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
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Email submitgroupPFML@mutualofomaha.com

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 claim is being filed? (check all that apply)
❑ MA PFML ❑ STD ❑ LTD

Effective Date

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

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)

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:

Estimated Return to Work Date

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

Information For Federal Income 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