Group Claim 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.

** **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 or 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.

** **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 of claim 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.

** **Maine, Tennessee or 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 a denial of insurance benefits.

** **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.

** **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. (PURSUANT TO 11 NYC RR86)

** **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.

** **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.

** **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.

Proof of Death Form

Group Operation

Please Return Completed Form To:
United of Omaha Life Insurance Company
Group Life Claims
Mutual of Omaha Plaza
Omaha, NE 68175-0001
Toll Free 1-800-775-8805

Instructions for Furnishing Proof of Death

1. Beneficiary or other claimant should complete Part II. Attach certified copy of deceased's Death Certificate and return to Policyholder or Group Administrator for completion of Part I.

2. If any beneficiary, other than a contingent beneficiary, died before the Insured, a copy of the Certificate of Death of such beneficiary must be attached to the proofs. In such case, claim should be made by the other beneficiaries, or if there be none, by the duly appointed representative of the Insured's estate.

3. If claim is made on behalf of the estate of the deceased, a certified copy of the Letters of Administration must be attached to the proofs.

4. If any beneficiary is a minor or legally incompetent, a certified copy of the appointment of a guardian must be attached to the proofs.

5. **IMPORTANT:** Attach original enrollment record plus any beneficiary changes.

Authorization To Disclose Personal Information

To physicians, medical or dental practitioners, hospitals, clinics, pharmacies, pharmacy benefit managers, other medical care facilities, health maintenance organizations, insurers, employers, consumer reporting agencies and all other providers of medical or dental services.

I authorize you to release to representatives of United of Omaha Life Insurance Company, personal information about the insued person including: medical history, mental and physical condition, prescription drug records, alcohol or drug use, financial and occupational information in order to evaluate my claim for benefits.

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 information may be redisclosed without the protection of the federal privacy regulations.

I understand that I may refuse to sign this authorization. I realize that if I refuse to sign, my claim for benefits may not be paid.

This authorization will expire 24 months after the date signed. I may revoke this authorization at any time by written notice to; ATTN: Group Life Claims, United of Omaha Life Insurance Company, Mutual of Omaha Plaza, Omaha, NE 68175-0001. Any revocation of this authorization will not affect any use or disclosure of Personal Information that occurred prior to the receipt of my revocation.

I understand that I am entitled to receive a copy of the authorization and that a copy is as valid as the original.

Name(s) used for medical records (if different than the name below): ____________________

____

____________________	____________________	____________________
Printed Name of Insured Person	Printed Name of Authorized Person	Signature of Authorized Person
____________________	____________________	
Relationship to Insured	Date	

Part I Statement of Policyholder or Group Administrator

Employee ☐ Spouse ☐ Child ☐ Other ☐

1. Full name of deceased ______________________ Soc. Sec. No. ______________ Eff. date of deceased insurance __________

   Name of Employee ______________________ Soc. Sec. No. ______________ Eff. date of employee's insurance __________
2. Date employment began ______________ Occupation at time of death ______________
3. Date of last active work ______________ If retired, date retired ______________
4. Premium for the above deceased has been paid through ______________
5. If date deceased last worked was more than 31 days prior to death, was deceased:

   totally disabled? ☐ on leave of absence? ☐ on temporary layoff? ☐
6. If benefits are based on earnings, give amount of monthly earnings ______________

   (Note: We may require supporting documentation of earnings and paid premiums to process the claim.)
7. If your plan has more than one class, show class deceased was covered under ______________
8. Name of beneficiary shown on your records______________ Relationship ______________

   Note: Attach Original Enrollment Record plus any beneficiary changes.

   We hereby certify that to the best of our knowledge and belief, the above statements are correct and that said deceased's insurance was in force on the date of his or her death for the amount of $______________.

Master Policy No. ______________ ______________
Name of Policyholder

Date ______________ By ______________
Signature and Title

Part II Statement of Beneficiary or Other Claimant

1. Full name of deceased ______________
2. Date of birth of deceased ______________ Your date of birth ______________
3. Your relationship to the insured ______________ Your telephone no. ( ) ______________
4. Your address ______________

   Street City or Town State ZIP Code
5. If you are not the named beneficiary, in what capacity do you make this claim? ______________

   ____
6. Your (Claimant's) Taxpayer Identification Number

   For exempt payees write "Exempt" here ______________

   Social Security Number ______ - ______ - ______ OR Employer Identification Number _____ - _____

   CERTIFICATION — Under penalty of perjury, I certify that:

   (a) The number shown on this form is my correct Taxpayer Identification Number (or I am waiting for a number to be issued to me); and

   (b) I am not subject to backup withholding either because I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of failure to report all interest and dividends, or the IRS has notified me that I am no longer subject to backup withholding.
7. Does the deceased have any other life insurance coverage with Mutual of Omaha? Yes ____ No ____

______________ ____/____/____ ______________
Signature of Claimant Date Relationship To Insured

Mailing Address of Claimant

______________ ______________
Street City State ZIP Code

Please Complete Authorization on Reverse Side