



Mutual of Omaha Insurance Company
 United of Omaha Life Insurance Company
Group Critical Illness/Accident Claims

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 Email submitgrpacc@mutualofomaha.com

Group Critical Illness/Accident Health Screening Benefit Claim Form

Section 1 - Policyholder/Employer Information

| | |
|------------------|-----------------------|
| Employer Name | Group Number |
| | G000 ____ _ |
| Employer Address | Employer Phone Number |

Section 2 - Claimant Statement (completed by employee/member)

| | | | |
|---|------------------------|-------|----------|
| Claimant/Patient Name: First/Last | | | |
| Claimant/Patient Date of Birth: Mo./Day/Yr. | Sex: M/F | | |
| Relationship to Employee: Self/Dependent/Spouse/Domestic Partners | | | |
| Employee Name: First/Last | Social Security Number | | |
| Employee Date of Birth: Mo./Day/Yr. | Sex: M/F | | |
| Address | City | State | ZIP Code |
| Phone | Email | | |

Section 3 - Claimant Information

WHICH POLICY IS THIS BENEFIT BEING REQUESTED FOR? CHECK ALL THAT APPLY: Accident Critical Illness Both Unsure

Section 4 - Health Screening Test/Procedure Information

PLEASE CHECK THE HEALTH SCREENING TEST/PROCEDURE FOR WHICH THIS CLAIM IS BEING FILED:

****Please note this benefit is payable once per calendar year for each Insured Person****

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Abdominal aortic aneurysm ultrasound | <input type="checkbox"/> CA 125 (blood test for ovarian cancer) | <input type="checkbox"/> EKG (electrocardiogram) | <input type="checkbox"/> Pap smear |
| <input type="checkbox"/> Blood test for triglycerides | <input type="checkbox"/> Carotid ultrasound | <input type="checkbox"/> Double contrast barium enema | <input type="checkbox"/> PSA (blood test for prostate cancer) |
| <input type="checkbox"/> Bone marrow testing | <input type="checkbox"/> CEA (blood test for colon cancer) | <input type="checkbox"/> Fasting blood glucose test | <input type="checkbox"/> Serum cholesterol test (HDL & LDL) |
| <input type="checkbox"/> Bone density screening | <input type="checkbox"/> Chest X-ray | <input type="checkbox"/> Flexible sigmoidoscopy | <input type="checkbox"/> SPEP (blood test for myeloma) |
| <input type="checkbox"/> Breast ultrasound | <input type="checkbox"/> Colonoscopy | <input type="checkbox"/> Hemoccult stool analysis | <input type="checkbox"/> Stress test (on a bicycle or treadmill) |
| <input type="checkbox"/> CA 15-3 (blood test for breast cancer) | <input type="checkbox"/> CT angiography | <input type="checkbox"/> Mammography | <input type="checkbox"/> Thermography |

| | | |
|---|----------------|------------------------|
| DATE THE TEST/PROCEDURE WAS PERFORMED (MM/DD/YYYY) | PHYSICIAN NAME | PHYSICIAN PHONE NUMBER |
|---|----------------|------------------------|

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. (Note: This fraud warning does not apply to residents of AL, AR, CA, CO, DC, FL, KS, KY, LA, MA, MD, ME, NJ, NM, NY, OH, OR, PR, RI, TN, VA, VT and WA. Please read the specific fraud warning for your state of residence included with this form or available online at www.mutualofomaha.com.)

By signing below, I certify that I have read and understand the fraud warning that applies to my state of residence, and that all information provided on this form is true and complete to the best of my knowledge and belief.

Section 5 - Acknowledgement & Signature

| | |
|-----------------------|------|
| SIGNATURE OF CLAIMANT | DATE |
|-----------------------|------|

| | |
|---|------|
| SIGNATURE OF PATIENT, IF AGE 18 OR OLDER (AND NOT THE CLAIMANT) | DATE |
|---|------|

Check if Patient is deceased or incapable of signing