

Short-Term Disability Claim Form

Mutual of Omaha Insurance Company
 United of Omaha Life Insurance Company
 Group Disability Management Services
 Mutual of Omaha Plaza
 Omaha, NE 68175-0001
 800-877-5176 Fax (402) 997-1865



Part I – Employee Statement (ALL QUESTIONS MUST BE ANSWERED TO AVOID DELAY)

Employer Name		Policy Number	Job Title	Hours Worked per Week
Name				
Address		City	State	ZIP
(Area Code) Phone Number			Social Security Number	
Date of Birth	Height	Weight	Dominant Hand: <input type="checkbox"/> Right <input type="checkbox"/> Left	<input type="checkbox"/> Male <input type="checkbox"/> Female
			<input type="checkbox"/> Single <input type="checkbox"/> Married	<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced
Date of Disability (1st Day Absent) (Mo.)/(Day)/(Year)		Date First Treated (Mo.)/(Day)/(Year)		Physician's Name
Nature of illness and when symptoms first appeared, or describe how and where accident occurred.				
Was the disability work related? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you filed a Worker's Compensation Claim? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Other income you have filed for, are receiving, or are eligible for:				
	Amount	Date Claim Filed	Date Benefits Began	
Workers' Compensation	_____	_____	_____	
State Disability	_____	_____	_____	
Other	_____	_____	_____	

Part II – Employer's Statement (ALL QUESTIONS MUST BE ANSWERED TO AVOID DELAY)

Company Name		Policy Number	Class	Division or Location
Address		City	State	ZIP
Weekly earnings as defined by the Plan: (Please note: Benefits will be calculated based on premium received.)			No. of Hours Scheduled to Work Weekly: _____	
Was disability caused by employment? <input type="checkbox"/> Yes <input type="checkbox"/> No Has workers' compensation claim been filed? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Does the employee contribute toward the premium? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what percent is paid by the employee? _____ % Pre-tax _____ Post-tax _____?				
Is this employee eligible for salary continuation/sick leave? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what is the weekly amount? \$ _____				
When do benefits begin? _____ End _____				
Date of Hire (Mo.)/(Day)/(Year)		Date Covered Under This Plan		
Is employee covered for long-term disability by a Mutual of Omaha/United of Omaha policy? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Is employee covered for Group Life by a United of Omaha policy? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, and it would appear your employee's disability will last longer than 6 months, please answer the following questions: Effective Date of Life Insurance _____ Annual Salary _____				
Date Insurance Terminated or if not Terminated, "paid to" date _____ Master Policy Number _____ Insurance Class _____				
Amount of Insurance on the last day worked _____				
Please contact employee's direct supervisor and then circle the strength demand below which best describes the employee's job:				
	S - Sedentary	10 Lbs. Maximum lifting, occasional lift/carry of small articles. Some occasional walking or standing may be required.		
	L - Light	20 Lbs. Maximum lifting with frequent lift/carry up to 10 Lbs. A job is light if less lifting is involved but significant walking/standing is done or if done mostly sitting but requires push/pull on arm or leg controls.		
Circle	M - Medium	50 Lbs. Maximum lifting with frequent lift/carry up to 25 Lbs.		
One	H - Heavy	100 Lbs. Maximum lifting with frequent lift/carry up to 50 Lbs.		
	V - Very Heavy	Over 100 Lbs. Lifting with frequent lift/carry over 50 Lbs.		
Employee's Job Title		Last Day at Work (Mo.)/(Day)/(Year)	On that day, did the employee work a full day? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, how many hours were worked?	
Description of major job duties – please attach Job description		Has the employee returned to work? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when?		
Signature/Title		Date	(Area Code) Phone Number	(Area Code) Fax Number

Please notify us if the employee returns to work after the submission of this form.

Part III – Attending Physician’s Statement (ALL QUESTIONS MUST BE ANSWERED TO AVOID DELAY)

Employer Name _____ Policy Number _____

Name of Patient (Last, First, M.I.) – Please Print _____ Date of Birth _____

Diagnosis _____ ICD-9 Code _____

Symptoms _____ Date symptoms first appeared (Mo. Day Year) _____

Is disability due to: _____ Accident/Injury _____ Sickness _____ Work related? Yes No

If Disability is Due To Pregnancy, Please Provide the Information Below:
 LMP: _____ Expected Date of Delivery: _____ Actual Date of Delivery: _____ Type: C-Section Vaginal

Name of Surgical Procedure (Describe fully and provide dates if any) _____

If any of the Following questions are answered “Yes,” then please provide the information to the right of that question.

Was the patient treated in an emergency room? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date Treated in Emergency Room	Name of Hospital	Physician
Was the patient treated by another physician? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date Treated	Physician’s Name and Address	
Was the patient hospital confined? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date Confined In Hospital From _____ To _____		Name of Hospital
Did patient have outpatient surgery in a hospital or ambulatory surgical center? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of Surgery	Name of Facility	

Functional Limitations - Abilities

indicate frequency per day the listed activity can be performed. (n - never, o - occasional, f - frequent, c - constant)		Indicate longest single time duration each activity can be performed.			
Lifting	Carrying	_____ Sitting	_____ Kneeling	_____ R Finger Dexterity	
_____ 1-5 lbs.	_____ 1-5 lbs.	_____ Total time on feet	_____ L	} Reaching	
_____ 6-10 lbs.	_____ 6-10 lbs.	_____ Standing	_____ Inside		_____ R Below Shoulder
_____ 11-25 lbs.	_____ 11-25 lbs.	_____ Walking	_____ L		_____ R Above Shoulders
_____ 26-50 lbs.	_____ 26-50 lbs.	_____ Bending	_____ Outside		_____ L
_____ 51-100 lbs.	_____ 51-100 lbs.	_____ Squatting	_____ Working with Others		_____ Other (explain) _____
_____ over 100 lbs.	_____ over 100 lbs.	_____ Stooping			

Mental Limitations - Abilities

	Excellent	Good	Fair	Guarded
Judgement/decision making	_____	_____	_____	_____
Deal with work stresses	_____	_____	_____	_____
Function independently	_____	_____	_____	_____
Concentration/attention span	_____	_____	_____	_____
Emotional liability	_____	_____	_____	_____
Patient follows recommendations	_____	_____	_____	_____
Caring for self/family	_____	_____	_____	_____
Estimate overall prognosis	_____	_____	_____	_____

The patient has been continuously disabled (unable to work) from _____ to _____

The patient should be able to work Full-time Part-time on (date) _____ or in 1 mth. 1-3 mths. 3-6 mths. Other _____

Remarks _____

Name of Attending Physician - Please Print _____ Tax Identification Number _____

Address (No., Street, City, State, ZIP Code) _____ Telephone Number _____ Fax Number _____

Signature of Attending Physician _____ Date Signed _____

Authorization to Disclose Health Information to my Employer

I authorize Mutual of Omaha Insurance Company and United of Omaha Life Insurance Company to disclose health information about me to my employer, and to my employer's broker. I understand that this information will be used by my employer, and its broker, to monitor and manage the disability benefits program provided under my Group disability policy. I also understand that my employer and its broker will use the information solely for the purposes of auditing disability benefits paid, providing claims assistance, determining waiver or discontinuance of premium deductions, and coordinating with other subsidized salary continuance plans my employer may offer.

The health information which may be disclosed pursuant to this authorization includes such items as medical history, mental and physical condition, prescription drug records and alcohol or drug use.

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 is valid for 24 months from the date I sign it. I understand that I may revoke this authorization at any time. If I would like to revoke this authorization, I should send my revocation request to:

ATTN: 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

I also understand that any revocation of this authorization will not affect any use or disclosure of health information that occurred prior to receipt of my revocation.

I understand that I am entitled to receive a copy of this authorization.

(Printed Name and Address)

(Signature)

(Date)

or

If Applicable: I am the legal representative of the person whose financial and health information is to be disclosed, and I am authorized to grant permission on behalf of that person.

Printed name of Legal Representative: _____

Signature of Legal Representative: _____

Type of Legal Representative: _____

Date: _____

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

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 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.

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