Mutual of Omaha Insurance Company
United of Omaha Life Insurance Company
Group Accident Claims

3300 Mutual of Omaha Plaza
Omaha, NE 68175-0001
Toll Free (800) 775-8805
Fax (402) 997-1898
Email submitgrpacc@mutualofomaha.com

Group Accident Claim Form – Express Benefit

Section 1 – Policyholder/Employer Information

Employer Name

Group Number
G000 B 5 B 6

Employer Address

Employer Phone Number

Section 2 – Claimant Statement (completed by employee/member)

Claimant/Patient Name: First/Last

Claimant/Patient Date of Birth: Mo./Day/Yr.

Sex: M/F

Relationship to Employee: Self/Dependent/Spouse/Domestic Partners

Employee Name: First/Last

Social Security Number

Employee Date of Birth: Mo./Day/Yr.

Sex: M/F

Address | City | State | ZIP Code

Phone | Email

Section 3 – Accident/Injury Details

Date of Accident: Mo./Day/Yr.

Location of Injury: On or Off Job

Was claimant injured in a Motor Vehicle Accident?
❑ Yes ❑ No

Was the accident investigated by Law Enforcement?
❑ Yes ❑ No

To date, has the patient sought medical treatment for any injury sustained as a result of the accident? ❑ Yes ❑ No

If Yes, briefly describe the type of treatment received and from whom?

Explanation of Accident/Injury(s)

Section 4 – 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, MD, ME, NJ, NM, NY, OH, OR, PR, RI, TN, VA, VT 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 provided on this form is 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 if Patient is deceased
or incapable of signing

DATE