

# Statement of Claim for Living Benefits

United of Omaha Life Insurance Company  
Home Office – Omaha, Nebraska



## To Be Completed by Insured

Answer all questions that apply.

The Insured or guardian is responsible for completion of this proof without expense to the Company. The Company in furnishing this form does so without admitting any liability or waiving any of its rights under the policy on which this claim is made.

Insured's full name		Insured's Marital Status	M	Div. Legal Sep.	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of birth	Cert. or Soc. Sec. Number
			S				
			Wid.				
Home address (Number and Street)	(City)			(State)		(ZIP Code)	Telephone Number
Employed by					Occupation	Date employed	
Name of Group						Group Master Policy Number	

Describe injury or sickness

Give the date you were first diagnosed for this injury or sickness

On what date were you first treated by a physician? Name below all physicians who have treated you since that date.

Name	Address	From	Dates of treatment	To
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Are you insured under any other policies issued by this company?  Yes If "Yes," give policy numbers.  No

I hereby request any living benefit payable to me under the terms of my group life insurance coverage. I understand that any living benefit is payable only while I am alive and that this benefit may be taxed to me when received. In a community property state, my spouse must consent to the payment of this benefit. The consent of my beneficiary is required. I understand that the benefit paid to my beneficiary will be reduced by the amount of living benefit paid to me. I have read and understand the Disclosure Statement for Accelerated Benefits.

Insured's Signature \_\_\_\_\_ Date \_\_\_\_\_

Beneficiary's Signature \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_

(Witnesses) \_\_\_\_\_ Date \_\_\_\_\_

List of community property states: Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington State.

## Authorization To Disclose Personal Information

To physicians, medical or dental practitioners, hospitals, clinics, pharmacies, pharmacy benefit managers, other medical care facilities, health maintenance organizations, insurers, employers, consumer reporting agencies and all other providers of medical or dental services.

I authorize you to release to representatives of United of Omaha Life Insurance Company, personal information about the insured person including: medical history, mental and physical condition, prescription drug records, alcohol or drug use, financial and occupational information in order to evaluate my claim for benefits.

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 information may be redisclosed without the protection of the federal privacy regulations.

I understand that I may refuse to sign this authorization. I realize that if I refuse to sign, my claim for benefits may not be paid.

This authorization will expire 24 months after the date signed. I may revoke this authorization at any time by written notice to; ATTN: Group Life Claims, United of Omaha Life Insurance Company, Mutual of Omaha Plaza, Omaha, NE 68175-0001. Any revocation of this authorization will not affect any use or disclosure of Personal Information that occurred prior to the receipt of my revocation.

I understand that I am entitled to receive a copy of the authorization and that a copy is as valid as the original.

Name(s) used for medical records (if different than the name below): \_\_\_\_\_

Printed Name of Insured Person \_\_\_\_\_ Printed Name of Authorized Person \_\_\_\_\_ Signature of Authorized Person \_\_\_\_\_

Relationship to Insured \_\_\_\_\_ Date \_\_\_\_\_

## Notice

**GENERAL** — FEDERAL TAX LAWS IMPOSE WITHHOLDING REQUIREMENTS WITH RESPECT TO LIFE INSURANCE POLICIES. IF YOU ELECT TO HAVE FEDERAL INCOME TAX WITHHELD FROM PAYMENT, SOME STATES WILL REQUIRE THAT STATE INCOME TAX ALSO BE WITHHELD.

**YOU MUST FURNISH YOUR SOCIAL SECURITY NUMBER WHETHER OR NOT YOU ELECT NO WITHHOLDING.**

**CAUTION** — IF YOU ELECT NOT TO HAVE WITHHOLDING APPLY, OR IF YOU DO NOT HAVE ENOUGH FEDERAL INCOME TAX WITHHELD, YOU MAY BE RESPONSIBLE FOR PAYMENT OF ESTIMATED TAX. YOU MAY INCUR PENALTIES UNDER THE ESTIMATED TAX RULES IF YOUR WITHHOLDING AND ESTIMATED TAX PAYMENTS ARE NOT SUFFICIENT FOR THE TAX YEAR.

### **Required Disclosure Statement For Accelerated Benefits United of Omaha Life Insurance Company**

#### **Living Benefits Are Not Payable If The Master Policy Ends**

(Washington — only) If you incur a **terminal condition** while insured for group term life insurance offered by your employer, you may request an accelerated payment of a portion of those life insurance benefits. You may receive as much as 50% of the face amount of your life insurance benefit. **If you receive a payment of accelerated benefit from a life insurance policy, you may lose your right to receive certain public funds, such as Medicare, Medicaid, Social Security, Supplemental Security, Supplemental Security Income (SSI) and possibly others. Also, receiving accelerated benefits from a life insurance policy may have tax consequences for you. We cannot give you advice about this. You may wish to obtain advice from a tax professional or an attorney before you decide to receive accelerated benefits from a life insurance policy.**

(Generic — all other states) If you incur a **terminal condition** while insured for group term life insurance offered by your employer, you may request an accelerated payment of a portion of those life insurance benefits. You may receive \_\_\_\_\_ % of the face amount of your life insurance benefit up to a maximum of \$ \_\_\_\_\_ .

**Your Life Insurance Death Benefit Will Be Reduced By The Amount Of Accelerated Benefit That Is Paid. Unlike Conventional Life Insurance Benefits, Accelerated Benefits May Be Taxable. You Or Your Designated Beneficiary Should Consult A Personal Tax Advisor.**

#### **Accelerated Death Benefit Application Instruction**

To apply for an Accelerated Death Benefit, please follow the steps noted below:

- Step 1. Attending physicians' Statement of Condition must be filled out in its entirety.
- Step 2. You must contact the beneficiary you have noted and inform him/her of your accelerated death benefit request and the amount you have requested.
- Step 3. Your beneficiary must complete the Consenting Beneficiary Form and return it to you in order for you to file the claim.
- Step 4. Submit both the Physicians' Statement of Condition along with the Consenting Beneficiary Form and return to:

United of Omaha Life Insurance Company  
Attention: Group Life Claims  
Mutual of Omaha Plaza  
Omaha, NE 68175

**Consent Beneficiary Form**

I have read and understood that \_\_\_\_\_ will receive  
Name of Insured

the sum of \$ \_\_\_\_\_, as an Accelerated Death Benefit. I further understand that as the beneficiary, the remaining life insurance benefit will be reduced by \_\_\_\_\_ %.

Beneficiary Signature

Date

Address

**To Be Completed By Master Policyholder or Group Administrator**

Name of Insured

Date of birth	Cert. or Soc. Sec. Number		Eff. date of certificate
Date of employment	Date last at work	Last occupation	Annual salary

Why did he or she cease work on date given above?

Date insurance terminated	If not terminated, give "paid to" date.	
Master Policy Number	Insurance class	Amount of life insurance at time of last day of work
Name of beneficiary shown on your records	Address	Relationship to Insured

We hereby certify that, to the best of our knowledge and belief, the above statements are correct.

Name of Group	Branch or division	
Address of Group	Authorized representative's signature	Date

## Attending Physician's Statement of Terminal Condition

The patient is responsible for the completion of this form without expense to the Company.

1. PATIENT'S NAME _____	AGE _____
2. HISTORY (a) When did symptoms first appear or accident happen? (b) Has patient ever had same or similar condition? If "Yes," state when and describe.	(a) Mo. _____ Day _____, _____ (b) <input type="checkbox"/> Yes <input type="checkbox"/> No
3. PRESENT CONDITION (a) Subjective symptoms (b) Objective findings (Includes results of current X-rays, EKGs or any other special tests.) (c) Is patient (Check one).....	(a) _____ (b) _____ (c) <input type="checkbox"/> ambulatory? <input type="checkbox"/> bed confined? <input type="checkbox"/> house confined? <input type="checkbox"/> hospital confined?
4. DIAGNOSIS	_____ _____ _____
5. TREATMENT (a) Date of first visit ..... (b) Date of last visit. .... (c) Frequency of visits..... (d) When did you last examine the patient?.....	(a) Mo. _____ Day _____, _____ (b) Mo. _____ Day _____, _____ (c) <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Other _____ (d) Mo. _____ Day _____, _____
6. TERMINAL CONDITION (a) Current treatment (b) Prognosis: Is this injury or sickness terminal (expected to result in death from which there is no reasonable prospect of recovery)? If Yes, please give expectations for continued survival: ____ 6, ____ 12, or ____ 24 months. If "No," please give expectations for continued survival, _____ months. (c) Has patient been seen/examined by any consultant? If so, please attach any pertinent reports (tissue pathology, radiology, oncology, etc.) and name/address of same.	
7. MENTAL CONDITION Is the patient competent to endorse checks and direct the use of the proceeds thereof?	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. REMARKS _____ _____ _____ _____	

Attending Physician:

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

- Office notes for the period of treatment to the present
- Test results showing objective findings
- Hospital discharge summaries
- Consulting physician reports

Date	Type or Print Physician's Name	Tax I.D. or Social Security Number
Signature (Attending Physician)	Degree	Telephone
Street Address	City or Town	State or Province
		ZIP Code

# Group Claim Fraud Statements



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.