Underwritten by
United of Omaha Life Insurance Company
A Mutual of Omaha Company

Group Life Claims
3300 Mutual of Omaha Plaza
Omaha, NE 68175-0001
Toll Free (800) 775-8805
Fax (402) 997-1835

Instructions for Filing a Group Life Waiver of Premium Claim

An insured employee or plan member, the employer/plan administrator and the attending physician 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. Waiver of Premium claim form:

   Part I – Completed by the employer/plan administrator
   Part II – Completed by the employee/member
   Part III – Attending Physician's Statement
   Authorization – Completed by the employee/member

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

The Waiver of Premium claim form should be returned to:

United of Omaha Life Insurance Company
Group Life Claims
3300 Mutual of Omaha Plaza
Omaha, NE 68175-0001
or
Fax (402) 997-1835

Fraud Warnings

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.

Waiver of Premium Claim Form

Part I – To Be Completed by the Employer or Plan Administrator

1. Name of employee/member _____

2. Date of birth _____

3. Employee/Member Social Security number _____

4. Amount of insurance: Basic life_____

   Supplemental life _____

   Voluntary life_____

   Date premium for the above employee/member has been paid through_____

5. Date employed: Full time _____ Part time _____

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

6. Effective date of insurance with Mutual of Omaha or United of Omaha _____

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

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

9. Average hours employee worked per week _____ Occupation_____ Class _____

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

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 Employee/Member

A. Information about you

Name _____
First Middle initial Last

Social Security number _____

Date of birth _____ Home phone _____ Cell phone _____

Address _____

City _____ State _____ ZIP code _____

Email address _____

Date of total disability _____ Describe disability _____

B. Information about the disability

Have you been CONTINUOUSLY disabled since you became unable to work? ❑ Yes ❑ No

If YES, when can you resume your duties? _____

If NO, when did you become able to work? _____

On what date were you first treated by a physician? _____

Name below all physicians who have treated you since that date (who may be contacted to obtain medical information):

Doctor's Name _____

Address _____

Telephone _____ Fax _____

Dates of Treatment _____ Specialty _____

Doctor's Name _____

Address _____

Telephone _____ Fax _____

Dates of Treatment _____ Specialty _____

Doctor's Name _____

Address _____

Telephone _____ Fax _____

Dates of Treatment _____ Specialty _____

Doctor's Name _____

Address _____

Telephone _____ Fax _____

Dates of Treatment _____ Specialty _____

C. Information about your training, education and experience

Did you graduate from high school? ❑ Yes ❑ No If no, grade completed? _____ GED? _____

Did you attend college? ❑ Yes ❑ No Did you graduate? ❑ Yes ❑ No List Degree(s) earned _____

Name of College _____ Major(s) _____

Do you have any other formal or vocational training? ❑ Yes ❑ No Please list _____

Were you in the Military? ❑ Yes ❑ No Branch _____ Rank _____ Specialty _____

List all languages spoken fluently _____

Part II – To Be Completed by Employee/Member (continued)

Work Experience – Please list your work experience beginning with your most recent employer in chronological order.

Employer _____ Dates: From _____ To _____

Job Title _____

List Job Duties _____

Employer _____ Dates: From _____ To _____

Job Title _____

List Job Duties _____

Employer _____ Dates: From _____ To _____

Job Title _____

List Job Duties _____

Employer _____ Dates: From _____ To _____

Job Title _____

List Job Duties _____

Employer _____ Dates: From _____ To _____

Job Title _____

List Job Duties _____

Employer _____ Dates: From _____ To _____

Job Title _____

List Job Duties _____

Employer _____ Dates: From _____ To _____

Job Title _____

List Job Duties _____

List any additional courses you have taken, any hobbies and special skills. _____

_____

Part III – To Be Completed by Attending Physician

Attending Physician's Statement
This form should be completed without expense to United of Omaha Life Insurance Company.

General Information

Patient's full name _____

Patient's mailing address _____

Patient's date of birth_____ Primary diagnosis including ICD9/10 or DSM code _____

Complete this section for all conditions

Date of first treatment_____ Date of last treatment _____

Frequency of visits? ❑ Weekly ❑ Monthly ❑ Other (specify) _____

Symptoms _____

Are there any secondary conditions contributing to the disability? ❑ Yes ❑ No

If yes, what are they?_____

If this is a cardiac condition, what is the functional capacity?
❑ Class 1 (No limitation) ❑ Class 2 (Slight limitation) ❑ Class 3 (Marked limitation) ❑ Class 4 (Complete limitation)

Information about the patient's inability to work – Briefly describe restrictions and limitations.

Restrictions (What the patient SHOULD NOT do) _____

_____

Limitations (What the patient CANNOT do) _____

_____

What is your prognosis for recovery?_____

Has patient achieved maximum medical improvement? ❑ Yes ❑ No If no, complete the following:
How soon do you expect fundamental changes in the patient's medical condition?
❑ 1-2 months ❑ 3-4 months ❑ 5-6 months ❑ 6-12 months ❑ 1-1.5 years ❑ more than 1.5 years

Give details concerning expected improvement or deterioration _____

_____

In an eight-hour workday, the patient can: (Check full hourly capacity **for each** activity.)

Sit	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	❑ 6	❑ 7	❑ 8
Stand	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	❑ 6	❑ 7	❑ 8
Walk	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	❑ 6	❑ 7	❑ 8

Are there restrictions in:	Yes	No	Comments
Lifting/Carrying	❑	❑	_____
Use of hands in repetitive actions	❑	❑	_____
Use of feet in repetitive movements	❑	❑	_____
Bending	❑	❑	_____
Squatting	❑	❑	_____
Crawling	❑	❑	_____
Climbing	❑	❑	_____
Reaching above shoulder level	❑	❑	_____
Other (please specify)	❑	❑	_____

When do you expect patient to return to prior level of functioning? _____

Is the patient now TOTALLY disabled from PRESENT occupation? ❑ Yes ❑ No

Is the patient now TOTALLY disabled from ANY and ALL occupations? ❑ Yes ❑ No

Physician Name _____ Degree _____

Specialty _____ Telephone _____

Address _____ Fax Number _____

X _____ _____
Signature of Attending Physician (no stamp) Date

Authorization to Release Personal Information

1. I (the undersigned) authorize any physician, medical or dental practitioner, pharmacist, other health care provider, hospital, clinic, or medical facility, insurer, reinsurer, insurance services support organization, employer, government agency, consumer reporting agency, or insurance policy or benefit plan administrator to release records containing the Personal Information of:

   Name of Claimant _____
   (Last) (First) (Middle)

   Date of Birth_____/_____/_____ Social Security Number_____-_____-_____

   This medical or health information may include information on the diagnosis and treatment of mental illness, alcohol, and drug use. This also may include information on the diagnosis, treatment, and testing results related to HIV, AIDS, and sexually transmitted diseases, unless otherwise restricted by state law. .

2. **Personal Information to be released:**
   - data or records regarding my medical history, treatment, prescriptions, consultations (including medical and psychological reports, records, charts, notes (excluding psychotherapy notes), X-rays, films or correspondence, and any medical condition I may now have or have had;
   - any information regarding insurance or benefit plan coverage, claims or benefits; and/or
   - any information, data or records regarding my activities (including records relating to my Social Security, Workers' Compensation, retirement income, financial information, earnings and employment history)

3. **You may release my Personal Information to:**
   Group Life Claims
   United of Omaha Life Insurance Company
   3300 Mutual of Omaha Plaza
   Omaha, NE 68175-0001
   or Fax: 402-997-1835 or Email: submitgrplife@mutualofomaha.comm

4. **I understand my Personal Information will be used by Mutual to evaluate my claim for benefits, or as required or permitted by law, and that if I refuse to sign this Authorization, my claim for benefits may not be paid. I also authorize Mutual to release my Personal Information as follows:**
   - to its reinsurer, or other persons or organizations performing business, legal or insurance support services in connection with my claim(s); or
   - to a vendor specializing in the application for Social Security Disability Benefits; or
   - to vendors/consultants providing me with wellness, disability or leave related services as part of an employer sponsored benefit plan; or
   - for self-insured disability plans only, to my employer; or
   - for fully insured plans to my employer for use in discussions with Mutual regarding my functional capacity, and any related restrictions and limitations, in order to facilitate my return to work; or
   - as otherwise required or permitted by law or as I further authorize

5. I understand my Personal Information may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

6. I understand that I may revoke this Authorization at any time by providing a written request to Mutual at the address above. If I revoke this Authorization, it will not affect any use or disclosure of Personal Information that occurred prior to Mutual's receipt of my revocation. If written revocation is not received, this Authorization will remain valid until 24 months after the date signed

7. 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

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