A Guide for Successfully Completing the Group Accident Claim Form

Mutual of Omaha appreciates the opportunity to provide you with valuable income protection. We rely on the information you provide on this form to effectively determine if you qualify for group accident benefits.

This guide provides information and instruction to help you successfully complete and submit the claim form. Please consult your employer/benefits administrator if you need assistance in providing information for the form.

Important Tips for Paper Copy Submission

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 will be delayed. All parts of this form are to be completed without expense to the underwriting company.

- The following guidelines provide valuable information to help you successfully complete the form.
- Please make a copy of the completed form for your records before submitting it to Mutual of Omaha/United of Omaha
- Please use the Group Accident Express Benefit Claim Form for all accident express benefit claims.
- Please use the Group Health Screening Benefit Claim Form for all health screening benefit claims.
- Medical documentation must be submitted to support the benefits claimed.

Guidelines for Section 1: Employee/Member & Claimant Statement

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.

- Group ID Number for your Employer will consist of eight characters, beginning with “G000” and followed by four additional letters or numbers specific to your Employer.
- Claimant Statement (completed by employee/member)
- Accident Information Completed
- Claim & Benefit Information Selected
- Authorization and Signature Completed, Signed, and Dated

Guidelines for Section 2: Policyholder/Employer Statement

This section is to be completed by the Employer. Dates should include the month, date and year. In order to be complete, the form must be signed by the Employer.

- Group ID Number consists of eight characters, beginning with “G000” and followed by four additional letters or numbers.
- Employee/Member (EE) & Claimant Information
- Accident Insurance Information Completed
- A copy of the employee/member’s enrollment form/record and current beneficiary designation, if necessary
- Employee/Member Employment Information (To be completed only if the policyholder is the employer of the employee/member)

Guidelines for Section 3: Attending Physician/Medical Professional Statement

This section is to be completed by the Attending Physician. Dates should include the month, date and year. In order to be complete, the form must be signed by the Attending Physician.

- Employee/Member & Patient Information
- Accident Information Completed
- A copy of the employee/member’s enrollment form/record and current beneficiary designation, if necessary
- Employee/Member Employment Information (To be completed only if the policyholder is the employer of the employee/member)

Required Fraud Warnings

Before completing the claim form, please read the Required Fraud Warnings listed on the following page.

Fraud Warnings

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

3300 Mutual of Omaha Plaza • Omaha, NE 68175-0001
Phone (800) 775-8805 (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/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 Claim Form

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Section 1: Employee/Member & Claimant Statement

CLAIMANT NAME	☐ Male ☐ Female	DOB _____/_____/_____	SSN

RELATIONSHIP TO EMPLOYEE/MEMBER:
☐ Self ☐ Spouse ☐ Domestic Partner ☐ Dependent ☐ Beneficiary ☐ Other (ex., Power of Attorney, Conservator)

EMPLOYEE/MEMBER NAME (if other than claimant)	DOB _____/_____/_____	SSN

ADDRESS	CITY	STATE	ZIP CODE

EMAIL	CONTACT NUMBER

DATE OF ACCIDENT (MM/DD/YYYY)	TIME OF ACCIDENT (HH:MM) ☐ AM ☐ PM	WHERE DID THE ACCIDENT HAPPEN (LOCATION)?

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

DID THE ACCIDENT HAPPEN WHILE WORKING? ☐ Yes* ☐ No	DID ANY LAW AGENCY INVESTIGATE THE ACCIDENT? ☐ Yes* ☐ No

PROVIDE A DETAILED EXPLANATION OF HOW THE ACCIDENT OCCURRED AND THE NATURE/TYPE OF INJURIES SUSTAINED BY THE PATIENT (IF MORE SPACE IS REQUIRED, PROVIDE ON A SEPARATE SHEET OF PAPER AND SUBMIT WITH THIS CLAIM):

IF ANY LAW ENFORCEMENT AGENCY INVESTIGATED THIS ACCIDENT, A COPY OF THE AGENCY/POLICE REPORT MUST BE SUBMITTED WITH THIS CLAIM.

Claim & Benefit Information

CHECK EACH INJURY, TREATMENT OR SERVICE FOR WHICH A BENEFIT IS REQUESTED FOR THE PATIENT WITH THIS CLAIM AS A RESULT OF THE ACCIDENT. NOT ALL BENEFITS ARE INCLUDED IN ALL POLICIES. REFER TO THE APPLICABLE CERTIFICATE FOR AVAILABLE BENEFITS, LIMITATIONS AND EXCLUSIONS. IF ANY PREVIOUS CLAIMS HAVE BEEN SUBMITTED FOR THIS ACCIDENT AND PATIENT, ONLY CHECK THE BENEFITS THAT ARE APPLICABLE TO THIS NEW CLAIM.

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

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

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

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

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

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

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

Additional Benefits
- ☐ Transportation
- ☐ Lodging
- ☐ Child Care

PROOF REQUIREMENTS

- Documentation must be submitted to support the benefits claimed, which in addition to Section 3 – Attending Physician/Medical Professional Statement may include medical records, physician notes, ER/UC/IPO discharge papers, radiology reports, hospital/physician/ambulance bills, toxicology reports or other proof. Documentation must provide: 1) the date of service; 2) the specific procedure/service received; and 3) the diagnosis; for all benefits claimed, as applicable.
- A copy of the hospital bill or admission/discharge summary showing the number of days the Patient was hospitalized must be submitted with this claim.
- If death was a result of this accident, a certified copy of the death certificate for the Patient must be submitted with this claim.

EMPLOYEE/MEMBER NAME _____ EMPLOYEE/MEMBER SSN OR ID # _____ PATIENT NAME _____

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, MA, MD, ME, NC, 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.)*

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 accident 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 1 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 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 4: 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

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 SIGNED (MM/DD/YYYY)

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Section 2: Policyholder/Employer Statement

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)

DATE OF ACCIDENT (MM/DD/YYYY)	DESCRIPTION OF ACCIDENT	DID THE ACCIDENT HAPPEN WHILE WORKING? ☐ Yes ☐ No

Employee/Member Employment Information – To be completed only if the policyholder is the employer of the employee/member.

****A COPY OF THE EMPLOYEE/MEMBER'S ENROLLMENT FORM/RECORD AND CURRENT BENEFICIARY DESIGNATION MUST BE SUBMITTED WITH THIS CLAIM.****

EFFECTIVE DATE OF INSURANCE FOR EMPLOYEE/MEMBER (MM/DD/YYYY)	EFFECTIVE DATE OF INSURANCE FOR PATIENT (MM/DD/YYYY)

COVERAGE TIER (ELECTED/IN EFFECT) ☐ EE Only/All Insured Persons ☐ EE + Spouse ☐ EE + Child(ren) ☐ EE + Family	PREMIUM PAID THROUGH DATE (MM/DD/YYYY)

CLASS	FULL-TIME EMPLOYMENT DATE (MM/DD/YYYY)	AVERAGE HOURS WORKED/WEEK

DATE LAST WORKED, IF APPLICABLE (MM/DD/YYYY)	IF THE EMPLOYEE IS NOT WORKING THE MINIMUM HOURS REQUIRED UNDER THE POLICY, INDICATE WHY: ☐ Termination ☐ Layoff ☐ Personal Leave ☐ Medical/Protected Leave (e.g., FMLA) ☐ Other (Explain in Section 4)

DOES THE EMPLOYEE PAY ANY PREMIUM FOR THIS INSURANCE? ☐ Yes* ☐ No	*IF YES, ARE THEY PAID PRE-TAX OR POST-TAX? _____% Pre-tax _____% Post-tax

DOES MUTUAL OF OMAHA COVER THE EMPLOYEE FOR ANY OF THE FOLLOWING GROUP POLICIES? ☐ LIFE ☐ STD ☐ LTD

Policyholder/Employer Additional Information

USE THIS SPACE TO PROVIDE ANY ADDITIONAL INFORMATION RELATED TO THE ACCIDENT OR INFORMATION STATED ABOVE, AS NEEDED:

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, NC, 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 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 OF POLICYHOLDER/EMPLOYER REPRESENTATIVE	TITLE

EMAIL ADDRESS	PHONE NUMBER	FAX NUMBER

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Section 3: Attending Physician/Medical Professional Statement

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 (OR "SELF")	DATE OF ACCIDENT (MM/DD/YYYY)

DESCRIPTION OF ACCIDENT AND PRIMARY DIAGNOSIS

IS/WAS A MEDICAL DEVICE (FOR LOCOMOTION/MOBILITY) RECOMMENDED TO THE PATIENT? ☐ Yes ☐ No

ARE ALL INJURY/TREATMENTS/SERVICES IDENTIFIED BELOW FOR THE PATIENT A DIRECT RESULT OF THE ACCIDENT? ☐ Yes ☐ No – Explain:

IS THERE ANY OTHER ILLNESS OR INFIRMITY AFFECTING THE PATIENT'S CONDITION OR INJURIES SUSTAINED IN THE ACCIDENT? ☐ Yes ☐ No – Explain:

Injury, Treatment & Service Information

CHECK EACH INJURY, TREATMENT OR SERVICE FOR WHICH YOU ATTENDED TO THE PATIENT AS A DIRECT RESULT OF THE ACCIDENT STATED ABOVE, AND SUBMIT ANY RELEVANT TEST RESULTS, HOSPITAL DISCHARGE SUMMARY AND/OR YOUR MEDICAL STATEMENTS/RECORDS WITH THIS FORM, IN ADDITION TO THE INFORMATION BELOW. EACH INJURY, TREATMENT OR SERVICE MUST BE INDEPENDENT OF BODILY INFIRMITY, SICKNESS AND ALL OTHER CAUSES.

INJURY/TREATMENT/SERVICE	DATE(S) OF SERVICE	DIAGNOSIS/PROCEDURE CODE(S) (ICD-9/10, CPT4, ETC.)	DIAGNOSIS/PROCEDURE(S) DESCRIPTION & ADDITIONAL INFORMATION
Initial Care & Emergency			
☐ Emergency Room			
☐ Urgent Care Center			
☐ Initial Physician Office Visit			
Follow-Up Care			
☐ Physician Follow-Up Visit			
☐ Therapy Services (OT, PT, speech, chiropractic care)			
Specified Injury			
☐ Fracture(s) and/or Dislocations(s)			
☐ Laceration(s) (Repair incl. sutures, adhesives, staples or closure strips)			Total length of all lacerations requiring repair: _____ inches If no laceration required repair, check here: ☐
☐ Second or Third Degree Burn(s)			% of Total Body Surface Area for Second Degree Burns: _____ % of Total Body Surface Area for Third Degree Burns: _____
☐ Skin Graft (Incl. stem cells or skin substitute)			
☐ Dental Crown, Filling and/or Extraction			
Surgical			
☐ Exploratory or Arthroscopic Surgery			
☐ Abdominal, Cranial or Thoracic Surgery			
☐ Herniated Disc Surgery			
☐ Torn Knee Cartilage Surgery			
☐ Ligament/Tendon/Rotator Cuff Surgery			
☐ Eye Procedure (Removal of object or surgery, other than eyelid)			
☐ Blood Products (Blood, red cells, plasma, platelets or granulocytes)			
☐ Epidural Anesthesia			
Diagnostic			
☐ X-ray and/or Diagnostic Exam			
☐ Brain Injury Diagnosis (TBI or MTBI, incl. concussions)			

EMPLOYEE/MEMBER NAME _____ EMPLOYEE/MEMBER SSN OR ID # _____ PATIENT NAME _____

Attending Physician Remarks/Additional Information

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

ATTENDING PHYSICIAN/MEDICAL PROFESSIONAL NAME	PHONE NUMBER	FAX NUMBER

STREET ADDRESS	CITY	STATE	ZIP CODE

MEDICAL SPECIALTY	DEGREE	BOARD CERTIFICATION(S)

TAX ID NUMBER	ARE YOU RELATED TO OR FAMILIAR WITH THE PATIENT? ☐ Yes* ☐ No	*IF YES, EXPLAIN THE RELATIONSHIP:

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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

SIGNATURE OF PHYSICIAN COMPLETING THIS FORM	DATE (MM/DD/YYYY)