LOSS(ES)

Section 7: Paralysis

PARALYSIS MEANS TOTAL AND PERMANENT (IRREVERSIBLE) LOSS OF USE OF AN ENTIRE LIMB WITHOUT SEVERANCE. DO NOT COMPLETE THIS SECTION IF ANY PARALYSIS DOES NOT MEET THIS DEFINITION.

WHICH LIMBS ARE PARALYZED? (CHECK ALL THAT APPLY) ☐ Right Arm ☐ Left Arm ☐ Right Leg ☐ Left Leg	DIAGNOSIS/DESCRIPTION	
ICD-9/10 CODE(S)	DATE OF DIAGNOSIS (MM/DD/YYYY)	CAUSE OF LOSS(ES)

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. DO NOT COMPLETE THIS SECTION FOR ANY LOSS THAT DOES NOT MEET THE APPLICABLE DEFINITION.

WHICH CONDITION(S) APPLY? (CHECK ALL THAT APPLY) ☐ Loss of Sight ☐ Loss of Speech ☐ Loss of Hearing	DIAGNOSIS/DESCRIPTION – FOR LOSS OF SIGHT, STATE LEFT, RIGHT OR BOTH EYES	
ICD-9/10 CODE(S)	DATE OF DIAGNOSIS (MM/DD/YYYY)	CAUSE OF LOSS(ES)

Section 9: Coma

COMA MEANS A PROFOUND STUPOR OR STATE OF COMPLETE AND TOTAL UNCONSCIOUSNESS WITH NO REACTION TO EXTERNAL STIMULI, 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 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? ☐ Yes ☐ No	GLASGOW SCORE ON DAY 1 OF COMA	GLASGOW SCORE ON DAY 7 OF COMA	GLASGOW SCORE ON DAY 14 OF COMA

Section 10: Hospital Confinement Information

IF THE PATIENT WAS HOSPITALIZED AS AN INPATIENT FOR ANY INJURY/PROCEDURE STATED ABOVE, PROVIDE HOSPITAL INFORMATION.

HOSPITAL NAME	CITY	STATE	ZIP CODE
DATE OF ADMISSION (MM/DD/YYYY)	DATE OF DISCHARGE (MM/DD/YYYY)	REASON FOR VISIT/CARE	
DURING THIS CONFINEMENT, WAS THE PATIENT EVER CONFINED TO THE ICU (OR EQUIVALENT)? ☐ Yes* ☐ No	*IF YES, DATES OF ICU CONFINEMENT: START: END:	*IF YES, PROVIDE NAME OF UNIT, IF SPECIALIZED:	

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	FAX NUMBER	
STREET ADDRESS	CITY	STATE	ZIP CODE
MEDICAL SPECIALTY	DEGREE	BOARD CERTIFICATION(S)	

EMPLOYEE/MEMBER NAME _____ EMPLOYEE/MEMBER SSN OR ID # _____ PATIENT NAME _____

Section 12: Attending Physician Remarks/Additional Information

USE THIS SPACE TO PROVIDE ANY ADDITIONAL INFORMATION RELATED TO THE ILLNESS/PROCEDURE STATED ABOVE, AS NEEDED:

Section 13: Attending Physician/Medical Professional Information

ATTENDING PHYSICIAN/MEDICAL PROFESSIONAL NAME		PHONE NUMBER	FAX NUMBER
STREET ADDRESS	CITY	STATE	ZIP CODE
MEDICAL SPECIALTY	DEGREE	BOARD CERTIFICATION(S)	
TAX ID NUMBER	ARE YOU RELATED TO OR FAMILIAR WITH THE PATIENT? ☐ Yes* ☐ No	*IF YES, EXPLAIN THE RELATIONSHIP:	

Section 14: 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. 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.

SIGNATURE OF ATTENDING PHYSICIAN	DATE

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Group Accident Claim Form

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 NAME	EMPLOYEE/MEMBER SSN OR ID NUMBER	GROUP ID NUMBER G000 __ __ __ __
PATIENT NAME (IF NOT THE EMPLOYEE/MEMBER)	PATIENT SSN OR ID NUMBER (IF NOT THE EMPLOYEE/MEMBER)	

PATIENT DATE OF BIRTH (MM/DD/YYYY)	PATIENT GENDER ☐ Male ☐ Female	RELATIONSHIP TO EMPLOYEE/MEMBER (WRITE "SELF" IF PATIENT IS THE EMPLOYEE/MEMBER)

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 __ __ __ __
CITY	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) ☐ EE Only/All Insured Persons ☐ EE + Spouse ☐ EE + Child(ren) ☐ EE + Family	PREMIUM PAID THROUGH DATE (MM/DD/YYYY)

****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.

CLASS	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' COMP CLAIM BEEN FILED? ☐ Yes/To be Filed* ☐ No ☐ NA	*IF YES, PROVIDE NAME AND CONTACT INFORMATION FOR WORKERS' COMP CARRIER:

ARE THE PREMIUMS FOR THIS INSURANCE GROSSED-UP (ADDED TO THE EMPLOYEES INCOME/W-2)? ☐ Yes ☐ No	IS THIS INSURANCE OFFERED TO THE EMPLOYEE THROUGH A SECTION 125 PLAN? ☐ Yes ☐ No
DOES THE EMPLOYEE PAY ANY PREMIUM FOR THIS INSURANCE? ☐ Yes* ☐ No	*IF YES, WHAT % OF TOTAL PREMIUM IS PAID PRE-TAX BY THE EMPLOYEE? _____% 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. 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.

SIGNATURE OF POLICYHOLDER/EMPLOYER REPRESENTATIVE	DATE
PRINTED NAME	TITLE

EMAIL ADDRESS	PHONE NUMBER	FAX NUMBER

Fraud Warnings

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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.