



Mutual of Omaha Insurance Company
United of Omaha Life Insurance Company
Group Insurance Claims Management

Mutual of Omaha Plaza
Omaha, NE 68175-0001
Customer Service (800) 877-5176
Fax (402) 997-1865

Claim # _____

Supplementary Report of Disability — Proof of Continuing Loss

This form is to be completed without expense to the company and returned by: (MM/DD/YYYY) _____

To Be Completed By Insured Employee (To Avoid Delay Please Answer All Questions)

Full Name _____ Social Security Number _____ Date of Birth _____ Phone Number _____

Home Address: Number and Street _____ City _____ State _____ ZIP Code _____

Alternate Point of Contact: Name _____ Phone _____ Relationship to Insured _____

Are you currently working? ☐ Yes ☐ No If Yes, when did you start? _____ How many hours of work per week? _____

If currently working, name and phone number of employer: _____

If not currently working, are you interested in Vocational Rehabilitation Assistance? ☐ Yes ☐ No

If not currently working, do you anticipate returning to work? ☐ Yes ☐ No If Yes, when do you anticipate returning to work? _____

Describe your daily activities since our last report: _____

Describe any change in your condition: _____

What was your last date of medical treatment? _____ If you have undergone X-rays, examinations, treatment or diagnostic work that you have not previously advised us of, please furnish us with the names and addresses of the facilities that provided the services and the dates of services: _____

List all physicians and/or hospitals you have visited for this condition below.

Physician's Name/Hospital _____ Physician's Specialty _____ Telephone () _____

Fax () _____

Physician's/Hospital's Address _____ Date(s) you were seen by this physician

From _____ To _____

Physician's Name/Hospital _____ Physician's Specialty _____ Telephone () _____

Fax () _____

Physician's/Hospital's Address _____ Date(s) you were seen by this physician

From _____ To _____

Source of Income – Are you now eligible for, have you applied for or are you now receiving income benefits from:

	Amount	Weekly/Monthly	Date claim was filed	Date payments began	Date payments ended
Social Security Retirement	_____	Monthly	_____	_____	_____
Social Security Disability	_____	Monthly	_____	_____	_____
Canadian Pension Plan	_____	Monthly	_____	_____	_____
Workers' Compensation	_____	Monthly	_____	_____	_____
State Disability	_____	Monthly	_____	_____	_____
Pension Retirement	_____	Monthly	_____	_____	_____
Pension Disability	_____	Monthly	_____	_____	_____
Short-Term Disability	_____	Monthly	_____	_____	_____
Unemployment	_____	Monthly	_____	_____	_____
No-Fault Insurance	_____	Monthly	_____	_____	_____
Other (include Individual or Group benefits)	_____	Monthly	_____	_____	_____

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

To Be Completed By The Attending Physician

Claim # _____

General Information

Patient's Name _____

Are you currently advising the patient
to not work? ☐ Yes ☐ No

If Yes, on what date? _____

Date of Treatment _____

(a) Date of most recent visit: _____ (b) Frequency of treatment: ☐ Weekly ☐ Monthly ☐ Other (specify) _____

Primary Diagnosis Including ICD 10 or DSM-5 code _____

Objective Findings _____

Are there secondary conditions contributing to the disability? ☐ Yes ☐ No If Yes, what are they? (Please include ICD 10 or DSM-5 code.) _____

Please indicate other types treatment (surgery/labs/imaging/medications). _____

Has the patient been referred to a medical rehabilitation or therapy program? ☐ Yes ☐ No If Yes, give details. _____Have you referred the patient for other types of consultations? ☐ Yes ☐ No If Yes, give details. _____Has the patient been hospital confined? ☐ Yes ☐ No If Yes, complete the following: _____

Name of Hospital _____

Address _____

Dates of Confinement _____

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 ☐ 5 - 6 months
☐ 3 - 4 months ☐ more than 6 monthsWhat is your medical
prognosis for recovery? _____When do you expect your
patient to return to work? _____In an eight hour workday, claimant can complete the following activities: (Place an **X** for the hourly capacity for each activity.)

Activity	Never	Occasionally (0 to 2.6 hours)	Frequently (2.7 to 6.5 hours)	Continuously (6.6 to 8 hours)
☐ Standing				
☐ Walking				
☐ Sitting				
☐ Balancing				
☐ Stooping				
☐ Kneeling				
☐ Crouching				
☐ Crawling				
☐ Reaching/Working overhead				
☐ Climbing stairs				
☐ Climbing ladders				
☐ Pushing/Pulling				
☐ Lifting/Carrying				

Claimant can lift/carry: ☐ 0-10 lbs ☐ 10-20 lbs ☐ 20-50 lbs ☐ 50-100 lbs ☐ No Restriction ☐ Other (specify) _____Are there any psychological restrictions or limitations? ☐ Yes ☐ No If Yes, please specify on the line below. _____Would you release the patient to pursue vocational rehabilitation? ☐ Yes ☐ No

Your Name _____

Degree _____

Specialty _____

Telephone () _____

Fax () _____

Address _____

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

Please fax to our office at (402) 997-1865.

Fraud Warnings

Required Fraud Warnings (State specific warnings apply to the resident of such state)

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.

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.

Arkansas/Kentucky/Louisiana/Maine/New Mexico/Ohio/Tennessee: Any person who, with intent to defraud or knowing that he/she 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.

California: For your protection, California law requires the following to appear on this form. Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a 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.

District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the 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.

Kansas: 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 as determined by a court of law.

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.

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 York: 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

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.

Puerto Rico: Any person who furnishes information verbally or in writing, or offers any testimony on improper or illegal actions which, due to their nature constitute fraudulent acts in the insurance business, knowing that the facts are false shall incur a felony and, upon conviction, shall be punished by a fine of not less than five thousand (5,000) dollars, nor more than ten thousand (10,000) dollars for each violation or by imprisonment for a fixed term of three (3) years, or both penalties. Should aggravating circumstances be present, the fixed 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 on an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Vermont: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claims containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto may be committing a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties.

Virgin Islands: 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 penalties.

Virginia: Any person who, with the 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 may have violated state law.