

Policyowner Information

If you have a claim question — phone toll free 1-800-775-1000

Mutual of Omaha Insurance Company ■ United of Omaha Life Insurance Company
 United World Life Insurance Company ■ Omaha Insurance Company
 Home Office: Mutual of Omaha Plaza, Omaha, Nebraska 68175



This form is acceptable for reporting to either or both companies. The furnishing of this blank is for the convenience of the policyowner and is not an acknowledgment of liability or waiver of any right.

Please Print

1. Policyowner's Full Name	Social Security No.	Date of Birth Mo. Day Yr.		Height Ft. In. Lbs.	Weight Lbs.
Address No. and Street	Please check if this is a new address <input type="checkbox"/> Is the change Permanent <input type="checkbox"/> Temporary <input type="checkbox"/>	Policy Nos. _____		Telephone No. _____	
City or Town State ZIP		Area _____			
2. If claim is for dependent, show full name and relationship to policyowner.	Social Security No.	Date of Birth Mo. Day Yr.		Height Ft. In. Lbs.	Weight Lbs.
3. What sickness or injury was suffered?					
4. What date did sickness begin or accident happen?	If accident, describe how it happened. Where?				
5. What date were you first treated by a physician for this sickness or injury?	Hour <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.				
6. Were you confined in a hospital for this sickness or injury? <input type="checkbox"/> Yes <input type="checkbox"/> No	Hospital Name	Confined From To , ;			
7. Has any other physician treated you for this condition? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, when?	Physician's Name Address				
8. Have you ever had the same kind of sickness or injury before? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," when? Hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," where?	Physician's Name Address Hospital Name Confined From To , ;				
9. Have you had any medical or surgical advice during the past five years for any other condition? <input type="checkbox"/> Yes <input type="checkbox"/> No For what? Hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No	Physician's Name Address Treatment Dates Hospital Name Confined From To , ;				
10. Do you have hospital insurance with other companies? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have disability insurance with other companies? <input type="checkbox"/> Yes <input type="checkbox"/> No	If "Yes," give name of company.	Effective Date	Daily/Weekly/Monthly Rate of Benefit?	Policy/Certificate No.	
			\$		
			\$		
11. Are you receiving or applying for — Workers' compensation? <input type="checkbox"/> Yes <input type="checkbox"/> No Unemployment compensation? <input type="checkbox"/> Yes <input type="checkbox"/> No					
12. Are you covered by Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," when did it become effective? _____					

If Claiming Loss of Time Benefits — Answer These Additional Questions

13. Are you receiving a disability pension or compensation? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, for what?	Amount \$	Date of first payment
14. What is your occupation? _____ Average monthly earnings? \$ _____ If retired, date of retirement _____ Does your employer pay any portion of the premium on your Mutual of Omaha policy(policies) under which you are filing this claim? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," what percentage? _____%		
15. Name and address of your employer or, if self-employed, full business address.		
16. Give first date you did not work because of this sickness or injury. _____		
17. What date were you first able to do any part of your work, supervisory or otherwise? _____		
18. What duties are you now unable to perform due to this sickness or injury?		
19. What date did you resume your regular duties? _____		

As part of our claim procedure, a consumer report may be secured through personal interviews with third parties, which may include information as to your character, reputation, mode of living, etc. You have the right to make written request within a reasonable period of time concerning the nature and scope of this investigation.

Sign And Date Here **Policyowner's Signature** _____ (If claim is on dependent) _____ Date _____
Dependent's Signature _____ Date _____

If claim is for a minor dependent, parent or legal guardian must also sign this form.

MU9110_0212

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

PICA

CARRIER

1. MEDICARE <input type="checkbox"/> (Medicare #) MEDICAID <input type="checkbox"/> (Medicaid #) TRICARE CHAMPUS <input type="checkbox"/> (Sponsor's SSN) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (SSN or ID) FECA BLK LUNG <input type="checkbox"/> (SSN) OTHER <input type="checkbox"/> (ID)		1a. INSURED'S I.D. NUMBER (For Program in Item 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		3. PATIENT'S BIRTH DATE MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>	
5. PATIENT'S ADDRESS (No., Street)		6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	
CITY STATE		7. INSURED'S ADDRESS (No., Street)	
ZIP CODE TELEPHONE (Include Area Code) ()		8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO:	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO	
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>		b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) _____	
c. EMPLOYER'S NAME OR SCHOOL NAME		c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	
d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. RESERVED FOR LOCAL USE	
11. INSURED'S POLICY GROUP OR FECA NUMBER		11. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>	
a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>		b. EMPLOYER'S NAME OR SCHOOL NAME	
c. INSURANCE PLAN NAME OR PROGRAM NAME		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, return to and complete item 9 a-d.	

PATIENT AND INSURED INFORMATION

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY.	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. _____ 17b. NPI _____	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. RESERVED FOR LOCAL USE	20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES _____
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. _____ 3. _____ 2. _____ 4. _____	22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1								NPI	
2								NPI	
3								NPI	
4								NPI	
5								NPI	
6								NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN <input type="checkbox"/> <input type="checkbox"/>	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO	28. TOTAL CHARGE \$ _____	29. AMOUNT PAID \$ _____	30. BALANCE DUE \$ _____
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED _____ DATE _____	32. SERVICE FACILITY LOCATION INFORMATION a. NPI _____ b. _____		33. BILLING PROVIDER INFO & PH # () a. NPI _____ b. _____		

Fraud Statements

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:** 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 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.
- ** **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 a 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.
- ** **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.
- ** **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 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 for 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 AN 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 by 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 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 in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
- ** **Tennessee:** 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.
- ** **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:** 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.
- ** **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.
- ** **West Virginia:** 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.
- ** **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 materially related to a claim is provided by the claimant.