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

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Group Critical Illness/Accident Health Screening Benefit Claim Form

Section 1 – Policyholder/Employer Information

Employer Name | Group Number G000 ___ ___ ___ ___

Employer Address | Employer Phone Number

Section 2 – Claimant Statement (completed by employee/member)

Claimant/Patient Name: First/Last

Claimant/Patient Date of Birth: Mo./Day/Yr. | Sex: M/F

Relationship to Employee: Self/Dependent/Spouse/Domestic Partners

Employee Name: First/Last | Social Security Number

Employee Date of Birth: Mo./Day/Yr. | Sex: M/F

Address | City | State | ZIP Code

Phone | Email

Section 3 – Claimant Information

WHICH POLICY IS THIS BENEFIT BEING REQUESTED FOR? CHECK ALL THAT APPLY: ❑ Accident ❑ Critical Illness ❑ Both ❑ Unsure

Section 4 – Health Screening Test/Procedure Information

PLEASE CHECK THE HEALTH SCREENING TEST/PROCEDURE FOR WHICH THIS CLAIM IS BEING FILED:
****Please note this benefit is payable once per calendar year for each Insured Person****

❑ Abdominal aortic aneurysm ultrasound	❑ CA 125 (blood test for ovarian cancer)	❑ EKG (electrocardiogram)	❑ Pap smear
❑ Blood test for triglycerides	❑ Carotid ultrasound	❑ Double contrast barium enema	❑ PSA (blood test for prostate cancer)
❑ Bone marrow testing	❑ CEA (blood test for colon cancer)	❑ Fasting blood glucose test	❑ Serum cholesterol test (HDL & LDL)
❑ Bone density screening	❑ Chest X-ray	❑ Flexible sigmoidoscopy	❑ SPEP (blood test for myeloma)
❑ Breast ultrasound	❑ Colonoscopy	❑ Hemoccult stool analysis	❑ Stress test (on a bicycle or treadmill)
❑ CA 15-3 (blood test for breast cancer)	❑ CT angiography	❑ Mammography	❑ Thermography

DATE THE TEST/PROCEDURE WAS PERFORMED (MM/DD/YYYY) | PHYSICIAN NAME | PHYSICIAN PHONE NUMBER

Fraud Warning: 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. (Note: This fraud warning does not apply to residents of AL, AR, CA, CO, DC, FL, KS, KY, LA, MA, MD, ME, NJ, NM, NY, OH, OR, PR, RI, TN, VA, VT and WA. Please read the specific fraud warning for your state of residence included with this form or available online at www.mutualofomaha.com.)

By signing below, I certify that I have read and understand the fraud warning that applies to my state of residence, and that all information provided on this form is true and complete to the best of my knowledge and belief.

Section 5 – Acknowledgement & Signature

SIGNATURE OF CLAIMANT | DATE

SIGNATURE OF PATIENT, IF AGE 18 OR OLDER (AND NOT THE CLAIMANT) | DATE
❑ Check if Patient is deceased or incapable of signing