Group Accident Claim Form – Express Benefit

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

Group 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. **This form is to be used to file a claim for the Group Accident Express Benefit only. All applicable information should be completed to avoid delays in the processing of the claim.** To submit a claim for the Express Benefit, fax/email the completed form to the number/email provided above. Please use the Group Accident Claim Form (Parts A-D, as applicable) to file a claim for any group accident benefits other than the Express Benefit. Please use the Group Health Screening Benefit Claim Form for all health screening benefit claims.

Section 1: Policyholder/Employer Information

POLICYHOLDER/EMPLOYER NAME		GROUP ID NUMBER G000 __ __ __ __
CITY	STATE	ZIP CODE

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: Accident Information

DATE OF ACCIDENT (MM/DD/YYYY)	TIME OF ACCIDENT (HH:MM) ☐ AM ☐ PM	WHERE DID THE ACCIDENT HAPPEN (LOCATION)?

DID THE ACCIDENT HAPPEN WHILE WORKING? ☐ Yes* ☐ No	DID ANY LAW AGENCY INVESTIGATE THE ACCIDENT? ☐ Yes ☐ No
TO DATE, HAS THE PATIENT SOUGHT MEDICAL TREATMENT FOR ANY INJURY SUSTAINED AS A RESULT OF THE ACCIDENT? ☐ Yes* ☐ No	*IF YES, BRIEFLY DESCRIBE THE TYPE OF TREATMENT RECEIVED AND FROM WHOM:

PROVIDE AN EXPLANATION OF HOW THE ACCIDENT OCCURRED AND THE NATURE/TYPE OF INJURIES SUSTAINED BY THE PATIENT:

Section 4: 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