Group Critical Illness/Specified Disease Claim Form

Part A – Employee/Member, Patient & Claimant Statement

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

Group Critical Illness Claims • Mutual of Omaha Plaza • Omaha, NE 68175-0001
Phone (800) 775-8805 (toll-free) • Fax (402) 997-1835 • www.mutualofomaha.com/customer-service

Please print clearly in blue or black ink. **All applicable information should be completed to avoid delays in the processing of the claim. When Part A is complete, submit the form to the address or fax above. Provide Part D to the attending physician and Part E to the policyholder for completion.** All parts of this form are to be completed without expense to the underwriting company. 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

E-MAIL 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

DURING THE PAST 12 MONTHS, HAS THE EMPLOYEE/MEMBER USED TOBACCO OR NICOTINE (INCLUDING REPLACEMENT) IN ANY FORM? ☐ Yes ☐ No

IS THE EMPLOYEE/MEMBER ELIGIBLE FOR OR RECEIVING BENEFITS FROM MEDICAID? ☐ Yes ☐ No

DOES THE EMPLOYEE/MEMBER HAVE MAJOR MEDICAL INSURANCE, OR A COMBINATION OF BASIC HOSPITAL AND BASIC MEDICAL INSURANCE? ☐ Yes* ☐ No

*If YES, PROVIDE NAME OF INSURANCE CARRIER & POLICY NUMBER:

IF THE POLICYHOLDER IS YOUR EMPLOYER, ARE YOU CURRENTLY ACTIVELY WORKING? ☐ Yes ☐ No†

†IF NO, PROVIDE DATE LAST WORKED (MM/DD/YYYY):

AVERAGE HOURS WORKED PER WEEK

Section 3: Patient Information

WHO IS THE PATIENT (THE PERSON THAT INCURRED THE CRITICAL ILLNESS/SPECIFIED DISEASE)? ☐ Employee/Member ☐ Spouse/Partner ☐ Child

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

LAST NAME	FIRST NAME	MI

STREET ADDRESS	CITY	STATE	ZIP CODE

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

DURING THE PAST 12 MONTHS, HAS THE PATIENT USED TOBACCO OR NICOTINE (INCLUDING REPLACEMENT) IN ANY FORM? ☐ Yes ☐ No

IS THE PATIENT ELIGIBLE FOR OR RECEIVING BENEFITS FROM MEDICAID? ☐ Yes ☐ No

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, IF 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: Critical Illness/Specified Disease Information

PLEASE CHECK THE ILLNESS/PROCEDURE FOR WHICH THIS CLAIM IS BEING FILED. THE ILLNESS/PROCEDURE SELECTED MUST BE INCLUDED IN YOUR CERTIFICATE FOR THE CLAIM TO BE CONSIDERED. REFER TO THE DEFINITIONS IN YOUR CERTIFICATE FOR ADDITIONAL INFORMATION, IF NEEDED.

- ☐ Heart Attack (Myocardial Infarction)
- ☐ Heart Transplant/Placement on UNOS List
- ☐ Heart Valve Surgery
- ☐ Coronary Artery Bypass
- ☐ Aortic Surgery
- ☐ Stroke
- ☐ Major Organ Transplant/Placement on UNOS List
- ☐ End-Stage Renal Failure
- ☐ Acute Respiratory Distress Syndrome (ARDS)
- ☐ Cancer (Invasive)
- ☐ Bone Marrow Transplant
- ☐ Carcinoma in Situ
- ☐ Benign Brain Tumor
- ☐ Skin Cancer
- ☐ Cerebral Palsy (children only)
- ☐ Structural Congenital Defect(s) (children only)
- ☐ Genetic Disorder(s) (children only)
- ☐ Congenital Metabolic Disorder(s) (children only)
- ☐ Type 1 Diabetes (children only)
- ☐ ALS (Lou Gehrig's) Disease
- ☐ Advanced Alzheimer's Disease
- ☐ Advanced Parkinson's Disease

DATE THE PATIENT WAS DIAGNOSED WITH THE ILLNESS OR NEED FOR THE PROCEDURE, OR THE DATE THE PROCEDURE WAS PERFORMED (MM/DD/YYYY)

BRIEFLY DESCRIBE THE ILLNESS OR PROCEDURE:

HAS THE PATIENT EVER HAD THE SAME OR SIMILAR ILLNESS/PROCEDURE? ☐ Yes* ☐ No

*IF YES, PROVIDE THE DATE OF PRIOR ILLNESS/PROCEDURE AND DATE OF LAST TREATMENT (MM/DD/YYYY):

HAS A BENEFIT EVER BEEN PAID FOR THE PATIENT UNDER ANY OTHER CRITICAL ILLNESS/ SPECIFIED DISEASE POLICY SPONSORED BY THE POLICYHOLDER/EMPLOYER? ☐ Yes† ☐ No

†IF YES, PROVIDE THE DATE (MM/DD/YYYY) AND AMOUNT OF EACH BENEFIT:

Section 5: Hospital & Physician Information

IF THE PATIENT WAS HOSPITALIZED FOR THE ILLNESS/PROCEDURE STATED IN SECTION 4, 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

Section 5: Hospital & Physician Information (Continued)

PROVIDE INFORMATION FOR ANY OTHER HOSPITAL AT WHICH THE PATIENT RECEIVED CARE FOR THE ILLNESS/PROCEDURE STATED IN SECTION 4:

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	

PROVIDE INFORMATION FOR THE PATIENT'S PRIMARY CARE PHYSICIAN (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/SPECIALIST FOR THE ILLNESS/PROCEDURE STATED IN SECTION 4:

PHYSICIAN NAME		PHONE NUMBER	FAX NUMBER
STREET ADDRESS	CITY	STATE	ZIP CODE

IF THE PATIENT WAS TREATED AT MORE THAN TWO HOSPITALS OR BY MORE THAN TWO PHYSICIANS, PROVIDE THE INFORMATION REQUIRED ABOVE FOR EACH HOSPITAL OR PHYSICIAN ON A SEPARATE SHEET OF PAPER AND SUBMIT IT WITH THIS CLAIM.

Section 6: 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, ME, MD, NJ, NM, NY, OH, OR, PR, RI, TN, VT, VA and WA. Please read the specific fraud warning for your state of residence included with this form or available online at www.mutualofomaha.com.)*

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 critical illness/specified disease 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 medical 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 7: 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 7 ONLY IF THE CLAIMANT IS NOT THE EMPLOYEE/MEMBER.

LAST NAME	FIRST NAME	MI	E-MAIL 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.

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Part B – Physician, Hospital and Medication Information

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Please print clearly in blue or black ink. **Part B is required if this claim is being filed within the first year following the effective date of insurance for the Patient.** If Part B is required, complete and 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)

Section 2: Hospital Information

IF THE PATIENT WAS HOSPITALIZED WITHIN THE YEAR PRIOR TO THE EFFECTIVE DATE OF INSURANCE FOR THE PATIENT, PROVIDE THE FOLLOWING:

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

PROVIDE INFORMATION FOR ANY OTHER HOSPITAL AT WHICH THE PATIENT WAS HOSPITALIZED WITHIN THE YEAR PRIOR TO THE EFFECTIVE DATE OF INSURANCE FOR THE PATIENT:

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 AT MORE THAN TWO HOSPITALS, PROVIDE THE INFORMATION REQUIRED ABOVE FOR EACH ADDITIONAL HOSPITAL ON A SEPARATE SHEET OF PAPER AND SUBMIT IT WITH THIS FORM.

Section 3: Physician Information

IF THE PATIENT WAS TREATED BY ANY PHYSICIAN WITHIN THE YEAR PRIOR TO THE EFFECTIVE DATE OF INSURANCE FOR THE PATIENT, PROVIDE PHYSICIAN INFORMATION:

PHYSICIAN NAME	PHONE NUMBER	FAX NUMBER

STREET ADDRESS	CITY	STATE	ZIP CODE

PROVIDE INFORMATION FOR ANY OTHER PHYSICIAN FROM WHOM THE PATIENT RECEIVED TREATMENT WITHIN THE YEAR PRIOR TO THE EFFECTIVE DATE OF INSURANCE FOR THE PATIENT:

PHYSICIAN NAME	PHONE NUMBER	FAX NUMBER

STREET ADDRESS	CITY	STATE	ZIP CODE

IF THE PATIENT WAS TREATED BY MORE THAN TWO PHYSICIANS, PROVIDE THE INFORMATION REQUIRED ABOVE FOR EACH ADDITIONAL PHYSICIAN ON A SEPARATE SHEET OF PAPER AND SUBMIT IT WITH THIS FORM.

Section 4: Drug Information

LIST ANY OVER THE COUNTER DRUGS, PRESCRIPTION DRUGS OR MEDICATION TAKEN BY THE PATIENT FOR ANY REASON WITHIN THE YEAR PRIOR TO THE EFFECTIVE DATE OF INSURANCE FOR THE PATIENT:

NAME OF DRUG/MEDICINE	DATE(S) TAKEN	PHARMACY NAME, PHONE, CITY & STATE	PRESCRIBING PHYSICIAN NAME

IF THERE ARE ADDITIONAL DRUGS/MEDICINES TO BE LISTED, PROVIDE THE INFORMATION REQURIED ABOVE FOR EACH ADDITIONAL DRUG/MEDICINEON A SEPARATE SHEET OF PAPER AND SUBMIT IT WITH THIS FORM.

Section 5: 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, ME, MD, NJ, NM, NY, OH, OR, PR, RI, TN, VT, VA and WA. Please read the specific fraud warning for your state of residence included with this form or available online at www.mutualofomaha.com.)*

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

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

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Part C – Optional Authorization to Disclose Information to Third Parties

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Please print clearly in blue or black ink. **Part C 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 C 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)

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 critical illness/specified disease 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

Group Critical Illness/Specified Disease Claim Form

Part D – Attending Physician 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.** When Part D is complete, submit the form and any supporting documentation (reports, office notes, medical records or statements, consultations, test results, etc.) 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)

Section 2: Critical Illness/Specified Disease Information

PLEASE CHECK THE ILLNESS/PROCEDURE FOR WHICH THIS CLAIM IS BEING FILED, AND SUBMIT ANY RELEVANT TEST RESULTS, HOSPITAL DISCHARGE SUMMARY AND/OR YOUR DETAILED MEDICAL STATEMENTS/RECORDS WITH THIS FORM, IN ADDITION TO INFORMATION INDICATED BELOW:

ILLNESS/PROCEDURE	MEDICAL DOCUMENTATION (AS APPLICABLE)	ADDITIONAL INFORMATION	
☐ Heart Attack (Myocardial Infarction)	EKG, cardiac enzymes, biochemical markers, thallium scan, MUGA scan, echocardiogram, cardiac catheterization	Troponin T Level:	Troponin I Level:
☐ Heart Transplant/Placement on UNOS List	Surgical report, proof of listing with UNOS	Is the patient on the UNOS list? ☐ Yes ☐ No If yes, provide date added to list:	
☐ Heart Valve Surgery	EKG, X-ray, echocardiogram, cardiac catheterization, MRI, surgical report (open surgery required)		
☐ Coronary Artery Bypass	Angiogram, electrocardiogram (EKG), echocardiogram, stress test, EBCT, surgical report (open surgery required)		
☐ Aortic Surgery	Angiogram, CT, MRI, surgical report (open surgery required)		
☐ Stroke	Neuroimaging studies, documented neurological deficits	mRS Level:	
☐ Major Organ Transplant/ Placement on UNOS List	Surgical report, proof of listing with UNOS	Is the patient on the UNOS list? ☐ Yes ☐ No If yes, provide date added to list:	
☐ End-Stage Renal Failure	Proof of regular dialysis	Does the patient have chronic, irreversible failure of both kidneys to function? ☐ Yes ☐ No Does the patient require dialysis at least weekly? ☐ Yes ☐ No	
☐ Acute Respiratory Distress Syndrome (ARDS)	Arterial blood gas, X-ray, ARDS definition satisfied using the AECC, Murray LIS, Delphi or Oxygenation Index (OI) methods	P/F Ratio: PCWP:	OI: Murray LIS:
☐ Cancer (Invasive)	Pathology report, clinical diagnosis (only if pathological diagnosis is not possible), surgical report	TNM Stage: Clark Level:	Rai or Binet Stage: Breslow Thickness:
☐ Carcinoma in Situ	Pathology report, clinical diagnosis (only if pathological diagnosis is not possible), surgical report	TNM Stage: Clark Level:	Rai or Binet Stage: Breslow Thickness:
☐ Skin Cancer (Basal or squamous cell carcinoma)	Pathology report, clinical diagnosis (only if pathological diagnosis is not possible), surgical report	TNM Stage:	
☐ Bone Marrow Transplant	Surgical report, proof of listing with NMDP		
☐ Benign Brain Tumor	Pathology report, CT, MRI, angiogram, MRA, surgery report		
☐ ALS (Lou Gehrig's) Disease	EMG, NCV, X-ray, MRI, blood and urine studies, spinal tap, myelogram, neurological examination, muscle and/or nerve biopsy		
☐ Advanced Alzheimer's Disease	CT, MRI, PET, CSF, neurological examination	FAST Stage:	MMSE Score:
☐ Advanced Parkinson's Disease	CT, MRI, PET, neurological examination	Stage:	
☐ Cerebral Palsy (children only)	Formal diagnosis after age of 18 months		
☐ Structural Congenital Defect(s) (children only)	Diagnostic tests, clinical diagnosis		
☐ Genetic Disorder(s) (children only)	Genetic tests, clinical diagnosis		
☐ Congenital Metabolic Disorder(s) (children only)	GC/MS, blood tests, clinical diagnosis		
☐ Type 1 Diabetes (children only)	Blood tests, clinical diagnosis		

Section 3: Diagnosis Information

DIAGNOSIS

ICD-9/10 CODE	DATE OF DIAGNOSIS (MM/DD/YYYY)	DATE FIRST CONSULTED (MM/DD/YYYY)
WAS SURGERY PERFORMED? ☐ Yes* ☐ No	*IF YES, PROVIDE CPT 4 CODES:	*DATE SURGERY PERFORMED (MM/DD/YYYY)

HAS THE PATIENT EVER HAD THE SAME OR SIMILAR ILLNESS(ES)/PROCEDURE(S)? ☐ Yes† ☐ No ☐ Unknown	IS THE PATIENT STILL UNDER YOUR CARE? ☐ Yes ☐ No‡	‡IF NO, FINAL DATE OF TREATMENT (MM/DD/YYYY):

†IF YES, PROVIDE THE DATE OF PRIOR ILLNESS(ES)/PROCEDURE(S) AND/OR DATE OF LAST TREATMENT (MM/DD/YYYY):

Section 4: Attending Physician Information

ATTENDING PHYSICIAN NAME	PHONE NUMBER	FAX NUMBER	
STREET ADDRESS	CITY	STATE	ZIP CODE

MEDICAL SPECIALTY	DEGREE	BOARD CERTIFICATION(S)
TAX ID NUMBER	ARE YOU (THE ATTENDING PHYSICIAN) RELATED TO THE PATIENT? ☐ Yes* ☐ No	*IF YES, EXPLAIN THE RELATIONSHIP:

EMPLOYEE/MEMBER NAME ______________________ EMPLOYEE/MEMBER SSN OR ID # ________________ PATIENT NAME ______________________________

Section 5: Hospital & Other Physician Information

IF THE PATIENT WAS HOSPITALIZED FOR THE ILLNESS/PROCEDURE STATED ABOVE, 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	

PROVIDE INFORMATION FOR ANY OTHER HOSPITAL AT WHICH THE PATIENT RECEIVED CARE FOR THE ILLNESS/PROCEDURE STATED ABOVE:

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	

PROVIDE INFORMATION FOR THE PATIENT'S PRIMARY CARE PHYSICIAN (EX. FAMILY DOCTOR OR PEDIATRICIAN):

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

PROVIDE INFORMATION FOR ANY OTHER TREATING PHYSICIAN/SPECIALIST FOR THE PATIENT FOR THE ILLNESS/PROCEDURE STATED ABOVE:

PHYSICIAN NAME		PHONE NUMBER	FAX NUMBER
STREET ADDRESS	CITY	STATE	ZIP CODE
REASON FOR CARE			
MEDICAL SPECIALTY	DEGREE	BOARD CERTIFICATION(S)	

IF THE PATIENT WAS TREATED AT MORE THAN TWO HOSPITALS OR BY MORE THAN TWO ADDITIONAL PHYSICIANS, PROVIDE THE INFORMATION REQUIRED ABOVE FOR EACH HOSPITAL OR PHYSICIAN EITHER BELOW OR ON A SEPARATE SHEET OF PAPER AND SUBMIT IT WITH THIS CLAIM.

Section 6: Attending Physician Remarks/Additional Information

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

Section 7: 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, ME, MD, NJ, NM, NY, OH, OR, PR, RI, TN, VT, VA and WA. Please read the specific fraud warning for your state of residence included with this form or available online at www.mutualofomaha.com.)*

By signing below, I certify that I have read and understand the fraud warning that applies to my state of residence, and that all information 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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Part E – Policyholder/Employer Statement

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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)

Section 2: Policyholder/Employer Information

POLICYHOLDER/EMPLOYER NAME		GROUP ID NUMBER G000 __ __ __ __
CITY	STATE	ZIP CODE
E-MAIL ADDRESS	PHONE NUMBER	FAX NUMBER

Section 3: Critical Illness/Specified Disease Insurance Information

EFFECTIVE DATE OF INSURANCE FOR EMPLOYEE/MEMBER (MM/DD/YYYY)	EFFECTIVE DATE OF INSURANCE FOR PATIENT (MM/DD/YYYY)
EMPLOYEE/MEMBER BENEFIT AMOUNT (ELECTED/IN EFFECT)	PATIENT BENEFIT AMOUNT (ELECTED/IN EFFECT, IF APPLICABLE)
DATE OF LAST BENEFIT INCREASE/CHANGE (MM/DD/YYYY)	PREMIUM PAID THROUGH DATE (MM/DD/YYYY)

WAS THE EMPLOYEE/MEMBER OR PATIENT PREVIOUSLY INSURED UNDER ANY OTHER CRITICAL ILLNESS INSURANCE POLICY OFFERED THROUGH THE POLICYHOLDER/EMPLOYER? ☐ Yes ☐ No

HAS A BENEFIT EVER BEEN PAID FOR THE PATIENT UNDER ANY OTHER CRITICAL ILLNESS/ SPECIFIED DISEASE POLICY SPONSORED BY THE POLICYHOLDER/EMPLOYER? ☐ Yes† ☐ No	†IF YES, PROVIDE THE DATE (MM/DD/YYYY) AND AMOUNT OF EACH BENEFIT:

****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)	AVG. HOURS WORKED/WEEK
DATE LAST WORKED, IF APPLICABLE (MM/DD/YYYY)	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

IF THE EMPLOYEE IS NO LONGER WORKING THE MINIMUM HOURS REQUIRED UNDER THE POLICY, INDICATE WHY:
☐ Termination ☐ Layoff ☐ Personal Leave of Absence ☐ Medical Leave of Absence (e.g. FMLA) ☐ Other (explain):

Section 5: Policyholder/Employer Additional Information

USE THIS SPACE TO PROVIDE ANY ADDITIONAL INFORMATION RELATED TO THE 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, ME, MD, NJ, NM, NY, OH, OR, PR, RI, TN, VT, VA and WA. Please read the specific fraud warning for your state of residence included with this form or available online at www.mutualofomaha.com.)*

By signing below, I certify that I have read and understand the fraud warning that applies to my state of residence, and that all information 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	
E-MAIL ADDRESS	PHONE NUMBER	FAX NUMBER

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/New Mexico/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 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.

New Jersey: Any person who includes any false or misleading information on an application for insurance is subject to criminal and civil 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.

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.

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.

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