Underwritten by
United of Omaha Life Insurance Company
A Mutual of Omaha Company

Group Life Claims
3300 Mutual of Omaha Plaza
Omaha, NE 68175-0001
Toll Free (800) 775-8805
Fax (402) 997-1835
Email submitgrplife@mutualofomaha.com

Instructions for Filing an Accidental Dismemberment Claim Form

Upon the accidental dismemberment of an insured employee, plan member or insured dependent, the employer/plan administrator must complete the claim form as indicated and send attachments mentioned below. Be advised that further documentation might be necessary in the future to complete the claim process.

Please submit the required documentation:

1. Application for Accidental Dismemberment claim form:

   Part I – Completed by the employer/plan administrator
   Part II – Completed by the employee/claimant

2. Original, photocopies or screen-print of enrollment form.

3. The following items, including but not limited to:

   a. Detailed medical documentation supporting accidental dismemberment details:
      -hospital admit and discharge summaries
      -emergency room records to include toxicology results from the date of the accident
      -surgical reports for the period of treatment to present
      -office notes for the period of treatment to the present
      -test results showing objective findings
      -consulting physician report

   b. Accident Report – if applicable (ex: police report, motor vehicle crash report, OSHA report)

The Application for Accidental Dismemberment claim form should be returned to:

United of Omaha Life Insurance Company
Group Life Claims
3300 Mutual of Omaha Plaza
Omaha, NE 68175-0001
or
Fax (402) 997-1835
Email submitgrplife@mutualofomaha.com

Fraud Warnings

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.

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.

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: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

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.

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.

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.

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.

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.

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.

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 CRIMINAL 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 the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances [be] present, the 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 in an application for insurance is guilty of a crime and may be subject to fines and confinement in 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.

Application for Accidental Dismemberment Benefits

Part I – To Be Completed by the Employer/Plan Administrator

The claimant is insured as: ❑ Employee/Member ❑ Spouse ❑ Child

1. Name of Claimant _____

   Name of Insured/Member (If not the claimant)_____

2. Amount of insurance for the Claimant:

   Basic Life _____ Voluntary Life_____

   Basic AD&D _____ Voluntary AD&D _____

   Basic Dependent Life_____ Voluntary Dependent Life _____

   Voluntary Dependent AD&D _____

   If applicable attach enrollment record from when coverage was first elected (in written or electronic format).

3. Date on which the Employee was last present at work? _____

4. For Dependent Claims – Is the Employee still actively working? ❑ Yes ❑ No

   If **No**, give employees last date of active work _____

5. Reason for Employee/Insured ceased work:
   ❑ Illness (Including disability leave of absence/partial disability) ❑ Leave of absence (Other than disability)

   ❑ Quit ❑ Dismissed ❑ Vacation ❑ FMLA ❑ Retired (Date)_____ ❑ Layoff ❑ Deceased

6. Date Premium for the above Claimant has been paid through _____

7. Date of Hire_____ ❑ Full Time ❑ Part Time
   ❑ Union ❑ non-Union ❑ Hourly ❑ Exempt ❑ non-Exempt ❑ Salaried

   Annual Salary (If salary based) $_____ Date of last salary increase_____

   Average hours worked per week_____ Occupation_____ Class_____

8. Effective date of claimant's insurance with Mutual of Omaha or United of Omaha _____

We hereby certify that to the best of our knowledge and belief, the above statements are correct and that said deceased's insurance was in force on the date of his or her death.

Group Policy Number _____ Name of Policyholder _____

Printed name of authorized Employer/Plan Representative _____

Signature of authorized
Employer/Plan Representative _____ Date_____

Phone number _____ Email address _____

Part II – Employee/Member & Claimant Section

Employer Name_____ Employer Group Policy Number: G000 __ __ __ __

Employee First Name _____ Employee MI _____ Employee Last Name_____

Employee Street Address _____ City _____ State_____ ZIP Code_____

Employee Email Address _____

Employee Home Phone Number _____ Employee Cell Phone Number _____

Employee Date of Birth (MM/DD/YYYY) _____ Employee SSN or ID Number _____

Employee Gender ❑ Male ❑ Female

Employee Marital Status ❑ Single ❑ Married/Partnered ❑ Widowed ❑ Divorced

COMPLETE THE FOLLOWING ONLY IF THE CLAIMANT IS NOT THE EMPLOYEE/MEMBER

Claimant First Name _____ Claimant MI _____ Claimant Last Name _____

Claimant Street Address_____ City _____ State_____ ZIP Code_____

Claimant Email Address _____

Claimant Home Phone Number_____ Claimant Cell Phone Number _____

Claimant Date of Birth (MM/DD/YYYY) _____ Claimant SSN or ID Number _____

Claimant Gender ❑ Male ❑ Female

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.

Please check the loss for which this Claim is being filed. The loss selected must be included in your policy for the Claim to be considered. Refer to the Definitions in your policy for additional information, if needed.

❑ Eye Loss ❑ Hearing Loss ❑ Speech Loss ❑ Coma ❑ Hospital Confinement

❑ Paralysis *Level of paralysis you are filing for (ex: Paraplegia) _____

❑ Limb Loss *Type of Limb Loss you are filing for (ex: Loss of Hand) _____

Accident/Injury Details Date of Accident (MM/DD/YYYY) _____

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): _____

After you have fully completed this form, attach copies of the following:

- Detailed medical documentation supporting accidental dismemberment details to include but not limited to:
  - hospital admit and discharge summaries
  - emergency room records to include toxicology results from the date of the accident
  - surgical reports for the period of treatment to present
  - office notes for the period of treatment to the present
  - test results showing objective findings
  - consulting physician report
- Accident Report – if applicable (ex: police report, OSHA report)

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_____-_____-_____

   This medical or health information may include information on the diagnosis and treatment of mental illness, alcohol, and drug use. This also may include information on the diagnosis, treatment, and testing results related to HIV, AIDS, and sexually transmitted diseases, unless otherwise restricted by state law.

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 Life Claims
   United of Omaha Life Insurance Company
   3300 Mutual of Omaha
   Omaha, NE 68175-0001
   or Fax: 402-997-1835 or Email: submitgrplife@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 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