A Guide for Successfully Completing the Group Critical Illness/Specified Disease 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 critical illness/specified disease 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 Health Benefit Screening Claim Form for all health screening benefit claims.
- Group ID Number consists of eight characters, beginning with "G000" and followed by four additional letters or numbers.

Guidelines for Section 1: Employee/Member, Patient & Claimant Statement

This section is to be completed by the Employee/Member. Dates should include month, date and year. In order to be considered complete, the form must be signed by you.

- Employee/Member Information
- Patient Information
- Critical Illness/Specified Disease Information
- Hospital and Physician Information
- Authorization & Signature Completed and Dated

Guidelines for Section 2: Physician, Hospital and Medication Information

This section is required if this claim is being filed within the first year following the effective date of insurance for the Patient.

- Employee/Member & Patient Information
- Hospital and Physician Information
- Drug Information
- Acknowledgement & Signature Completed and Dated

Authorization to Disclose Personal Information & Optional Authorization to Disclose Information to Third Parties

Both authorizations are to be completed by the Employee. Dates should include the month, date and year.

- By signing the authorization, you are applying for critical illness benefits with Mutual of Omaha/United of Omaha and are agreeing to allow disclosure of personal information to the necessary parties for the purpose of claim processing.
- By signing the optional third party authorization, you are allowing Mutual of Omaha/United of Omaha to communicate with a third party about this claim. A third party includes a family member, friend or other person identified.

Guidelines for Section 3: Policyholder/Employer Statement

This section is to be completed by the policyholder/employer. In order to be considered complete, the form must be signed by the policyholder/employer.

- Employee/Member & Patient Information
- Critical Illness/Specified Disease Insurance Information completed
- 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, if necessary
- Policyholder/Employer Acknowledgement, Signed & Date

Guidelines for Section 4: Attending Physician Statement

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

- Employee/Member & Patient Information
- Critical Illness/Specified Disease Information completed
- Diagnosis Information
- Attending Physician, Hospital & Other Physician Information
- Physicians Acknowledgement, Signed & Date

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

Mutual of Omaha Plaza • Omaha, NE 68175-0001
Phone (800) 775-8805 (toll-free) • www.mutualofomaha.com/customer-service

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.

Group Critical Illness/Specified Disease Claim Form

Mutual of Omaha Insurance Company
United of Omaha Life Insurance Company
Group Critical Illness Claims
3300 Mutual of Omaha Plaza
Omaha, NE 68175-0001
Phone (800) 775-8805 (toll-free) Fax (402) 997-1835 www.mutualofomaha.com/customer-service

Section 1 – Employee/Member, Patient & Claimant Statement

POLICYHOLDER/EMPLOYER NAME			GROUP ID NUMBER G000 __ __ __ __
CITY		STATE	ZIP CODE
INSURED LAST NAME	INSURED FIRST NAME		INSURED MI
STREET ADDRESS	CITY	STATE	ZIP CODE
EMAIL 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	
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	
WHO IS THE PATIENT (THE PERSON THAT INCURRED THE CRITICAL ILLNESS/SPECIFIED DISEASE)? ☐ Employee/Member ☐ Spouse/Partner ☐ Child			

COMPLETE THE FOLLOWING ONLY IF THE PATIENT IS NOT THE EMPLOYEE/MEMBER.

PATIENT LAST NAME	PATIENT FIRST NAME		PATIENT MI
PATIENT STREET ADDRESS	PATIENT CITY	PATIENT STATE	PATIENT ZIP CODE
PATIENT DATE OF BIRTH (MM/DD/YYYY)	PATIENT GENDER ☐ Male ☐ Female	PATIENT SSN OR ID NUMBER	PATIENT 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	
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:			

Eligibility Information (Only applicable for CA, DC, MA, NJ and NY)

DOES THE EMPLOYEE/MEMBER AND THE PATIENT (IF NOT 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 FOR THE EMPLOYEE/MEMBER AND THE PATIENT (IF DIFFERENT):

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

 Form continued on Page 2

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

IF THE PATIENT WAS HOSPITALIZED FOR THE ILLNESS/PROCEDURE STATED ABOVE, PROVIDE HOSPITAL INFORMATION:			
HOSPITAL NAME	HOSPITAL PHONE NUMBER		HOSPITAL FAX NUMBER
HOSPITAL STREET ADDRESS	HOSPITAL CITY	HOSPITAL STATE	HOSPITAL 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:			
HOSPITAL NAME	HOSPITAL PHONE NUMBER		HOSPITAL FAX NUMBER
HOSPITAL STREET ADDRESS	HOSPITAL CITY	HOSPITAL STATE	HOSPITAL 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	PHYSICIAN PHONE NUMBER		PHYSICIAN FAX NUMBER
PHYSICIAN STREET ADDRESS	PHYSICIAN CITY	PHYSICIAN STATE	PHYSICIAN ZIP CODE
PROVIDE INFORMATION FOR THE PATIENT'S ATTENDING OR TREATING PHYSICIAN/SPECIALIST FOR THE ILLNESS/PROCEDURE STATED IN SECTION 4:			
PHYSICIAN NAME	PHYSICIAN PHONE NUMBER		PHYSICIAN FAX NUMBER
PHYSICIAN STREET ADDRESS	PHYSICIAN CITY	PHYSICIAN STATE	PHYSICIAN 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.			
WHO IS THE CLAIMANT (THE PERSON FILING THIS CLAIM)? ☐ Employee/Member ☐ Spouse/Partner ☐ Beneficiary ☐ Other** (ex. Power of Attorney, Conservator) **COMPLETE THE FOLLOWING ONLY IF THE CLAIMANT IS NOT THE EMPLOYEE/MEMBER.**			

CLAIMANT LAST NAME	CLAIMANT FIRST NAME	CLAIMANT MI	CLAIMANT EMAIL ADDRESS
CLAIMANT STREET ADDRESS	CLAIMANT CITY	CLAIMANT STATE	CLAIMANT ZIP CODE
CLAIMANT DATE OF BIRTH (MM/DD/YYYY)	CLAIMANT SSN OR ID NUMBER	CLAIMANT HOME PHONE NUMBER	CLAIMANT 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.****			

Section 2 – Physician, Hospital and Medication 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)

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.

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	STREET ADDRESS

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.

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.

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

Authorization to Disclose Personal Information

1. I authorize any physician, medical or dental practitioner, hospital, clinic, pharmacy benefit manager, other medical care facility, health maintenance organization, insurer, employer, consumer reporting agency and any other provider of medical or dental services to release records containing the personal information of:

   Claimant/Patient Name: _____
   (Last) (First) (Middle)

   Date of Birth: _____/_____/_____

2. Personal information includes medical history, mental and physical condition, prescription drug records, alcohol or drug use, financial and occupational information.

3. You may release information to:

   Group Critical Illness/Specified Disease Management Services
   Mutual of Omaha Insurance Company/United of Omaha Life Insurance Company
   3300 Mutual of Omaha Plaza
   Omaha, NE 68175-0001
   Or
   Fax 402-997-1835
   Or
   Email submitgrplife@mutualofomaha.com

4. I understand that the personal information that is disclosed will be used by Mutual of Omaha Insurance Company and United of Omaha Life Insurance Company to evaluate my claim for critical illness/specified disease benefit plan reimbursement and that if I refuse to sign this authorization my claim for benefits may not be paid.

5. I understand that if the person or entity to whom information is disclosed is not a health care provider or health plan subject to federal privacy regulations, the personal information may be redisclosed without the protection of the federal privacy regulations.

6. This authorization will expire 24 months after the date signed.

7. I understand that I may revoke this authorization at any time by providing a written request to Mutual of Omaha Insurance Company and United of Omaha Life Insurance Company at the address above. If I revoke this authorization, it will not affect any use or disclose of personal information that occurred prior to the receipt of my revocation.

8. 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

Optional Authorization to Disclose Information to Third Parties

A third party includes a family member, friend, or other person identified.

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 below.

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:

_____

Spouse/Partner Name:	Phone	
Other Family Member/Person Name:	Relationship to Patient	Phone
Other Family Member/Person Name:	Relationship to Patient	Phone
Other Family Member/Person Name:	Relationship to Patient	Phone
Other Family Member/Person Name:	Relationship to Patient	Phone
Other Family Member/Person Name:	Relationship to Patient	Phone

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.

_____
Printed Name of Claimant

_____ _____
Signature of Claimant Date

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

☐ Check here if Patient is deceased or incapable of signing

Section 3 – 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)

POLICYHOLDER/EMPLOYER NAME	GROUP ID NUMBER G000 __ __ __ __

CITY	STATE	ZIP CODE

EMAIL ADDRESS	PHONE NUMBER	FAX NUMBER

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.****

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):

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

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

EMAIL ADDRESS	PHONE NUMBER	FAX NUMBER

Section 4: Attending Physician 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)

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:	OI:
		PCWP:	Murray LIS:
☐ Cancer (Invasive)	Pathology report, clinical diagnosis (only if pathological diagnosis is not possible), surgical report	TNM Stage:	Rai or Binet Stage:
		Clark Level:	Breslow Thickness:
☐ Carcinoma in Situ	Pathology report, clinical diagnosis (only if pathological diagnosis is not possible), surgical report	TNM Stage:	Rai or Binet Stage:
		Clark Level:	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		

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):

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 _____

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.

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

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