Group Critical Illness/Accident Health Screening Benefit Claim Form

United of Omaha Life Insurance Company • Mutual of Omaha Insurance Company

Group Critical Illness/Accident Claims • 3300 Mutual of Omaha Plaza • Omaha, NE 68175-0001
Phone (800)775-8805 (toll-free) • Fax (402)997-1898 • www.mutualofomaha.com/customer-service • submitgrpacc@mutualofomaha.com

Please print clearly in blue or black ink. **All applicable information should be completed to avoid delays in the processing of the claim. When complete, submit the form to the address or fax above.** This form is to be completed without expense to United of Omaha Life Insurance Company or Mutual of Omaha Insurance Company.

Section 1: Policyholder/Employer Information

POLICYHOLDER/EMPLOYER NAME			GROUP ID NUMBER
Grant County			G000 B N 3 W
CITY	STATE	ZIP CODE	PHONE NUMBER
Ephrata	WA	98823	509-754-2011

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

CLAIMANT NAME	☐ Male ☐ Female	DOB ____/____/____	SSN
EMPLOYEE/MEMBER NAME (if other than claimant)		DOB ____/____/____	SSN
ADDRESS	CITY	STATE	ZIP CODE
EMAIL	CONTACT NUMBER		

RELATIONSHIP TO EMPLOYEE/MEMBER:
☐ Self ☐ Spouse ☐ Domestic Partner ☐ Dependent ☐ Beneficiary ☐ Other (ex., Power of Attorney, Conservator)

DOES THE EMPLOYEE/MEMBER HAVE MAJOR MEDICAL INSURANCE OR A COMBINATION OF BASIC HOSPITAL AND BASIC MEDICAL INSURANCE?
☐ Yes ☐ No

Section 3: Claimant Information

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

Section 4: Health Screening Test/Procedure Information

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

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

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

****A COPY OF THE TEST/PROCEDURE RESULTS, PROVIDER INVOICE OR OTHER PROOF OF THE TEST/PROCEDURE MUST BE SUBMITTED WITH THIS FORM.****

Section 5: Acknowledgement & Signature

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.

SIGNATURE OF CLAIMANT	DATE
SIGNATURE OF PATIENT, IF AGE 18 OR OLDER (AND NOT THE CLAIMANT) ☐ Check if Patient is deceased or incapable of signing	DATE