Long-Term Disability Claim Form

Mutual of Omaha Insurance Company
United of Omaha Life Insurance Company
Group Insurance Claims Management
Mutual of Omaha Plaza
Omaha, NE 68175-0001
Phone 800-877-5176 Fax 402-997-1865 Email newdisabilityclaim@mutualofomaha.com

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

A. Information About You

Last Name	First Name	Middle Initial	Group Policy Number

Address	City	State/Province	ZIP

Telephone ( )	Email Address	Social Security Number

Date of Birth	Height	Weight	☐ Male ☐ Female	☐ Right Handed ☐ Left Handed	☐ Single ☐ Married	☐ Widowed ☐ Divorced

Name of Your Employer (include Division/Location, if applicable)

Your Occupation/Job Title

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

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 31 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

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.

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

Doctor who first provided medical attention to you for your current disability.	Doctor's Specialty	Telephone ( ) Fax ( )
Doctor's Address		Date(s) you were seen by this doctor From _____ To _____

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

Doctor's Name	Doctor's Specialty	Telephone ( ) Fax ( )
Doctor's Address		Date(s) you were seen by this doctor From _____ To _____
Doctor's Name	Doctor's Specialty	Telephone ( ) Fax ( )
Doctor's Address		Date(s) you were seen by this doctor From _____ To _____
Name of Hospital	Department of Treatment	Telephone ( ) Fax ( )
Hospital's Address		Date(s) you were treated at the hospital From _____ To _____

Have you ever had the same or a similar condition in the past? ☐ Yes ☐ No If Yes, provide the following information concerning past treatments.

Doctor's Name	Doctor's Specialty	Telephone ( ) Fax ( )
Doctor's Address		Date(s) you were seen by this doctor 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					
Social Security Disability					
Canadian Pension Plan					
Workers' Compensation					
State Disability					
Pension Retirement					
Pension Disability					
Short-Term Disability					
Unemployment					
No-Fault Insurance					
Other (include Individual or Group benefits)					

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 anytime 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

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Education, Training and Work Experience

Name_____

Policy No. _____ Claim No. _____

Educational Background

High School Graduate ☐ Yes ☐ No If **No**, what was the last grade completed? _____ Last date attended _____

GED ☐ Yes ☐ No Field of Study ☐ General ☐ Business ☐ Vocational ☐ Other

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

Name and Address of College: _____

_____

Major(s): _____

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

Degree(s) earned: _____

Other formal training: _____

Certification(s): _____

Computer Skills: _____

Military Service ☐ Yes ☐ No If **Yes**, in which branch did you serve? _____

Rank: _____

Specialty: _____

What computer programs are you able to use? _____

List all languages spoken fluently: _____

Work Experience

Please fill out completely. Start with your most recent employment and list chronologically.

Dates: From _____ To _____

Employer: _____

Job Title: _____

List job duties: _____

List physical requirements of job: _____

Product/service produced: _____

Did you supervise others? ☐ Yes ☐ No

Reason for leaving? _____

Dates: From _____ To _____

Employer: _____

Job Title: _____

List job duties: _____

List physical requirements of job: _____

Product/service produced: _____

Did you supervise others? ☐ Yes ☐ No

Reason for leaving? _____

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Dates: From _____ To _____

Employer: _____

Job Title: _____

List job duties: _____

List physical requirements of job: _____

Product/service produced: _____

Did you supervise others? ☐ Yes ☐ No

Reason for leaving? _____

Dates: From _____ To _____

Employer: _____

Job Title: _____

List job duties: _____

List physical requirements of job: _____

Product/service produced: _____

Did you supervise others? ☐ Yes ☐ No

Reason for leaving? _____

Dates: From _____ To _____

Employer: _____

Job Title: _____

List job duties: _____

List physical requirements of job: _____

Product/service produced: _____

Did you supervise others? ☐ Yes ☐ No

Reason for leaving? _____

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 currently involved in a vocational rehabilitation program? ☐ Yes ☐ No

If yes, please provide the name, address and phone # of the rehabilitation case worker _____

_____

_____

Are you interested in learning about our vocational rehabilitation program? ☐ Yes ☐ No

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

Date: _____ **Signature:** _____

Authorization to Disclose Personal Information

1. I authorize any physician, medical or dental practitioner, hospital, clinic, pharmacy benefit manager, other medical care facility, health maintenance organization, insurer, employer, consumer reporting agency and any other provider of medical or dental services to release records containing the personal information of:

   Claimant/Patient Name: _____
   (Last) (First) (Middle)

2. Personal information includes medical history, mental and physical condition, prescription drug records, alcohol or drug use, financial and occupational information.

3. You may release information to:

   Group Disability Management Services
   Mutual of Omaha Insurance Company/United of Omaha Life Insurance Company
   Mutual of Omaha Plaza
   Omaha, NE 68175-0001
   Or
   Fax 402-997-1865
   Or
   Email SubmitGrpDisInfo@mutualofomaha.com

4. I understand that the personal information that is disclosed will be used by Mutual of Omaha Insurance Company and United of Omaha Life Insurance Company to evaluate my claim for disability benefit plan reimbursement and that if I refuse to sign this authorization my claim for benefits may not be paid.

5. I understand that if the person or entity to whom information is disclosed is not a health care provider or health plan subject to federal privacy regulations, the personal information may be redisclosed without the protection of the federal privacy regulations.

6. This authorization will expire 24 months after the date signed.

7. I understand that I may revoke this authorization at any time by providing a written request to Mutual of Omaha Insurance Company and United of Omaha Life Insurance Company at the address above. If I revoke this authorization, it will not affect any use or disclose of personal information that occurred prior to the receipt of my revocation.

8. 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

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Section 2 – Employer's Statement (Answer all questions to avoid delay.)

Employee's Name	Social Security Number	Date of Birth

Employee's Address	Employee's Phone Number

A. Information About the Employer

Company's Name	Group Policy Number	Class No. or Description

Company's Address (Number, Street, City, State, ZIP)	Company's Telephone ( ) Company's Fax ( )

Name and Address of Location Where Employee Works	Location No.	Location Telephone ( ) Location Fax ( )

B. Information About Employee

Employee's Hire Date	Date Employee became insured under this plan: _____ Date Employee became insured under prior plan: _____	No. of hours Employee regularly works per day/per week? _____ # of hours per/week _____ # of hours per/day

C. Information For Tax Withholding

If this section is left blank, we will calculate FICA taxes based on the following assumption: 100% Employer contribution or any portion paid by Employee is paid with pre-tax dollars.

Does Employee contribute post-tax dollars toward the premium? ☐ Yes ☐ No If **Yes**, what percent is paid by Employee? _____% Post-Tax

D. Information About the Claim

Before Employee became fully disabled, were changes made to Employee's job responsibilities due to the disabling condition? ☐ Yes ☐ No

If yes, please describe the changes and when they were made.

Date Employee Last Worked	Did Employee work a full day? ☐ Yes ☐ No If **No**, how many hours were worked?

What was Employee's permanent job on his/her last day worked?	How long had Employee been in this job?

Why did Employee stop working?	Has Employee returned to work? ☐ Yes ☐ No If **Yes**, when?

Is Employee's condition work related? ☐ Yes ☐ No	Has a Workers' Compensation claim been filed? ☐ Yes ☐ No If **Yes**, send initial report of illness/injury and award notice.

Name of Workers' Comp Carrier	Address of Workers' Comp Carrier	Contact Person's Name & Phone No.

Name and Address of Medical Insurance Carrier	Is Employee covered under a Group Life policy with Mutual of Omaha? ☐ Yes ☐ No

E. Information For Life Waiver

Important Notice: If an Employee is age 60 or over, please refer to the policy provisions regarding group life continuation and conversion rights.

Is Employee covered under a Group Life policy with United of Omaha? ☐ Yes ☐ No If **Yes**, what is the effective date of the life insurance plan?

What is Employee's annual salary?	Amount of Life insurance as of last day worked

Master Policy Number	Class	Location

Date Life insurance terminated? If **not** terminated, what is the "paid to date"?	Name of beneficiary (per your records)? Relationship to Employee?

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F. Information About Your Pension Plan (Do not complete for maternity.)

Do you have a pension plan? ☐ Yes ☐ No | If **Yes**, what type? ☐ Defined Benefit ☐ 401(k) ☐ Other (specify) ☐ Defined Contribution ☐ Profit Sharing

Is Employee eligible for your pension plan? ☐ Yes ☐ No | If eligible, does Employee participate? ☐ Yes ☐ No
If **Yes**, when is Employee eligible for benefits under the pension plan?

If Employee is eligible but does not participate, explain why.

G. Information About Your Rehire or Return to Work Policies

Does your company have a rehire or return to work policy for disabled Employees? ☐ Yes ☐ No

Who should we contact if we identify a rehabilitation or return to work option? Name/Title:
Contact No.

H. Information About Employee's Salary (Please attach supporting payroll documentation.)

(Check all that apply) Employee ☐ is paid hourly ($ hourly rate) ☐ is salaried ☐ receives commissions ☐ receives bonuses

Will Employee file for disability benefits provided by any Employer/Employee Labor Management, State Disability or Union Welfare plan? ☐ Yes ☐ No
If **Yes**, please answer the following questions. Weekly amount? Date benefits begin? Date benefits end?

Is Employee eligible for Salary Continuation? ☐ Yes ☐ No If **Yes**, please answer the following questions.
Weekly amount? Date benefits begin? Date benefits end?

Is Employee eligible for Sick Leave? ☐ Yes ☐ No If **Yes**, please answer the following questions.
Weekly amount? Date benefits begin? Date benefits end?

Per the definition of Basic Monthly Earnings in your Policy, what are Employee's pre-disability monthly earnings?

Section 3 – Job Analysis (To be completed by the Employee's Supervisor or HR Department. Answer all questions to avoid delay.)

A. Information About Employee's Job

Job Title	Minimum education or training required?	How long will Employee's job be held open?

Does Employee perform supervisory functions? ☐ Yes ☐ No If **Yes**, how many people are supervised?

Describe Employee's job duties.

Indicate how each of the following related to Employee's job.

	Occasionally (0%-33%)	**Frequently (34%-66%)**	**Continuously (67%-100%)**
Computer use	_____	_____	_____
Relate to others	_____	_____	_____
Written and verbal communication	_____	_____	_____
Reasoning, math and language	_____	_____	_____
Make independent judgments	_____	_____	_____

Which of the following describe Employee's working environment? **Check all that apply.**

☐ Unprotected heights ☐ Changes in temperature ☐ Exposure to dust, fumes and gases
☐ Being near moving machinery ☐ Driving automotive equipment ☐ Other hazards (please explain)

Is Employee required to travel? ☐ Yes ☐ No If **Yes**, please answer the following questions.

How does Employee travel? ☐ Automobile ☐ Plane ☐ Train ☐ Other

What percent of the time does Employee travel?

Where does Employee travel?

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B. Physical Aspects of the Job

Select how each of the following relates to Employee's job.

Activity	Frequency of Occurrence: Occasionally (0%-33%)	Frequently (34%-66%)	Continuously (67%-100%)
☐ Standing			
☐ Walking			
☐ Sitting			
☐ Balancing			
☐ Stooping			
☐ Kneeling			
☐ Crouching			
☐ Crawling			
☐ Reaching/working overhead			
☐ Climbing			
☐ Number of stairs _____			
☐ Height of ladder _____			
☐ Pushing			
☐ Pulling			
☐ Lifting/Carrying			

Please indicate any activities that require lifting, carrying, pushing or pulling. In addition, specify the weight involved with this activity.

Describe Activity	Weight

Can alternating sitting and standing activity help Employee perform the job? ☐ Yes ☐ No

Does the job require use of the feet to operate foot controls? ☐ Yes ☐ No
If **Yes**, list type of equipment.

How important is good vision in the job?

List the major tasks which require the use of one or both hands.	One Hand	Both Hands

Can the job be modified to accommodate the disability either temporarily or permanently? ☐ Yes ☐ No If **Yes**, explain.

Is it possible to offer Employee assistance in doing the job (e.g., use of technology or personal assistance)? ☐ Yes ☐ No If **Yes**, explain.

Section 4 – Employer's Signature and Attachments (Please Attach Employee's job description and additional documentation.)

Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing false, incomplete, or misleading information is guilty of a felony of the third degree.

Name of person completing this form: _____

Title: _____ Email Address: _____

Telephone: ( ) _____ Fax: ( ) _____

Signature: _____ Date: _____

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

A. General Information

Patient's Name	Employer's Name	Policy Number

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?

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-9 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-9 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_____

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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 yo 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: **(Circle 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.

	Untimited	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	☐	☐	☐	☐

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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 No. ( ) Fax No. ( )

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