MUTUAL of OMAHA INSURANCE COMPANY
Mutual of Omaha Plaza
Omaha, NE 68175
1 800 775 1000
mutualofomaha.com

"Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison."

INSURED'S STATEMENT FOR DISABILITY BENEFITS **ANSWER ALL QUESTIONS THAT APPLY**

POLICY NUMBER: _____ Claim Number _____

1. Insured's Name (First) _____ (Last) _____ Date of Birth _____

   Insured's Address (Street) _____ (City) _____ (State) _____ (Zip Code) _____

   Social Security Number _____-_____-_____ Telephone Number ( )_____-_____

   Policy Number _____ _____ Life Policy Number _____

2. Employer Name _____ Telephone Number ( ) _____- _____

   Employer Address (Street)_____ (City) _____ (State) _____ (Zip Code) _____

3. If you are considered an employee or if you are self-employed and your business is incorporated, does your employer pay any portion of the insurance premium for your disability coverage with our company?

   Yes____ No____ If Yes, what percentage? _____%

4. What is your occupation? _____

5. What was your annual income prior to disability? _____

6. What sickness or injury was suffered? _____

7. What date did the sickness or injury happen? If an accident, describe how/where it happened. _____

   _____

8. What date were you first treated by a physician for this sickness or injury? _____

9. Were you confined in a hospital for this sickness or injury? Yes___ No___ If Yes, give name of Hospital and Dates of Confinement.

   _____

10. Has any other physician treated you for this condition? Yes___ No___ If Yes, when? _____

    Physician Name and Address _____

11. Have you had the same kind of sickness or injury before? Yes___ No___ If Yes, when? _____

    Physician Name and Address _____

12. Have you had any medical or surgical advice during the past five years for any other condition? Yes____ No____

    What was the condition?_____ Dates of Treatment _____

    Physician's Name and Address _____

POLICY NUMBER: _____

Hospitalized? Yes____ No____ If Yes, provide Dates of Confinement _____

Hospital Name and Address _____

13. Dates unable to work for current period of disability: _____/_____/_____ (Month Day Year) to _____/_____/_____ (Month Day Year)

14. What was your last day worked prior to disability? _____/_____/_____ (Month Day Year)

15. Date returned to work in a limited capacity: _____/_____/_____ (Month Day Year) to _____/_____/_____ (Month Day Year)

16. Date returned to work full time: _____/_____/_____ (Month Day Year)

17. If pregnancy is involved: Expected date of delivery: _____/_____/_____ (Month Day Year)

Exact date of delivery: _____/_____/_____ (Month Day Year) Expected return to work date: _____/_____/_____ (Month Day Year)

Please indicate the type of delivery and any complications: _____

_____

18. Please check any and all benefits that you are eligible to receive:

	Applied Y/N	Date Applied	Amount Receiving	Date Benefits Began
A. Social Security				
B. Worker's Compensation				
C. State Disability Insurance				
D. Retirement or Pension				
E. Short Term Disability				
F. Salary Continuation				
G. Unemployment				
H. Union				
I. Medicare/Medicaid				

Describe all insurance coverage in force: (A) Individual; (B) Group; (C) Salary Continuance; (D) Disability/Overhead Expense; (E) Hospital/Medical Coverage: **If none, so state by writing "none".**

Company or Source	Type (A,B,C,D,E)	Monthly Amount	Elimination Period	Benefit Period

As part of our claim procedure, a consumer report may be secured through personal interviews with third parties, which may include information as to your character, reputation, mode of living, etc. You have the right to make written request within a reasonable period of time concerning the nature and scope of this investigation.

Date_____, 20_____ Insured's Signature _____

Mutual of Omaha

Any person who knowingly, and with intent to injure, defraud or deceive any insurance company, files a statement of claim containing any false or misleading information is guilty of a felony.

INSURED'S OCCUPATIONAL DESCRIPTION

Policy Number:

1. Insured's Name _____ (First / Last) Date of Birth ____/____/____ (Month / Day / Year)
2. Job title(s): _____
3. Nature of employer's business _____
4. Number of hours worked in a normal week: _____ Years with employer _____ Years in occupation _____
5. List the duties of your occupation(s) in order of their importance, with a detailed description of each:

   Duty _____ Hours spent each week _____

   Description _____

   Duty _____ Hours spent each week _____

   Description _____

6. If your occupation includes lifting, please indicate extent according to the following classifications (circle one letter):

A.	Sedentary	Involves sitting, walking and standing. Objects lifted weight between zero and 10 pounds.
B.	Light	Involves frequently lifting and carrying of objects weighing between 10 and 20 pounds and jobs which require significant walking and/or standing.
C.	Medium	Involves lifting between 25 and 50 pounds.
D.	Heavy	Involves lifting between 50 and 100 pounds.
E.	Very Heavy	Involves lifting over 100 pounds.

7. How has your disability interfered with the performance of the job? Please describe sitting, standing, and walking requirements and limitations:
8. Previous employment:

Occupational Title	Employers Name	Dates Employed

9. Indicate your highest level of education completed: College: # of years completed _____ High School: # of years completed _____
   Grade School: # of years completed _____
   Please specify degree(s), diploma(s), or certificate(s) and area of concentration:

Date _____, 20____ Insured's signature _____

ATTENDING PHYSICIAN'S STATEMENT **CLAIM NUMBER:** _____

1. Insured's Name (First) _____ (Last) _____ Date of Birth _____ /_____ /_____
   Month Day Year

2. History:
   A. When did symptoms first appear/accident happen? _____ /_____ /_____
      Month Day Year
      Date patient ceased work due to disability: _____ /_____ /_____
      Month Day Year
   B. Has patient ever had same or similar conditions? ☐ Yes ☐ No If Yes, state when and describe:
      _____
   C. Is condition due to injury or sickness arising out of patient's employment? ☐ Yes ☐ No ☐ Unknown
   D. Is condition due to pregnancy? ☐ Yes ☐ No
      If Yes, Estimated Date of Conception: _____ /_____ /_____
      Month Day Year
   E. Have you treated this individual for any other conditions? ☐ Yes ☐ No If Yes, state when and describe:
      _____
   F. Have you completed claim forms for other insurance carriers? ☐ Yes ☐ No If Yes, state name of insurance company: _____
   G. Name and address of other treating physicians or consultants (If none, write none): _____
      _____

3. Diagnosis:
   A. Primary diagnosis _____
   B. Secondary diagnosis (include complications): _____
   C. Subjective symptoms: _____
   D. Objective findings: To assist us, we request your cooperation in forwarding: the results of diagnostic tests already taken (for example: electrocardiograms, angiograms, etc., for a heart condition; vital capacity readings for emphysema; X-rays for musculoskeletal disorders) and the results found through the use of other clinical techniques. For pregnancy, describe any complications.
      _____
      _____
      _____

4. Dates of treatment (include all dates)

   A. Office: Date of first visit: _____ /_____ /_____ Additional dates: _____
   Month Day Year

   B. Has patient been hospital confined? ☐ Yes ☐ No
   If Yes, confined _____ /_____ /_____ to _____ /_____ /_____
   Month Day Year Month Day Year

   If Yes, name and address of hospital: _____

5. Nature of treatment (include surgery/medication prescribed/physical therapy, if any): _____

   _____

6. Extent of disability: Has patient been released to return to work? ☐ Yes ☐ No
   If Yes, give date: _____ /_____ /_____
   Month Day Year

7. If patient has not been released to return to work, answer A through D.

   A. In your opinion, is the patient unable to work in his/her occupation? ☐ Yes ☐ No
   If Yes, give dates: _____ /_____ /_____ to _____ /_____ /_____
   Month Day Year Month Day Year

   B. If still unable to work in his or her occupation, when do you expect patient will be able to perform some of his/her work duties?

   ☐ 1-3 months ☐ 3-6 months ☐ 6-12 months ☐ more than 12 months

   C. If patient is able to do some work, how long until patient is able to perform all of his/her work duties:
   From _____ /_____ /_____ to _____ /_____ /_____
   Month Day Year Month Day Year

   D. What are patient's present limitations? _____

   _____

   _____

_____

Attending Physician's Name (Please Print) Degree Telephone

_____

Street Address City State ZIP Code

_____ _____ _____

Signature Date TIN/SS#

Mutual of Omaha Companies

EMPLOYER'S STATEMENT FOR DISABILITY BENEFITS

Claim Number: _____

1. Insured's Name _____ Date of Birth: _____/_____/_____
   First Last Month Day Year

2. Date employed: _____/_____/_____
   Month Day Year

3. Claimant is: ☐ Full-time ☐ Part-time # of hours worked per week: _____

4. Is claimant retired: ☐ Yes ☐ No Retirement date: _____/_____/_____
   Month Day Year

5. Claimant's salary immediately prior to date last worked: Amount $ _____
   (Check one) ☐ Weekly ☐ Monthly ☐ Annually

6. How long was claimant at this salary? _____/_____/_____ to _____/_____/_____
   Month Day Year Month Day Year

7. Date claimant last worked: _____/_____/_____
   Month Day Year

8. Initial date of total disability: (Usually one day after date last worked.) _____/_____/_____
   Any difference should be explained in REMARKS. Month Day Year

9. Is claimant's job being held open? ☐ Yes ☐ No If No, please explain _____

   _____

10. If employment terminated, give date:_____/_____/_____
    Month Day Year
    If necessary, please use REMARKS to explain circumstances.

11. Could accommodations be made to enable claimant to return to work? ☐ Yes ☐ No
    If No, please explain in REMARKS.

12. Has claimant returned to work: Full Time: ☐ Yes ☐ No If Yes, on what date? _____/_____/_____
Month Day Year

Part Time/Light Duty: ☐ Yes ☐ No If Yes, on what date? _____/_____/_____
Month Day Year
(Please provide details of part time or light duties in REMARKS.)

If No, when do you expect claimant to resume work? _____/_____/_____
Month Day Year

A. Is claimant receiving or entitled to any weekly or monthly disability benefits? ☐ Yes ☐ No

If Yes, give amounts and how long claimant is eligible: _____

B. Is claimant receiving or entitled to any pension or retirement benefits? ☐ Yes ☐ No

If Yes, give amounts: _____

C. Is claimant receiving or entitled to any Worker's Compensation/Employer Liability Benefits? ☐ Yes ☐ No

If Yes, give amounts: _____

D. Do you pay any portion of the claimant's Mutual of Omaha coverage premium? ☐ Yes ☐ No

If Yes, what percent? _____

E. Please provide a description of the claimant's job duties _____

_____

_____

F. REMARKS: _____

_____

_____

Employer's Information:

_____ _____
Employer's Signature Company Name

_____ _____-_____-_____
Mailing Address City State ZIP Code Telephone Number

Individual to contact if necessary (please print):

_____ _____-_____-_____
Name Title Telephone Number