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:** 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 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.

** **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 commits a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties.

** **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 intent to defraud or deceive any insurance company includes false information in an application for insurance or files, assists, or abets in the filing of a fraudulent claim to obtain payment of a loss or other benefits, or files more than one claim for the same loss or damage, may be guilty of a felony. Upon conviction, that person will be fined between $5,000 and $10,000, imprisoned for three (3) years or both. Aggravating or attenuating circumstances may result in the prison term being increased to five (5) years or reduced to two (2) years.

Cualquier persona quien con conocimiento y con la intensión de defraudar o engañar a cualquier compañía de seguros, incluye información falsa en una solicitud para seguro o introduce, o instiga en la introducción de una reclamación fraudulenta para obtener pago por una pérdida u otro beneficio, o presenta más de una reclamación por la misma pérdida o daño puede ser culpable de cometer un acto criminal. Al ser convicto, ese persona será multada con una cantidad de $5,000 a $10,000, encarcelamiento por tres (3) años o ambos. Circunstancias agravantes o atenuantes podrían resultar en que el período de tiempo de prisión aumente a cinco (5) años o se reduzca a dos (2) años en concordancia.

** **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.

United of Omaha Life Insurance Company
Group Life Claims
Mutual of Omaha Plaza
Omaha, NE 68175-0001
Toll Free (800) 775-8805
Fax (402) 997-1835

Instructions for Filing a Proof of Death Claim Form

Upon the death 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 following documentation:

1. Proof of Death claim form:

   Part I – Completed by the employer/plan administrator
   Part II – Completed by the beneficiary(ies)

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

3. Original certified death certificate. If the benefit amount is $30,000 or less, a copy is acceptable.

4. For accidental death benefits, provide the following items, including but not limited to:
   a. Official investigative report (police, accident, fire, FAA, OSHA)
   b. Proof of seatbelt/airbag use, if applicable
   c. Coroner's report or Medical Examiner's report findings and/or toxicology report

5. If the beneficiary is:
   a. An Estate – We require the Letters Testamentary or Letters of Administration appointing the personal representative of the estate
   b. A Trust – We require a copy of the following pages of the trust – Face page of Trust, Trustee or Successor Trustee designation and Signature page of Trust
   c. A Minor – According to state law, a minor lacks capacity to sign a binding release of an insurance contract.

      For this reason, life insurance benefits are not directly payable to a minor beneficiary. The following are options available when the beneficiary is a minor:

      1. UTMA (Uniform Transfer to Minors Act) – UTMA payment may be utilized providing that the benefit amount including interest is under the amount allowed for the minor beneficiary's state of residence.
      2. Guardianship papers – The minor's custodian may obtain formal guardianship papers for the minor's estate. These legal guardianship documents must be obtained prior to the release of the benefit.

6. If the beneficiary has predeceased the insured and no contingent beneficiary is named or the insured did not name a beneficiary:
   a. Payment of the life insurance benefits will be paid in order as specified in the policy provisions of the contract
   b. The surviving heir must complete an Affidavit of Preferential Beneficiary Designation Form, which must be notarized

The Proof of Death claim form should be returned to:

United of Omaha Life Insurance Company
Group Life Claims
Mutual of Omaha Plaza
Omaha, NE 68175-0001
or
Fax number: (402) 997-1835

Proof of Death Claim Form

Part I To Be Completed by the Employer or Plan Administrator

The deceased is insured as: ☐ Employee/Member ☐ Spouse ☐ Child

1. Name of deceased _____

   Name of employee/member (If not the deceased person) _____

2. Date of death _____ Date of birth _____ Age_____

3. Social Security number of deceased _____

4. Employee's/member's marital status
   ☐ Single ☐ Married ☐ Widow/widower ☐ Separated ☐ Divorced ☐ Domestic partner relationship ☐ Civil union

5. Amount of insurance: Basic life _____ Basic AD&D _____
   Voluntary life _____ Voluntary AD&D _____
   Supplemental life _____ Voluntary dependent AD&D _____
   Basic dependent life _____ Voluntary dependent life _____

6. Date premium for the above deceased has been paid through _____

7. Date employee's employment or member's membership began: Full time _____ Part time _____

   Annual salary (If salary based) $_____ Date of last salary increase _____

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

9. Date on which the employee was last present at work? _____

10. Reason for employee ceasing work
    ☐ Illness (Including disability leave of absence/partial disability) ☐ Leave of absence (Other than disability)
    ☐ Quit ☐ Dismissed ☐ Vacation ☐ Retired (Date)_____ ☐ Layoff ☐ Deceased ☐ Accident

11. Was the employee disabled? ☐ Yes ☐ No

    If yes, date disability began _____ Date partial disability began _____

12. Employee was: (Check all that apply) ☐ Full time ☐ Part time
    ☐ Union ☐ non-Union ☐ Hourly ☐ Salaried ☐ Exempt ☐ non-Exempt ☐ Other (Explain) _____

13. Average hours employee worked per week:_____ Occupation _____ Class _____

14. Name of beneficiary as shown on your records _____ Relationship _____
    Attach enrollment record plus any beneficiary changes (In written or electronic format)

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 _____ Date _____

Signature of authorized employer/plan representative _____

Phone number _____ Fax number _____ Email address _____

Part II To Be Completed by Beneficiary*

**If there is more than one beneficiary, each must complete a separate form.*

Name _____
First Middle initial Last

Beneficiary's Social Security number or Taxpayer Identification number _____

Date of birth _____ Home phone _____ Cell phone _____

Address _____

City _____ State _____ ZIP code _____

Email address _____

Name of deceased _____ Relationship to deceased _____

Group policy number of deceased _____

If the deceased was an employee/member, fill out the following:

Was the employee/member disabled? ☐ Yes ☐ No If yes, date disability began _____

If you are not the named beneficiary, in what capacity do you make this claim? _____

Does the deceased have any other life insurance coverage with Mutual of Omaha or United of Omaha? ☐ Yes ☐ No

If the deceased was a dependent fill out the following:

Dependent's occupation _____

Was the dependent disabled? ☐ Yes ☐ No

If yes, date disability began _____ Dependent's last day worked _____

Dependent's employer _____ Dependent's employer's phone number _____

Is child ☐ Full-time student ☐ Part-time student

Name & address of school _____
(Street) (City) (State) (ZIP code)

Certification

In order for us to comply with applicable IRS reporting requirements, please complete the following certification:

Under penalty of perjury, I certify that:

a) The statements I have made on this form, including my Taxpayer Identification Number (or the fact that I am waiting for a number to be issued to me), are correct, and
b) I am not subject to backup withholding either because I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of failure to report all interest and dividends, or the IRS has notified me that I am no longer subject to backup withholding.
c) I am a U.S. person.

The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

Your signature _____ Date _____

Printed name _____

Authorization To Disclose Personal Information

1. I authorize 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 and dental services to release Personal Information to representatives of United of Omaha Life Insurance Company for:

   Deceased name _____ Deceased date of birth _____

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

3. The Personal Information will be used to evaluate my claim for benefits.

4. 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.

5. 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.

6. 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.

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

_____ _____

Signature of claimant or individual authorized to represent the deceased

Date

_____ _____

Printed name

Relationship to deceased

Address _____ _____

(Street)

Phone number

_____

(City) (State) (ZIP code)