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

Group Insurance Claims Management
3300 Mutual of Omaha Plaza
Omaha, NE 68175-0001
Toll Free (833) 928-2179
Fax (402) 997-1878
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A Guide for Successfully Completing the Group Massachusetts Paid Family and Medical Leave 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 paid leave 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 may be delayed.
- 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.

Guidelines for Section 1: Employee Statement

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

- The type of leave requested is where you indicate whether the leave is for your own serious health condition, bonding time with your child, military leave for a deployed family member, or leave to care for a family member with a serious health condition.
- Continuous leave is time off with no periods of return to work; intermittent leave is time off that will be taken for a short period at a time over several months.

Documentation to include for each type of leave

Please include the requested documentation with your claim form to prevent any delay in processing.

Your own Serious Health Condition or the Serious Health Condition of a family member

- If for your own health condition, a certification completed by your treating physician or health care provider
- If you are taking leave to care for a family member with a serious health condition, a certification completed by the family member's treating physician or health care provider

Birth of a Child

- the child's birth certificate; or
- a statement from the child's health care provider stating the child's birth date; or
- a statement from the health care provider of the person who gave birth stating the child's birth date.

Placement of a Child for Adoption or Foster Care

- a statement from the child's health care provider or from an adoption or foster care agency involved in the placement or the Department of Children and Families and must confirm both the placement and the date of the placement.

Military Exigency

- a copy of the family member's active duty orders; or
- a letter of Impending Activation from the family member's Commanding Officer.

Care for Family Member Who is a Covered Military Service Member

- a statement that the covered individual is needed to care for the family member; and
- a statement that the employee is needed to care for the family member; and
- certification by the service member's health care provider and the employee that the health condition is connected to the service member's military service

Authorization to Disclose Personal Information & Authorization to Disclose Health Information to My Employer

Both authorizations are to be completed by the Employee. Dates should include the month, date and year. In order to be considered complete, the form must be signed by you or your legal representative.

- By signing the authorization, you are applying for paid family or medical leave benefits with United of Omaha and are agreeing to allow disclosure of personal information to the necessary parties for the purpose of claim processing.
- If the name associated with any of your medical records differs from the name provided on the form, provide any alternate names. This might occur in the event of a name change due to marriage or adoption.

Guidelines for Section 2: Paid Family Leave

This section is to be completed by the Employee if applying for paid family leave benefits. Dates should include the month, date and year. In order to be considered complete, the form must be signed by you.

- Provide all requested information about the family member for whom you are requesting leave.
- Briefly explain the reason the family member requires care.
- Provide the name and contact information for the family member's physician or health care provider.

Guidelines for Section 3: Certification of a serious health condition

This section is to be completed by the physician or health care provider who is certifying a serious health condition or pregnancy. Dates should include the month, date and year. In order to be considered complete, the form must be signed by the physician/health care provider. This form should be submitted with either a paid family leave or a paid medical leave claim.

Guidelines for Section 4: Employer's Statement

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

- Group ID Number consists of eight characters, beginning with "G000" and followed by four additional letters or numbers.
- Employee wages should include gross quarterly wages.
- Provide days and hours the Employee normally worked.
- Indicate the date the claim form was received from the Employee.
- Note any time off the Employee has taken in the last 52 weeks.
- Indicate if you are continuing to pay wages and are seeking reimbursement of benefit rather than us paying benefits to the employee.

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Section 1 – Employee Statement (Answer all questions to avoid delay)

Current Employer's Name

Employee Name

Employee Address | Employee City | Employee State | Employee ZIP

Employee (Area Code) Telephone Number | Employee Social Security Number

Employee Email Address | Employee Date of Birth

What type of leave are you requesting? (check boxes for each of the below)

❑ Own serious health condition – If own serious health condition, please describe your health condition:

_____

_____

_____

❑ Pregnancy – Expected due date _____

❑ Serious health condition of a family member
Your relationship to family member: _____

❑ Adoption/foster a child

❑ Bonding: Child's birth date: _____
Please include a copy of birth certificate

❑ Military leave

Employment Information

Job Title | Last Day at Work | First Work Day Missed

Has any time been missed prior to this occurrence for paid medical or family leave? ❑ Yes ❑ No
If Yes, what was the reason for leave?

Dates of leave | Type of leave: ❑ PFL ❑ PML

Work Address (If you work from home, home address) | City | State | ZIP

Will leave be for a continuous period of time and/or intermittent?

❑ **Continuous** Leave start date (MM/DD/YYYY) ☐☐ / ☐☐ / ☐☐☐☐ Leave end date (MM/DD/YYYY) ☐☐ / ☐☐ / ☐☐☐☐ ❑ Dates are estimated

❑ **Intermittent** Identify dates intermittent leave will be taken: ❑ Dates are estimated
_____

If providing less than 30 day's advance notice to the employer, please explain:

Other Income Sources ❑ Workers' Compensation ❑ Vacation/PTO/Sick/PFML ❑ Salary Continuation

Information For Tax Withholding If your request for benefits is approved, should Mutual of Omaha/United of Omaha withhold income taxes from your benefit checks? ❑ Yes ❑ No If Yes, how much should be withheld from each check (the minimum is $20.31 per week). $_____.00

Signature (Required for all claims.)
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.
The above statements are true and complete to the best of my knowledge and belief.

X_____ _____
Signature of Employee | Date

This page was left intentionally blank.

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 _____-_____-_____

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 including the presence of HIV infection, AIDS or ARC;
   - 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 Disability Management Services
   Mutual of Omaha Insurance Company/United of Omaha Life Insurance Company
   3300 Mutual of Omaha Plaza
   Omaha, NE 68175-0001
   or Fax: 402-997-1878 or Email: submitgroupPFML@mutualofomaha.com

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, except that disclosure of HIV-related information is authorized for 180 days from the date I sign it.

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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Section 2 – Paid Family Leave

This section is for paid family leave only, not paid medical leave. TO BE COMPLETED BY THE EMPLOYEE

Employee's name (first name, middle initial, last name)

Care recipient's (patient's) name (first name, middle initial, last name)

Care recipient's (patient's) date of birth (MM/DD/YYYY)

☐☐ / ☐☐ / ☐☐☐☐

Is leave requested due to a family member's serious health condition? ❑ Yes ❑ No

What is your relationship to the family member?

What is the requested start date of leave for the family member's serious condition?

What is the anticipated duration of the family member's serious health condition?

Does the family member with the serious health condition require your assistance? If yes, please explain. ❑ Yes ❑ No

Health Care Provider Information (to be completed by the care recipient or authorized representative)

Identify the health care provider who is currently providing you with treatment for a condition that is subject to the employee's request for PFL benefits.

Health care provider's name

Health care provider's mailing address

City | State | ZIP | Country (if not U.S.A.)

Health care provider's telephone number (provide area or country code)

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Section 3 – Certification of a serious health condition (PFL or PML)
TO BE COMPLETED BY THE PHYSICIAN OR HEALTH CARE PROVIDER

Name of person applying for leave:

Patient's name: (first name, middle initial, last name)

Patient's date of birth (MM/DD/YYYY)

☐☐ / ☐☐ / ☐☐☐☐

Serious Health Conditions

1. Date the condition started or will start: _____ (MM/DD/YYYY)
2. Duration of how long the condition lasted or will last: _____
3. Check the box(es) for the questions below, as applicable. For all box(es) checked, the amount of leave needed must be provided in the Required Leave Section.

   ❑ **Inpatient Care:** The patient (❑ has been / ❑ is expected to be) admitted for an overnight stay in a hospital, hospice, or residential medical care facility on the following date(s): _____

   ❑ **Incapacity plus Treatment:** (e.g., outpatient surgery, strep throat) Due to the condition, the patient (❑ has been / ❑ is expected to be) incapacitated for more than three consecutive, full calendar days from _____ (MM/DD/YYYY) to _____ (MM/DD/YYYY).

   The patient (❑ was / ❑ will be) seen on the following date(s): _____

   The condition (❑ has / ❑ has not) also resulted in a course of continuing treatment under the supervision of a health care provider (e.g., prescription medication (other than over-the-counter) or therapy requiring special equipment).

   ❑ **Pregnancy:** The condition is pregnancy. List the expected delivery date: _____ (MM/DD/YYYY).

   ❑ **Chronic Conditions:** (e.g., asthma, migraine headaches) Due to the condition, it is medically necessary for the patient to have treatment visits at least twice per year.

   ❑ **Permanent or Long Term Conditions:** (e.g., Alzheimer's, terminal stages of cancer) Due to the condition, incapacity is permanent or long term and requires the continuing supervision of a health care provider (even if active treatment is not being provided).

   ❑ **Conditions requiring Multiple Treatments:** (e.g., chemotherapy treatments, restorative surgery) Due to the condition, it is medically necessary for the patient to receive multiple treatments.

   ❑ **None of the above:** If none of the above condition(s) were checked, (i.e., inpatient care, pregnancy) no additional information is needed. Go to page 4 to sign and date the form.

Employee Name: _____

4. If applicable, briefly describe other appropriate medical facts related to the condition(s) for which the employee seeks PFML leave.

   (e.g., use of nebulizer, dialysis) _____

Required Leave Needed

For the medical condition(s) checked in the Serious Health Conditions above, complete all that apply. Several questions require a response as to the frequency/duration of a condition, treatment, etc. Your answer should be your **best estimate** based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine PFML coverage.

5. Due to the condition: the patient (❑ had / ❑ will have) **planned medical treatment(s)** (scheduled medical visits) (e.g., psychotherapy, prenatal appointments) on the following date(s): _____

   The patient (❑ was / ❑ will be) **referred to other health care provider(s)** for evaluation or treatment(s).

   State the nature of such treatments: (e.g., cardiologist, physical therapy) _____

   Provide your **best estimate** of the beginning date _____ (MM/DD/YYYY) and end date _____ (MM/DD/YYYY) for the treatment(s).

   Provide your **best estimate** of the duration of the treatment(s), including any period(s) of recovery _____ (e.g., 3 days/week)

6. Due to the condition, it is medically necessary for the employee to work a **reduced schedule**.

   Provide your **best estimate** of the reduced schedule the employee is able to work.

   From _____ (MM/DD/YYYY) to _____(MM/DD/YYYY) _____the employee is able to work: (e.g., 5 hours/day, up to 25 hours a week)

   The patient (❑ was / ❑ will be) **incapacitated for a continuous period of time**, including any time for treatment(s) and/or recovery.

   Provide your **best estimate** of the beginning date _____ (MM/DD/YYYY) and end date _____ (MM/DD/YYYY) for the period of incapacity.

7. Due to the condition, it (❑ was / ❑ is / ❑ will be) medically necessary for the employee to be absent from work on an **intermittent basis** (periodically), including for any episodes of incapacity i.e., episodic flare-ups. Provide your **best estimate** of how often (frequency) and how long (duration) the episodes of incapacity will likely last.

   Over the next 6 months, episodes of incapacity are estimated to occur _____ times per (❑ day / ❑ week / ❑ month) and are likely to last approximately _____ (❑ hours / ❑ days) per episode.

PROVIDER'S INFORMATION AND CERTIFICATION

I declare under penalty of perjury that the information provided in this form is true and correct, that the patient's condition causes an incapacitation from work and that I am a healthcare provider authorized to certify their condition.

Signature: Date:

Name and title:

Certificate license and state:

License area/area of practice:

Business name:

Address:

Phone number: Email address:

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Section 4 – Employer's Statement (Answer all questions to avoid delay)

Company Name | Group ID Number

Class No. or Description | Division/Location No. or Description

Address | City | State | ZIP

Employee's Name | Employee's Phone Number

Employee Address | Employee City | Employee State | Employee ZIP

Employee Date of Birth | Employee Social Security Number | Employee Date of Hire | Employee's Job Title

Employee Wages

Quarter No.	Quarter Ending Date (MM/DD/YYYY)	Gross Amount Paid	Average Hours Worked
1			
2			
3			
4			

Check Days Normally Worked/Hours Worked

- ❑ Monday . . . . . Hours Worked _____ (for each day)
- ❑ Tuesday . . . . . Hours Worked _____ (for each day)
- ❑ Wednesday . . . Hours Worked _____ (for each day)
- ❑ Thursday . . . . . Hours Worked _____ (for each day)
- ❑ Friday . . . . . Hours Worked _____ (for each day)
- ❑ Saturday . . . . . Hours Worked _____ (for each day)
- ❑ Sunday . . . . . Hours Worked _____ (for each day)

Calculated average gross quarterly wage:

Last Day at Work | First Work Day Missed | Has the employee returned to work? ❑ Yes ❑ No | If Yes, when?

Date employee notified of need for leave:

Has the employee been terminated? If so, date of termination.

If the employee received or will receive full wages, will employer be requesting reimbursement?

❑ Yes ❑ No If Yes, please answer the following questions: Amount paid? _____ Date benefits begin? _____ Date benefits end? _____

In the preceding 52 weeks has the employee taken leave for:
❑ Self ❑ Family Member

Enter total number of weeks and days taken or PFML in the last 52 weeks: Weeks _____ Days _____

Signature (Required for all claims.): 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. The above statements are true and complete to the best of my knowledge and belief.

Print Name | Signature of Person Completing Claim Form

Title of Person Completing Claim Form | Phone Number | Email Address | Date Signed