Mutual of Omaha
Long-Term Disability Claim Form

Instructions to Complete:

Please complete the attached claim form sections:

- Section 1: Employee Statement
    - Information About Your Family
    - Information About Your Disability Condition
    - Information About Work
    - Information About Care and Treatment
    - Information About Other Income Benefits
    - Information for Tax Withholding
- Education, Training, and Work Experience
- Authorization to Release Personal Information
- Electronic Funds Transfer (EFT) Authorization

Please give your physician the attached claim form sections to complete:

- Section 5: Attending Physician's Statement (3 pages)

All forms once completed, should be returned to Campus Benefits for processing.

- Scan and email to mybenefits@campusbenefits.com
- Upload securely through the secure link on the benefits website. (https://www.stoneschoolsbenefits.com/contact-campus)
- Fax to Campus Benefits at 770-394-0333

*Campus Benefits will work with your employer to obtain the employer section.

For questions, please feel free to reach out to Campus Benefits.
Phone: 866-433-7661, opt. 5
Email: mybenefits@campusbenefits.com

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

Group Insurance Claims Management
3300 Mutual of Omaha Plaza
Omaha, NE 68175-0001
Toll Free (800) 877-5176
Fax (402) 997-1865
Email newdisabilityclaim@mutualofomaha.com

A Guide for Successfully Completing the Group Disability 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 disability 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 all required information is provided and all questions have been answered completely and accurately. If information is missing or is illegible (unreadable), the processing of your form will be delayed.
- Refer to the guidelines for each section below, which provide valuable information to help you successfully complete the form.
- Make a copy of the completed form for your records before submitting it to Mutual of Omaha/United of Omaha.

Required Fraud Warnings

Before completing the claim form, please read the Required Fraud Warnings listed on the following page.

Guidelines for Section 1: Employee's Statement

This section is to be completed by the Employee. Please answer all questions in order to avoid possible delays. All dates should indicate the month, date and year.

A. Information About You

- The Group Policy Number will have eight characters, beginning with "G000" followed by four additional letters or numbers specific to your employer.
- Provide weight in pounds, and height in feet and inches.
- Your Occupation/Job Title is the title of your position held with the employer.
- Indicate any other Mutual of Omaha/United of Omaha plans in which you are currently insured.

C. Information About Your Disabling Condition

- The Date First Treated is the date you first sought out medical care because of the disabling condition.

D. Information About Work

- The Last Day Worked is the day before you were first absent from work because of the disabling condition.

E. Information About Care and Treatment

- Provide the name, specialty, phone and address for each physician or hospital that treated you for the disabling condition.

F. Information About Other Income Benefits

- Other Income means money you are currently receiving or have applied to receive from any source in addition to your claim for disability benefits with Mutual of Omaha/United of Omaha.
- Check all sources of other income that apply.

G. Information for Tax Withholding

- If your claim is paid, indicate whether or not you would like Mutual of Omaha to withhold income tax from your benefit payment, and if so, how much. Minimum is **$88** per month.

H. Signature

- Your signature is required.

Education, Training and Work Experience

- This form is to be completed by the employee. Please make sure all questions have been answered completely and accurately. If information is missing or is illegible (unreadable), the processing of your form will be delayed.
- Vocational rehabilitation services include, but are not limited to (a) job modification; (b) job placement; (c) retraining; and (d) other activities reasonably necessary to help you return to work.

Authorization to Disclose Personal Information

This authorization is to be completed by the employee.

- Please read this section in its entirety. By signing the authorization, you are applying for long-term disability benefits with Mutual of Omaha/ United of Omaha, and are agreeing to allow disclosure of personal information to the necessary parties for purposes 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, for example.
- IMPORTANT: To be complete, the form must be signed by you.

Guidelines for Section 2: Employer's Statement

Employer will complete this portion of the form

This section is to be completed by the employer. Please answer all questions in order to avoid possible delays. All dates should indicate the month, date and year.

A. Information About the Employer

- The Group Policy Number will have eight characters, beginning with "G000" followed by four additional letters or numbers.

B. Information About the Employee

- The Date Employee Became Insured Under This Plan indicates the date in which the employee's coverage became effective.
- The Date Employee Became Insured Under Prior Plan indicates the date in which the employee's coverage was in effect under a plan prior to the Mutual of Omaha plan.
- The No. of Hours Employee Regularly Works is the number of hours the employee is typically at work per day/per week for the employer.

C. Information for Tax Withholding

- If this section is not completed, Mutual of Omaha will assume that premium paid by the employee is with pre-tax dollars.
- If this is not true, indicate otherwise and provide the percentage amount.

E. Information for Life Waiver

- Date Life Insurance Terminated means the first day the coverage is no longer in force.
- If applicable, the Paid-To-Date for group life insurance is the date on which the next premium is due.

F. Information About Your Pension Plan

- This section is not applicable if the disabling condition is maternity.

H. Information About Employee's Salary

- Indicate the method in which the employee is paid.
- If hourly, also indicate the hourly rate in which the employee is paid.
- Please attach supporting payroll documentation.

Guidelines for Section 3: Job Analysis

Employer will complete this portion of the form

This section is to be completed by the employer if a formal job description is not available. If a formal job description is not available, please answer all questions in order to avoid possible delays. All dates should indicate the month, date and year.

A. Information About the Employee's Job

- Occasionally means the employee does this activity up to 33 percent of the time.
- Frequently means the employee does the activity 34 percent to 66 percent of the time.
- Continuously means the employee does the activity 67 percent to 100 percent of the time.

B. Physical Aspects of the Job

- Check all the activities that apply to the employee's job.
- Indicate the frequency with which the employee performs the activity using the guidelines in Section A, Information About the Employee's Job.

Guidelines for Section 4: Signature and Attachments

- Attach a copy of the employee's job description to the claim application.
- Attach any additional documentation that may be helpful when reviewing the application, including further explanation of any question(s) on the application.
- Your signature is required.

Guidelines for Section 5: Attending Physician's Statement

This section is to be completed by the attending physician. Please answer all questions in order to avoid possible delays. All dates should indicate the month, date and year.

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.

Disability Claim Form

What type of disability coverage do you have?
❑ **Short-Term Disability** ■ **Long-Term Disability** ❑ **Both**

3300 Mutual of Omaha Plaza | Omaha, NE 68175-0001
Phone (800) 877-5176 (toll-free) | Fax (402) 997-1865
Email newdisabilityclaim@mutualofomaha.com

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

A. Information About You

Employee Last Name | Employee First Name | Employee Middle Initial | Group Policy Number G000CD5F

Employee Address | Employee City | Employee State/Province | Employee ZIP

Employee Telephone ( ) | Employee Email Address | Employee Social Security Number

Employee Date of Birth | Height | Weight | ❑ Male ❑ Female | ❑ Right Handed ❑ Left Handed | ❑ Single ❑ Married | ❑ Widowed ❑ Divorced

Name of Your Employer (include Division/Location, if applicable): Stone County School District | Your Occupation/Job Title

Under what other Mutual of Omaha/United of Omaha policies are you currently covered?

Did you have disability coverage prior to being effective with Mutual of Omaha? ❑ Yes ❑ No

Important Notice: If you have group life insurance through your employer, please contact your benefits administrator as soon as possible to determine what options are available to you to continue your life insurance. Some options require action within 60 days of the date you stop working/insurance ends for life insurance to continue.

If your coverage is written in California, North Carolina or Michigan and includes Survivor Benefits, please check your policy to determine if you can elect a survivor benefit beneficiary. If so, you may obtain a Beneficiary Designation form on the internet or from your employer.

B. Information About Your Family (Required to determine your eligibility for Social Security benefits.)

Spouse's Name | Spouse's Social Security Number | Spouse's Date of Birth | Is your spouse employed? ❑ Yes ❑ No

First and Last Name of any children under the age of 25	Date of Birth	Social Security Number

C. Information About Your Disabling Condition

1. If your disability is due to an injury, answer the following questions and then proceed to #3 below.

When did the injury occur?

Where and how did the injury occur?

What is the date you were first treated by a physician?

2. If your disability is due to a pregnancy or an illness, answer the following questions. If <u>not</u> pregnancy-related, proceed to #3 below.

What were your first symptoms?

When did you notice these symptoms?

What is the date you were first treated by a physician?

3. If your disability is due to an injury or an illness, but not pregnancy, answer the following questions.

Why are you unable to work?

Before you stopped working, did your condition require you to change your job or the way you did your job? ❑ Yes ❑ No If **Yes**, please explain below.

Is your condition related to your occupation? ❑ Yes ❑ No If **Yes**, please explain below.

Have you filed, or do you intend to file a Workers' Compensation claim? ❑ Yes ❑ No

D. Information About Work

What is the date of your last day worked before the disability?

On your last day worked, did you work a full day? ❑ Yes ❑ No
If **No**, please explain.

What is the date you were first unable to work?

Have you returned to work? ❑ Yes, Part-Time ❑ Yes, Full-Time ❑ No
What date did you return to work?

If you haven't yet returned to work, do you expect to? ❑ Yes, Part-Time ❑ Yes, Full-Time ❑ No
What date do you expect to be able to return to work?

Are you currently self-employed or working for another employer? ❑ Yes ❑ No If **Yes**, provide details.

E. Information About Care and Treatment (If additional space is needed, please provide details on a separate page.)

Physician who **first** provided medical attention to you for your current disability. | Physician's Specialty | Telephone ( ) Fax ( )

Physician's Address | Date(s) you were seen by this physician From _____ To _____

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

Physician's Name | Physician's Specialty | Telephone ( ) Fax ( )

Physician's Address | Date(s) you were seen by this physician From _____ To _____

Physician's Name | Physician's Specialty | Telephone ( ) Fax ( )

Physician's Address | Date(s) you were seen by this physician From _____ To _____

Physician's Name | Physician's Specialty | Telephone ( ) Fax ( )

Physician's Address | Date(s) you were seen by this physician From _____ To _____

Name of Hospital | Department of Treatment | Telephone ( ) Fax ( )

Hospital's Address | Date(s) you were treated at the hospital From _____ To _____

Name of Hospital | Department of Treatment | Telephone ( ) Fax ( )

Hospital's Address | Date(s) you were treated at the hospital From _____ To _____

F. Information About Other Income Benefits (Check all benefits you are receiving or are eligible to receive.)

Source of Income	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	_____	_____	_____

	State	Leave Type	Date Leave Begins	Date Leave Ends	Weekly Amount
State Paid Family or Medical Leave	_____	❑ Paid Family ❑ Paid Medical	_____	_____	_____

G. 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 **$88.00** per month). $_____.00

Overpayment Notice: Should you become overpaid at any time during the duration of this claim we, Mutual of Omaha Insurance Company (Mutual) or United of Omaha Life Insurance Company (United), will request reimbursement of the overpaid amount. This amount is equal to the net benefit you received and any Federal Income Tax paid on your behalf for any time prior to current tax year. Your signature on the claim form authorizes Mutual or United to recover any overpaid Medicare and/or Social Security Tax that was paid on your behalf and certifies you will not attempt to recover a refund or credit of the Medicare and/or Social Security Tax with any Form W-2C that is furnished to you based on recoveries received.

H. 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

Education, Training and Work Experience

Name _____

Policy Number G000CD5F _____ Claim Number _____

Educational Background

High School Graduate: ❑ Yes ❑ No If **No**, what was the last grade completed? _____ Last Date Attended _____

GED: ❑ Yes ❑ No

Did you attend college? ❑ Yes ❑ No Last Date Attended _____

Major(s) _____

Final Status: ❑ Freshman ❑ Sophomore ❑ Junior ❑ Senior ❑ Undergraduate Degree ❑ Graduate School

Degree(s) earned _____

Other formal training _____

Certification(s) _____

Military Service: ❑ Yes ❑ No If **Yes**, which branch/rank/specialty? _____

List all languages spoken fluently _____

Computer Skills (complete each line):

Are you able to use Microsoft products such as Word, Excel, etc.? ❑ Yes ❑ No

Are you able to create emails and attach documents? ❑ Yes ❑ No

Are you able to use the Internet to search for information? ❑ Yes ❑ No

Are you able to use any social media platforms (Facebook, Instagram, etc.) ❑ Yes ❑ No

Are you able to use computers to operate production machines, cash registers, etc.? ❑ Yes ❑ No

Do you play video games? ❑ Yes ❑ No

Other computer skills? _____

Do you have a computer at home? ❑ Yes ❑ No

Work Experience

Please provide your past 15 years of Work Experience starting with your most recent employer going backwards chronologically.

Dates: From _____ To _____

Employer _____

Job Title _____

List job duties _____

What does/did the company do? _____

Did you supervise others? ❑ Yes ❑ No

Did you use a computer? Please explain. _____

Dates: From _____ To _____

Employer _____

Job Title _____

List job duties _____

What does/did the company do? _____

Did you supervise others? ❑ Yes ❑ No

Did you use a computer? Please explain. _____

Dates: From _____ To _____

Employer _____

Job Title _____

List job duties _____

What does/did the company do? _____

Did you supervise others? ❑ Yes ❑ No

Did you use a computer? Please explain. _____

Dates: From _____ To _____

Employer _____

Job Title _____

List job duties _____

What does/did the company do? _____

Did you supervise others? ❑ Yes ❑ No

Did you use a computer? Please explain. _____

Dates: From _____ To _____

Employer _____

Job Title _____

List job duties _____

What does/did the company do? _____

Did you supervise others? ❑ Yes ❑ No

Did you use a computer? Please explain. _____

Additional courses taken, hobbies and special skills. Please be specific such as computer skills either personal or professional, sales, carpentry, auto repair, etc.

_____

_____

_____

Are you involved in a vocational rehab program with a State or other agency? ❑ Yes ❑ No

If **Yes**, please provide the name, address and phone number of the rehabilitation case worker _____

_____

_____

Would you like information about Mutual of Omaha's Return-to-Work Program? ❑ Yes ❑ No

What is your employment goal or other work that you would be interested in doing? _____

Date _____ **Signature** _____

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_____-_____-_____

   This medical or health information may include information on the diagnosis and treatment of mental illness, alcohol, and drug use. This also may include information on the diagnosis, treatment, and testing results related to HIV, AIDS, and sexually transmitted diseases, unless otherwise restricted by state law.

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;
   - 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: 402-997-1865 or Email: newdisabilityclaim@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.

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

Electronic Funds Transfer (EFT) Authorization

Direct Deposit of Benefit Payments

I understand that by completing this form, I am authorizing United of Omaha Life Insurance Company to directly deposit into my bank account via Electronic Funds Transfer (EFT) payment(s) due to me under a contract issued or administered by United of Omaha to my financial institution with the information provided below, for credit to my account. I represent that the bank information listed below is not affiliated with a prepaid banking card or a non-standard checking/savings account, and I understand that such prepaid banking card or non-standard checking/savings accounts are not accepted by United of Omaha.

Furthermore, I authorize and direct the bank to charge said account or the account of my estate for any payment made in error as determined by United of Omaha and to refund any such payment made subsequent to my death or made in error and to refund any such payment to United of Omaha upon its written request to the bank.

I further understand and agree that it is my responsibility to ensure that all bank information reported on this form is accurate and correct for the appropriate deposit of my payment(s) and that United of Omaha can rely on this information and will have no obligation to ensure the correctness of the information. Completion of this form is not a guarantee that benefits will be paid.

I further understand and agree that any payment(s) made into an incorrect bank account (including, without limitation, to a prepaid banking card or non-standard checking/savings account, both of which are not accepted by United of Omaha) pursuant to the information reported on this form, will be forfeited by me and that United of Omaha has no obligation to retrieve those funds or make replacement payment(s) to me.

I further understand and agree for myself, my heirs, executors and estate to indemnify and hold United of Omaha harmless from any and all loss or damage of any nature whatsoever, including costs or attorney's fees incurred by reason of said bank acting pursuant to this Authorization.

I further understand and agree that United of Omaha is not responsible for any bank charges or other costs associated with or arising out of this agreement.

I further understand that if my bank is not able to accept EFTs, checks will be mailed to my residence.

I reserve the right to revoke and cancel this authorization. Such revocation and cancellation shall be effective within 5 business days following United of Omaha's receipt of the notice.

Payee Information	**Bank Information**
Full Name	Bank Name
Address	Address
Address	Address
City	City
State and ZIP Code	State and ZIP Code
Telephone Number ( )	Telephone Number ( )
Social Security Number	Account Number
Policy Number G000CD5F	Bank ABA Routing/Transit Number
Claim Number	❑ Checking ❑ Savings *(Check only one)* *Prepaid banking cards and non-standard checking/savings accounts not permitted.*
Payee Number *(for office use only)*	**Approved By/Date *(for office use only)***

X _____ _____

Payee Signature | Date

Contact Information

Please attach EITHER **a voided check for checking** OR **a deposit slip for savings** and return with this form to:

United of Omaha Life Insurance Company
HO8W-GDMS
3316 Farnam Street
Omaha, NE 68172-7420

You may also fax to 402-997-1865 or email to submitgrpdisinfo@mutualofomaha.com

Should you have any questions regarding EFT, please feel free to contact our customer service representatives toll free at **1-800-877-5176** (Monday – Thursday 7 a.m. – 5:30 p.m. and Friday 7 a.m. – 5 p.m. CST).

Section 5 – Attending Physician's Statement (Answer all questions to avoid delay.)

A. General Information

Patient's Name | Employer's Name | Policy Number G000CD5F

Patient's Social Security Number | Height | Weight | Blood Pressure | Date of Birth

B. Complete the following for normal pregnancy, then go to Section E.

Date of the patient's last menstrual period? | Expected date of delivery? | Actual date of delivery? | Type of delivery?

Expected length of postpartum recovery? | First date of treatment? | Last date of treatment?

C. Complete the following for all conditions except normal pregnancy.

Primary diagnosis (including ICD-10 or DSM code) | Symptoms

What diagnostic testing has been done? | Objective Findings

Are there secondary conditions contributing to the patient's disability? ❑ Yes ❑ No
If **Yes**, what are they (include ICD-10 or DSM)?

If this is a cardiac condition, what is the functional capacity (American Heart Association)?

❑ Ejection Fraction ❑ Class 1–No Limitation ❑ Class 2–Slight Limitation ❑ Class 3–Marked Limitation ❑ Complete Limitation

If this is a psychiatric condition, what is the current GAF/WHODAS score? | In the past year, what was the patient's highest GAF/WHODAS score?

When did symptoms first appear? | Date of patient's first visit? | Date patient was first unable to work?

Date of patient's last visit? | How often do you see this patient?

Is the patient's condition work related? ❑ Yes ❑ No If **Yes**, please explain.

Has patient undergone surgery or expected to have surgery in the future? ❑ Yes ❑ No If **Yes**, answer the following.

Date of surgery | Surgical Procedure | Result

What medication is the patient currently taking or been prescribed?

Please indicate other types and frequencies of treatment.

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**, please complete the following.

Name of Hospital | Address of Hospital | Dates of Confinement
From _____ To _____

D. Information About the Patient's Inability to Work

Briefly describe the patient's restrictions. (SHOULD NOT DO)

Briefly describe the patient's limitations. (CANNOT DO)

What is your prognosis for recovery?

Has patient achieved maximum medical improvement? ❑ Yes ❑ No If **No**, please complete the following.

How soon do you expect fundamental changes in the patient's medical condition?

❑ 1-2 months ❑ 3-4 months ❑ 5-6 months ❑ 6 months to a year ❑ 1 year or more ❑ Never

Give details concerning expected improvement or deterioration.

What is your treatment plan for the patient's return to work or return to prior level of function?

In an eight-hour workday, the patient can: **(Check full hourly capacity for <u>each</u> activity.)**

Sit	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	❑ 6	❑ 7	❑ 8
Stand	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	❑ 6	❑ 7	❑ 8
Walk	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	❑ 6	❑ 7	❑ 8

Are there restrictions in:	**Yes**	**No**	If **Yes**, please fully explain below.
Driving/Operating motorized equipment	❑	❑	_____
Lifting/Carrying	❑	❑	_____
Use of hands in repetitive actions	❑	❑	_____
Use of feet in repetitive movements	❑	❑	_____
Bending	❑	❑	_____
Squatting	❑	❑	_____
Crawling	❑	❑	_____
Climbing	❑	❑	_____
Reaching above shoulder level	❑	❑	_____
Other	❑	❑	_____

Please check off the appropriate response of the person's ability to adapt to these specific job situations at this time.

	Unlimited	**Somewhat Limited**	**Markedly Limited**	**Unable to Perform**
Follow work rules	❑	❑	❑	❑
Perform repetitive, or short cycle work	❑	❑	❑	❑
Perform at a constant pace	❑	❑	❑	❑
Maintain attention and concentration	❑	❑	❑	❑
Perform a variety of duties	❑	❑	❑	❑
Understand, remember and carry out complex job instructions	❑	❑	❑	❑
Attain set limits and standards	❑	❑	❑	❑
Relate to co-workers	❑	❑	❑	❑
Interact with supervisors	❑	❑	❑	❑
Interact with the public/customers	❑	❑	❑	❑
Use judgment and make decisions	❑	❑	❑	❑
Direct, control or plan activities of others	❑	❑	❑	❑
Influence people in their opinions, attitudes and judgments	❑	❑	❑	❑
Expressing personal feelings	❑	❑	❑	❑
Work alone or apart in physical isolation from others	❑	❑	❑	❑

D. Information About the Patient's Inability to Work (continued)

What functions of the person's own/usual occupation is the person unable to perform? (Please provide rationale here, if not already provided.)

What functional restrictions have been placed on this person?

When do you expect the patient to return to prior level of functioning?

Would you recommend vocational rehabilitation for this patient?

❑ Yes ❑ No

E. Required Attachments and Signature

After you have fully completed this form, please attach copies of the following materials.

- Office notes for the period of treatment received over the last two years
- Test results showing objective findings
- Hospital discharge summaries
- Consulting physician reports

Your Name

Degree

Specialty

Telephone ( )

Fax ( )

Address

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.

X _____ _____

Signature of Attending Physician (no stamp)

Date