Cardington Yutaka Technologies

Group Number: G000 AL1W

Steps for Successfully Filing a New Short Term Disability Claim

1. Inform your employer of your intent to file a new disability claim with Mutual of Omaha
2. File your claim telephonically with Mutual of Omaha: 800.877.5176, option 1
3. Bring attached forms to your physician:
   - "Attending Physician Statement" to be completed by your physician
   - Sign the "Authorization to Disclose Personal Information"

   Ask your physician's office to fax both documents to 402-997-1865 (Number is also on the forms). Mutual of Omaha will also try to get this information directly from your physician, but bringing the form to your physician's office typically expedites the processing of your claim.

IMPORTANT INFORMATION:

- Mutual of Omaha cannot make a claim determination without receiving your physician's statement – you are **encouraged** to contact your physician's office directly to ensure they send the **Attending Physician Statement** in a timely manner.
- After following the steps above, to check the status on your claim please contact your dedicated STD Claims analyst, Renee Summers
  - **Renee Summers** can be reached toll free at 800-877-5176 x4149 (or) direct: 402-351-4149

    Renee can also be reached at Renee.Summers@mutualofomaha.com

For general questions, or help initially filing a claim – our general claims service team is available to help: 800-877-5176

Frequently Asked Claim Questions:

1. Will I receive disability payments directly from Cardington Yutaka Tech., or Mutual of Omaha?
    - If approved, “Hourly” associates will receive benefit payments from Mutual of Omaha. “Salaried” associates should contact the Administration regarding pay while disabled.
2. How quickly will I receive claim payments?
    - A claim determination is typically made within 5 business days after receiving a complete claim form (including employee and employer statement, and attending physician statement). Mutual of Omaha will review the information to determine claim eligibility. If approved, Mutual of Omaha will notify you directly of the length of your approved claim. If approved, checks are issued on a <u>weekly</u> basis.
3. Should I contact my physician directly about my short term disability claim?
    - Yes. Mutual of Omaha cannot make a claim determination without your **Attending Physician Statement**. Mutual of Omaha will attempt to get this directly from your physician, but your physician will typically respond quicker if you proactively ask them to send the forms to Mutual of Omaha.
4. Which doctor should I take my paperwork to?
    - Mutual of Omaha will need statements from **<u>all doctors</u>** you are currently being treated by. If you are seeing multiple doctors/specialists, please request they each send a statement to Mutual of Omaha.
5. What would keep me from getting paid?
    - The most common reason a claim determination is delayed is medical information from your doctor. You are encouraged to reach out to your physician’s office and make sure they are sending this to Mutual of Omaha. If you are unsure what is holding up your claim, please contact your dedicated disability claims analyst, **Renee Summers** toll free at 800-877-5176 x4149.
6. What if my condition changes or what if my payments unexpectedly stop?
    - For changes in your condition or eligibility, please stay in contact with your dedicated disability claims analyst, **Renee Summers** toll free at 800-877-5176 x4149.
7. How long does STD last & how much am I going to receive from Mutual of Omaha?
    - Mutual of Omaha will make a claim determination specific to your claim. You will be informed during the process of the approved payment and duration. The maximum amount payable per the Mutual of Omaha contract is $240 per week, and the maximum payment duration is 26 weeks.
8. How will I know if I qualify for Long Term Disability?
    - Mutual of Omaha monitors short term disability claims and tries to identify claims that may transition to “LTD”. If you have questions on if you may qualify for Long Term Disability, please contact **Renee Summers** toll free at 800-877-5176 x4149.

Section 3 – Attending Physician's Statement (Answer all questions to avoid delay)

Employer Name Cardington Yutaka Technologies	Group ID Number G000 AL1W
Name of Patient (Last, First, MI) – Please Print	Date of Birth
Diagnoses	ICD-9 Code(s)
Symptoms	Date symptom first appeared

Initial date of treatment:	Last date of treatment:	Next date of treatment/office visit:

Is disability due to: ☐ Accident/Injury ☐ Sickness	Is the disability work related? ☐ Yes ☐ No

If applicable, list the surgical procedure(s) – Describe fully and provide dates if any.

If disability is due to Pregnancy, please provide the information below:

Date of Last Monthly Period	Expected Date of Delivery	Expected Type of Delivery ☐ Vaginal ☐ Cesarean Section

Actual Date of Delivery	Actual Type of Delivery ☐ Vaginal ☐ Cesarean Section

If any of the following questions are answered "Yes," then please provide the information to the right of that question.

Was the patient treated in an Emergency Room? ☐ Yes ☐ No	Date treated	Name of Hospital	Name of Physician
Did another physician treat or will be treating the patient? ☐ Yes ☐ No	Date treated	Physician's Name and Address	
Was the patient hospital confined? ☐ Yes ☐ No	Date Confined In Hospital: From______________ To________________	Name of Hospital	
Did patient have outpatient surgery in a hospital or ambulatory surgical center? ☐ Yes ☐ No	Date of Surgery	Name of Facility	

Functional Limitations – Abilities

Indicate frequency per day the listed activity can be performed.

(n = never, o = occasional, f = frequent, c = constant)

Lifting	**Carrying**
__________1-5 lbs.	__________1-5 lbs.
__________6-10 lbs.	__________6-10 lbs.
__________11-25 lbs.	__________11-25 lbs.
__________26-50 lbs.	__________26-50 lbs.
__________51-100 lbs.	__________51-100 lbs.
__________Over 100 lbs.	__________Over 100 lbs.

Indicate longest single time duration each activity can be performed.

_____ Sitting	_____ Kneeling	_____ R: Finger Dexterity	
_____ Total time on feet		_____ L: Finger Dexterity	
_____ Standing	_____ Inside	_____ R: Below Shoulder	**Reaching**
_____ Walking		_____ L: Below Shoulder	**Reaching**
_____ Bending	_____ Outside	_____ R: Above Shoulders	**Reaching**
_____ Squatting	_____ Working with Others	_____ L: Above Shoulders	**Reaching**
_____ Stooping	_____ Other (explain)_________________________________		

Please notify us if the Employee returns to work after the submission of this form.

Form continued on Page 6

Mental Limitations – Abilities

	Excellent	Good	Fair	Guarded
Judgment/Decision making	_______	_______	_______	_______
Deal with work stresses	_______	_______	_______	_______
Function independently	_______	_______	_______	_______
Concentration/Attention span	_______	_______	_______	_______
Emotional liability	_______	_______	_______	_______
Caring for self/family	_______	_______	_______	_______
Estimate overall prognosis	_______	_______	_______	_______

The patient has been continuously disabled (unable to work) from ____________________________ to ____________________________

Is the patient able to work with job modifications? ☐ Yes ☐ No

The patient should be able to work ☐ Full-time ☐ Part-time on ______________________ or a specific date is unavailable, in
☐ 1 month ☐ 1-3 months ☐ 3-6 months ☐ Other (please specify)

Remarks and/or treatment plan

Name of the Attending Physician – Please Print	Specialty/Degree(s)	Tax Identification Number
Address (No., Street, City, State, ZIP)	(Area Code) Telephone Number	(Area Code) Fax Number

If necessary, whom can we contact at the attending physician's office for additional information?

Name: (Area Code) Telephone Number:

Signature of Attending Physician Date

Please notify us if the Employee returns to work after the submission of this form.

Authorization to Disclose Personal Information

1. I authorize any physician, medical or dental practitioner, hospital, clinic, pharmacy benefit manager, other medical care facility, health maintenance organization, insurer, employer, consumer reporting agency and any other provider of medical or dental services to release records containing the personal information of:

   Claimant/Patient Name: ____
   (Last) (First) (Middle)

2. Personal information includes medical history, mental and physical condition, prescription drug records, alcohol or drug use, financial and occupational information.
3. You may release information to:

   Group Disability Management Services
   Mutual of Omaha Insurance Company/United of Omaha Life Insurance Company
   Mutual of Omaha Plaza
   Omaha, NE 68175-0001

   or

   Fax 402-997-1865

4. I understand that the personal information that is disclosed will be used by Mutual of Omaha Insurance Company and United of Omaha Life Insurance Company to evaluate my claim for disability benefit plan reimbursement and that if I refuse to sign this authorization my claim for benefits may not be paid.
5. I understand that 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 personal information may be redisclosed without the protection of the federal privacy regulations.
6. This authorization will expire 24 months after the date signed.
7. I understand that I may revoke this authorization at any time by providing a written request to Mutual of Omaha Insurance Company and United of Omaha Life Insurance Company at the address above. If I revoke this authorization, it will not affect any use or disclose of personal information that occurred prior to the receipt of my revocation.
8. I understand that I am entitled to receive a copy of this authorization and that a copy is as valid as the original.

RETAIN A SIGNED COPY FOR YOUR RECORDS

Name(s) used for records (if different than the name below): ______________________________

____

____ ______________
Signature of Claimant Date

If Applicable: I am the legal representative of the claimant and I am authorized to grant permission on behalf of the claimant.

Printed Name of Legal Representative:______________________________________

Signature of Legal Representative: ______________________________________

Type of Legal Representative: ______________________________________

THIS AUTHORIZATION COMPLIES WITH HIPAA AND OTHER FEDERAL AND STATE LAWS