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

A Guide for Successfully Completing the Group Accident Claim Form

Prior to submission, make sure you have provided all required information and answered all questions completely and accurately. If information is missing or cannot be read, the processing of your form may be delayed.

Employee/Claimant Portion: This section is to be completed by the Employee. Dates should include the month, date and year. In order to be considered complete, the form must be signed by you or your legal representative.

Once Mutual of Omaha receives your completed Employee/Claimant Portion along with your Supporting Documentation, we will reach out to your employer to verify eligibility status to continue processing the claim.

Supporting Documentation Needed

Please Note: If supporting documentation is not received with the Employee/Claimant Portion, this may cause a delay in processing.

- Detailed medical documentation supporting accident details
- Itemized bill from the hospital or medical facility if there was a hospital stay
- Chart Note to include admission and discharge paperwork if there was a hospital stay
- Itemized bill from treating physician's office
- Surgical Report if accident involved surgery
- Ambulance bill if emergency transport was required
- Appliance receipt if crutches, wheelchair or other medical equipment was required
- Follow Up Visit – receipts for follow up visits or physical therapy with dates and charges if applicable
- X-ray/Diagnostic Tests – receipts with dates and charges if applicable
- Accident Report – if applicable (ex: police report)
- Submit Employee/Claimant Portion and supporting documentation to Mutual of Omaha

Fraud Warnings

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.

Group Accident Insurance

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

Employee/Claimant Portion

Employer Name _____ Group Number: G000 B5B6 _____
Employer Address _____ Employer Phone Number _____
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 _____
Phone _____ Email _____

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 (If yes, please provide Police Report with claim submission.)
Name of Treating Facility _____
Treating Physician _____ Phone _____
Hospitalized: ❑ Yes ❑ No Admission Date _____ Discharge Date _____
Explanation of Accident/Injury(s) _____

Please submit any medical records you have regarding your accident/injury(ies). Please check mark which services or injuries and write the date you are claiming.

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

Date_____

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

Date_____

Additional Benefits
- ❑ Transportation
- ❑ Lodging
- ❑ Child Care

Date_____

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

Date_____

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

Date_____

Diagnostic
- ❑ X-ray or Other Diagnostic Exam
- ❑ Brain Injury Diagnosis

Date_____

Surgical
- ❑ Exploratory/Arthroscopic Surgery
- ❑ Abdominal/Cranial/Thoracic Surgery
- ❑ Herniated Disc Surgery
- ❑ Torn Knee Cartilage Surgery
- ❑ Ligament/Tendon/Rotator Cuff Surgery
- ❑ Eye Procedure
- ❑ Blood Products
- ❑ Epidural Anesthesia

Date_____

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

Date_____

Agreement and Signature

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 pretax 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.

Signature of Claimant _____ Date _____

Signature of Patient,
if age 18 or older (and not the claimant) _____ Date _____

If applicable, I signed on behalf of the insured as _____ (indicate relationship). If legal guardian, power of attorney designee, conservator, beneficiary or personal representative, please attach a copy of the document granting authority.

Printed Name of Legal Representative _____

Signature of Legal Representative _____ Date _____

Please use this portion of the form to provide any necessary information related to your claim:

Authorization to Release Personal Information

1. I (the undersigned) authorize any physician, medical or dental practitioner, pharmacist, other health care provider, hospital, clinic, or medical facility, insurer, reinsurer, insurance services support organization, employer, government agency, consumer reporting agency, or insurance policy or benefit plan administrator to release records containing the Personal Information of:

   Name of Claimant _____
   (Last) (First) (Middle)

   Date of Birth_____/_____/_____ Social Security Number_____-_____-_____

2. **Personal Information to be released:**
   - data or records regarding my medical history, treatment, prescriptions, consultations (including medical and psychological reports, records, charts, notes (excluding psychotherapy notes), X-rays, films or correspondence, and any medical condition I may now have or have had;
   - any information regarding insurance or benefit plan coverage, claims or benefits; and/or
   - any information, data or records regarding my activities (including records relating to my Social Security, Workers' Compensation, retirement income, financial information, earnings and employment history)

3. **You may release my Personal Information to:**
   Group Accident Claims
   Mutual of Omaha Insurance Company/United of Omaha Life Insurance Company
   3300 Mutual of Omaha Plaza
   Omaha, NE 68175-0001
   or Fax: 402-997-1898 or Email: submitgrpacc@mutualofomaha.com

4. **I understand my Personal Information will be used by Mutual to evaluate my claim for benefits, or as required or permitted by law, and that if I refuse to sign this Authorization, my claim for benefits may not be paid. I also authorize Mutual to release my Personal Information as follows:**
   - to its reinsurer, or other persons or organizations performing business, legal or insurance support services in connection with my claim(s); or
   - to a vendor specializing in the application for Social Security Disability Benefits; or
   - to vendors/consultants providing me with wellness, disability or leave related services as part of an employer sponsored benefit plan; or
   - for self-insured disability plans only, to my employer; or
   - for fully insured plans to my employer for use in discussions with Mutual regarding my functional capacity, and any related restrictions and limitations, in order to facilitate my return to work; or
   - as otherwise required or permitted by law or as I further authorize

5. I understand my Personal Information may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

6. I understand that I may revoke this Authorization at any time by providing a written request to Mutual at the address above. If I revoke this Authorization, it will not affect any use or disclosure of Personal Information that occurred prior to Mutual's receipt of my revocation. If written revocation is not received, this Authorization will remain valid until 24 contiguous months after the date signed.

7. 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

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Electronic Funds Transfer (EFT) Authorization

Direct Deposit of Accident Benefit Payments

I understand that by completing this form, I am authorizing United of Omaha Life Insurance Company to directly deposit into my bank account via Electronic Funds Transfer (EFT) payment(s) due to me under a contract issued by United of Omaha to my financial institution with the information provided below, for credit to my account. Furthermore, I authorize and direct the bank to charge said account or the account of my estate for any payment made in error as determined by United of Omaha and to refund any such payment made subsequent to my death or made in error and to refund any such payment to United of Omaha upon its written request to the bank.

I further understand and agree that it is my responsibility to ensure that all bank information reported on this form is accurate and correct for the appropriate deposit of my payment(s) and that United of Omaha can rely on this information and will have no obligation to ensure the correctness of the information. Completion of this form is not a guarantee that benefits will be paid.

I further understand and agree that any payment(s) made into an incorrect bank account pursuant to the information reported on this form, will be forfeited by me and that United of Omaha has no obligation to retrieve those funds or make replacement payment(s) to me.

I further understand and agree for myself, my heirs, executors and estate to indemnify and hold United of Omaha harmless from any and all loss or damage of any nature whatsoever, including costs or attorney's fees incurred by reason of said bank acting pursuant to this Authorization.

I further understand and agree that United of Omaha is not responsible for any bank charges or other costs associated with or arising out of this agreement.

I further understand that if my bank is not able to accept EFTs, checks will be mailed to my residence.

I reserve the right to revoke and cancel this authorization. Such revocation and cancellation shall be effective within 5 business days following United of Omaha's receipt of the notice.

Payee Information	**Bank Information**
Full Name	Bank Name
Address	Address
Address	Address
City	City
State and ZIP Code	State and ZIP Code
Telephone Number ( )	Telephone Number ( )
Social Security Number	Account Number
Policy Number	Bank ABA Routing/Transit Number
Claim Number	❑ Checking ❑ Savings *(Check only one)*
Payee Number *(for office use only)*	**Approved By/Date *(for office use only)***

X _____ _____

Payee Signature Date

Contact Information

Please attach EITHER **a voided check for checking** OR **a deposit slip for savings** and return with this form to:

United of Omaha Life Insurance Company
HO8W-GDMS
3316 Farnam Street
Omaha, NE 68172-7420

Should you have any questions regarding EFT, please feel free to contact our customer service representatives toll free at **1-800-775-8805** (Monday-Friday between the hours of 8 a.m. and 4 p.m. CST).

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