UnitedHealthcare Insurance Company

STATEMENT OF CLAIM

FOR ACCIDENTAL DISMEMBERMENT BENEFITS

UnitedHealthcare Specialty Benefits
PO Box 31328
Salt Lake City, UT 84131-0321
Tel: 1-866-293-1794
Fax: 1-800-980-0298
Unsecured E-mail: FPCustomerSupport@uhc.com

TO BE COMPLETED BY THE CLAIMANT

(Please answer all questions)

1. Employee's name (print) _____
   Employee Social Security # Date of Birth
2. Employee phone number with area code _____
3. Claimant Name (if different than Employee)_____
   Social Security # Date of Birth

   Present Address _____
   (Number) (Street) (City) (State) (Zip Code)
5. When did the accident happen? Date _____
6. Where did the accident happen? City _____ State _____
7. Give a brief description of the accident

_____

8. Please attach
(a) copy of your accident report and any newsletter clippings giving details of the accident.
(b) copy of the toxicology report if you were the driver in a motor vehicle accident.
(c) copy of the medical records that support the dismemberment.

I authorize the physician to release any information requested with respect to this Claim.
I certify that the information I furnished to support this claim is true and correct. I KNOW IT IS A CRIME TO FILL OUT THIS FORM WITH FACTS I KNOW ARE FALSE OR TO LEAVE OUT FACTS I KNOW ARE IMPORTANT. I acknowledge that I have read the applicable Fraud Warning Notices provided with this claim form.

Parent or Guardian Name (if under age 18, signature of parent or guardian is required) _____

Claimant Signature _____ Date _____
(claimant or guardian)

TO BE COMPLETED BY THE EMPLOYER

(Please answer all questions)

1. Name of Employer _____ Telephone Number of Employer (with area code)_____

   Address of Employer _____
2. Amount of Accidental Dismemberment Benefit, (Full) $ (Half) $ Issued Date YR
3. Employee's name _____ Date of Hire. _____ Group No. _____
   Please provide Enrollment Form
4. (a) Date last worked _____

   (b) Has Employee returned to work ◯ Yes ◯ No If Yes, what date did they return? _____

Please provide Employee's time records for 12 weeks prior to last day worked.

Final Signature and Certification

Name of person completing this form	E-mail address
Title	Phone number Ext
Signature (eSignature is allowed)	Date Signed

(Rev. 10/18)
UA 1.2020

TO BE COMPLETED BY ATTENDING PHYSICIAN

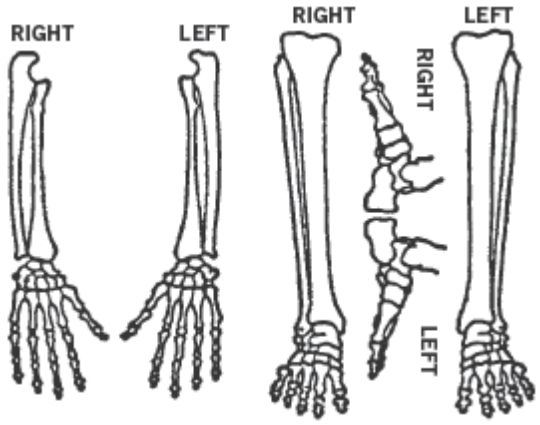
(Please answer all questions)

IT IS A CRIME TO FILL OUT THIS FORM WITH FACTS YOU KNOW ARE FALSE OR TO LEAVE OUT FACTS YOU KNOW ARE IMPORTANT.

1. Name of patient _____ Date of Birth _____

2. Date you first saw this patient for this injury _____ Date of last treatment _____ ICD 10 Code _____

3. Describe the exact nature, location, and extent of injuries sustained

TO BE COMPLETED ONLY FOR AMPUTATIONS	**TO BE COMPLETED ONLY FOR LOSS OF VISION**
4. (a) which limbs were severed or amputated and the cause of amputations? (b) State the dates on which the severances or amputations occurred. (c) State the exact point at which the amputation was performed or the severance occurred with respect to each limb lost. If the severance or amputation was below the elbow or knee joint indicate on the below chart, the exact point of severance:  	4. State the cause of loss of vision. 5. Please specify any functional deficit(s) your patient may have related to: Visual Acuity (Near) Corrected Visual Acuity Left Eye / Right Eye / Visual Acuity (Far) Corrected Visual Acuity Left Eye / Right Eye / 6. Indicate whether recover or useful vision is possible by operation or Treatment. O.D. ◯ Operation ◯ Treatment O.S. ◯ Operation ◯ Treatment 7. Was the injury the sole cause for the loss of vision? If not, please describe below.

Signature of Attending Physician

The above statements are true and complete to the best of my knowledge and belief. I acknowledge that I have completed this form in its entirety.		
Physician's Name	Degree & Specialty	NPI Number
Street Address	Phone Number	Fax Number
Are you related to this patient? ◯ Y ◯ N	If yes, what is the relationship?	
Physician's Signature (eSignature is allowed)		Date Signed

Please fax, email or mail this statement to UnitedHealthcare Specialty Benefits, at the following locations:
Fax: 800 980 0298 **Unsecured E-mail:** FPCustomerSupport@uhc.com
Mail: PO Box 31328 Salt Lake City UT 84131-0321

FRAUD WARNING NOTICES: (Please review notice that applies in your state)

For claimants in 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.

For claimants in 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.

For claimants in 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.

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.

For claimants in 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.

For claimants in Connecticut:
Any person who knowingly presents false information in an application for insurance or life settlement contract is guilty of a crime and may be subject to fines and confinement in prison.

For claimants in 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.

For claimants in District of Columbia:
WARNING: 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.

For claimants in 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

For claimants in Hawaii:
For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

For claimants in Idaho:
Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

For claimants in 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.

For claimants in Kansas:
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 may be guilty of fraud as determined by a court of law.

For claimants in Kentucky:
Any person who knowingly and with intent to defraud any insurance company or other person files a 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.

For claimants in 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.

For claimants in Maryland:
Any person who knowingly or willfully presents a false or fraudulent claim for payment for 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.

For claimants in Minnesota:
A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

For claimants in 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 for insurance fraud, as provided in RSA 638:20.

For claimants in New Jersey:
Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

For claimants in 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 penalties.

For claimants in 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.

For claimants in Oklahoma:
WARNING: Any person who knowingly, and with intent to injure, defraud or deceive and insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

For claimants in Oregon:
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 may be guilty of a crime and may be subject to fines and confinement in prison.

For claimants in 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.

For claimants in Tennessee 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.

For claimants in 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.

For claimants in Vermont:
Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing false, incomplete, or misleading information may be guilty of a crime.

For claimants in Virginia:
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 false, incomplete, or misleading information may have violated state law.

For claimants in All Other States:
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.

PO Box 31328 Salt Lake City, UT 84131-0321
Tel 866 293 1794
Fax 800 980 0298

Claims Department
Direct Deposit Agreement
For Payment of Benefit to Financial Institution

Section 1 (to be completed by benefit recipient)

Name of Benefit Recipient

UHCSB Claim Number

UHCSB Policy Number

Social Security Number

Telephone Number

Address (Number, Street, Route, P.O. Box, APO/FP, including directional such as NE, NW, SE, SW etc)

City

State

Zip (preferably the nine digit ZIP code)

"I authorize UnitedHealthcare Specialty Benefits to direct the net amount of my benefit payment to be deposited directly by electronic funds transfer and credited to my account as indicated at the financial institution designated below. If any payments made are dated after the date of my death, I hereby authorize and direct the said financial institution on my behalf and on behalf of my executors or administrators to refund any such payments to UnitedHealthcare Specialty Benefits and to charge the same to my account."

Signature of Benefit Recipient (eSignature is allowed)

Date Signed

Section 2

Name of Financial Institution

Address ((Number, Street, Route, P.O. Box, APO/FP, including directional such as NE, NW, SE, SW etc)

City

State

Zip (preferably the nine digit ZIP code)

Routing Number (9 digit number in lower left corner of check)

Bank Account Number (numbers following the Routing Number)

Type of Account ☐ Checking ☐ Savings (check one)

Attaching a Voided Blank Check will Expedite Processing Your Claim