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:** Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

** **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 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 containing any false, incomplete, or misleading information is guilty of a felony.

** **Kentucky:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.

** **Maryland:** Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

** **Maine:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or 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 of 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 APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND 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.

** **Puerto Rico:** Any person who knowingly, and with intent to defraud or deceive any insurance company includes false information in an application for insurance or files, assists, or abets in the filing of a fraudulent claim to obtain payment of a loss or other benefits, or files more than one claim for the same loss or damage, may be guilty of a felony. Upon conviction, that person will be fined between $5,000 and $10,000, imprisoned for three (3) years or both. Aggravating or attenuating circumstances may result in the prison term being increased to five (5) years or reduced to two (2) years.

Cualquier persona quien con conocimiento y con la intensión de defraudar o engañar a cualquier compañía de seguros, incluye información falsa en una solicitud para seguro o introduce, o instiga en la introducción de una reclamación fraudulenta para obtener pago por una pérdida u otro beneficio, o presenta más de una reclamación por la misma pérdida o daño puede ser culpable de cometer un acto criminal. Al ser convicto, ese persona será multada con una cantidad de $5,000 a $10,000, encarcelamiento por tres (3) años o ambos. Circunstancias agravantes o atenuantes podrían resultar en que el período de tiempo de prisión aumente a cinco (5) años o se reduzca a dos (2) años en concordancia.

** **Arkansas and 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.

** **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.

** **Rhode Island:** Any person who knowingly presents a false or fraudulent claim for the payment of a loss or knowingly presents false information in an application for insurance, is guilty of a crime and may be subject to fines and confinement in state prison.

** **Tennessee, Virginia, and 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.

** **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, 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 is related to a claim by the claimant.

Initial Claim Form

United of Omaha Life Insurance Company
Home Office - Omaha, Nebraska

Statement of Claim for Continuance of Life Insurance Protection During Total Disability
Please return completed form to: United of Omaha Life Insurance Company, Group Life Claims, Mutual of Omaha Plaza, Omaha, Nebraska 68175, Toll Free 1-800-775-8805

To Be Completed By Insured

The insured or guardian is responsible for completion of this proof without expense to the Company. The Company, in furnishing this form, does so without admitting any liability or waiving any of its rights under the policy on which this claim is made.

Insured's full name | Date of birth | Social Security Number

Mailing Address (Number and Street) (City) (State) (ZIP Code) Telephone Number

Describe disability

Give the date you were first totally disabled by this disability so that you were wholly unable to work.

Since that time, have you engaged in any occupation or business? ☐ Yes ☐ No

If "Yes," give type of work and name and address of your employer.

On what date were you first treated by a physician?

Name below all physicians who have treated you since that date (may be contacted to obtain medical information):

Name	Address	Dates of treatment From	To

In your opinion, are you now wholly unable to engage in any and all work and every occupation or business? ☐ Yes ☐ No

If you are insured under any other policies issued by a Mutual of Omaha Company, please list policy numbers ______________________________

Have you applied for, or are you receiving benefits from:

	Applied	Application Date	Receiving	Effective Date
a) Social Security	☐ Yes ☐ No	____/____/____	☐ Yes ☐ No	____/____/____
b) LTD Insurance	☐ Yes ☐ No	____/____/____	☐ Yes ☐ No	____/____/____

Please send copies of any letters or notices approving or denying benefits.

To Be Completed by Master Policyholder or Group Administrator

Name of Insured | Date of Birth | Social Security Number | Effective Date of Insured

Date of employment | Date last worked | Last Occupation | Annual Salary

Why did he or she cease work on the date given above? | Date insurance terminated | If not terminated, "paid to" date

Master Policy Number | Insurance Class | Amount of Insurance on last day worked

Name of beneficiary shown in your records (attach copy) | Relationship to insured

We hereby certify that, to the best of our knowledge and belief, the above statements are correct

Name of Group | Branch or Division

Address of Group | Authorized Representative's Signature | Date

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 United of Omaha Life 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 benefits.

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 Life Claims, United of Omaha Life 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): ______________________________

____

Printed Name of Insured ____________ Signature of Insured ____________ Date ____________

If Applicable: I am the legal representative of the person whose Personal Information is to be disclosed, and I am authorized to grant permission on behalf of that person.

Printed Name of Legal Representative ____________ Signature of Legal Representative ____________ Type of Legal Representative ____________ Date ____________

Attending Physician's Statement

This form is to be completed without expense to United of Omaha Life Insurance Company. Additional space is provided on the reverse side for comments.

Insured's full name | Disability File Number

Mailing Address (Number and Street) (City) (State) (ZIP Code) Date of Birth

1. When did symptoms first appear or accident happen? __________ 2. When did patient last work because of disability? __________
3. What was date of first treatment? __________ 4. What was date of last examination? __________
5. Frequency of visits? ☐ Weekly ☐ Monthly ☐ Other (specify) __________
6. Diagnosis: (Include any complications) __________
7. Subjective Symptoms: __________
8. CARDIAC (If applicable)
   a) Functional capacity (American Heart Association) ☐ Class 1 (No limitation) ☐ Class 2 (Slight limitation) ☐ Class 3 (Marked limitation) ☐ Class 4 (Complete limitation)
   b) Blood Pressure (last visit) ________/________ (systolic/diastolic)
9. Physical Impairment (* as defined in Federal Dictionary of Occupational Titles)
   - ☐ Class 1 - No limitation of functional capacity, capable of heavy work* No restrictions. (0-10%)
   - ☐ Class 2 - Medium manual activity.* (15-30%)
   - ☐ Class 3 - Slight limitation of functional capacity; capacity of light work.* (35-55%)
   - ☐ Class 4 - Moderate limitation of functional capacity; capable of clerical/administrative (sedentary*) activity. (60-70%)
   - ☐ Class 5 - Severe limitation of functional capacity; incapable of minimum (sedentary*) activity. (75-100%)

   Remarks: __________
10. Mental/Nervous Impairment (if applicable)
    a) Please define "stress" as it applies to this claimant. __________
    b) What stress and problems in interpersonal relations has claimant had on job? __________
    - ☐ Class 1 - Able to function under stress and engage in interpersonal relation (no limitations).
    - ☐ Class 2 - Able to function in most stress situations and engage in most interpersonal relations (slight limitations).
    - ☐ Class 3 - Able to engage in only limited stress situations and only limited interpersonal relations (moderate limitations).
    - ☐ Class 4 - Unable to engage in stress or engage in interpersonal relations (marked limitations).
    - ☐ Class 5 - Significant loss of psychological, physiological and personal and social adjustment (severe limitations).

    Remarks: __________
11. PROGRESS
    a) Patient is: ☐ Recovered ☐ Unchanged ☐ Improved ☐ Retrogressed
    b) Patient is: ☐ Ambulatory ☐ Bed Confined ☐ House Confined ☐ Hospital Confined – If hospital confined give name, address and dates of confinement: __________

Please answer questions 12 and 13 for both occupational categories	Regular Occupation	Any Occupation
12. Is patient now totally disabled?	Month Day Year	Month Day Year
Date patient was released to return to work:	Month Day Year	Month Day Year
13. Approximate date patient may resume work in either occupational category:	Month Day Year	Month Day Year
If date unknown, please select one of the adjacent classifications in each category.	☐ Indefinite ☐ Never	☐ Indefinite ☐ Never

14. What restrictions, if any, would be placed upon patient's return to work?

15. Remarks:

Physician's Name (Please type)	Degree/Specialty
Address	Physician's Signature
City, State, ZIP Code	
Telephone Number (Include Area Code)	Date