

# Group Benefit Services Application for Accidental Death Benefits



Please Return Completed Form To:  
Mutual of Omaha Insurance Company  
Group Life Claims  
Mutual of Omaha Plaza  
Omaha, NE 68175  
Toll Free 1-800-775-8805

**Certified Copy of Death Certificate Must be Furnished With This Proof.**

## Statement of Beneficiary or Other Claimant

1. Your full name \_\_\_\_\_ Date of Birth \_\_\_\_\_
2. Your relationship to deceased \_\_\_\_\_
3. Full name of deceased \_\_\_\_\_ Deceased's date of birth \_\_\_\_\_
4. Last legal address of deceased \_\_\_\_\_  
Street City or Town State
5. State date of accident upon which claim is based \_\_\_\_\_
6. How did the injury occur? \_\_\_\_\_
7. Your telephone number \_\_\_\_\_
8. What injury or injuries were received? \_\_\_\_\_
9. Who was present when the deceased was injured? (Give full names and addresses) \_\_\_\_\_  
\_\_\_\_\_
10. Was an inquest held? \_\_\_\_\_ 11. Was an autopsy held? \_\_\_\_\_
12. State name and address of doctor first called after this injury. Also, name of doctor who attended deceased at time of death \_\_\_\_\_  
\_\_\_\_\_
13. Was deceased sick from any cause within five years preceding death? \_\_\_\_\_  
If so, state name of disease and name and address of the physician who attended him or her in such sickness \_\_\_\_\_  
\_\_\_\_\_
14. Does the deceased have any other life insurance coverage with Mutual of Omaha? Yes \_\_\_\_\_ No \_\_\_\_\_

**Please attach a copy of the police report and toxicology records.**

## Authorization To Disclose Personal Information

To physicians, medical or dental practitioners, hospitals, clinics, pharmacies, pharmacy benefit managers, other medical care facilities, health maintenance organizations, insurers, employers, consumer reporting agencies and all other providers of medical or dental services.

I authorize you to release to representatives of Mutual of Omaha Insurance Company, personal information about the insured person including: medical history, mental and physical condition, prescription drug records, alcohol or drug use, financial and occupational information in order to evaluate my claim for benefits.

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 information may be redisclosed without the protection of the federal privacy regulations.

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 will expire 24 months after the date signed. I may revoke this authorization at any time by written notice to; ATTN: Group Life Claims, Mutual of Omaha Insurance Company, Mutual of Omaha Plaza, Omaha, NE 68175-0001. Any revocation of this authorization will not affect any use or disclosure of Personal Information that occurred prior to the receipt of my revocation.

I understand that I am entitled to receive a copy of the authorization and that a copy is as valid as the original.

Name(s) used for medical records (if different than the name below): \_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Printed Name of Insured Person

\_\_\_\_\_  
Printed Name of Authorized Person

\_\_\_\_\_  
Signature of Authorized Person

\_\_\_\_\_  
Relationship to Insured

\_\_\_\_\_  
Date

**Statement of Attending Physician**

1. Name of deceased \_\_\_\_\_
2. Where and when did you first attend deceased? \_\_\_\_\_
3. Was deceased hospitalized? \_\_\_\_\_ Name of hospital \_\_\_\_\_
4. Describe deceased's condition on your first visit \_\_\_\_\_
5. Were there any symptoms or signs of disease? Yes \_\_\_\_\_ No \_\_\_\_\_ If "Yes," describe \_\_\_\_\_
6. Give date of accident \_\_\_\_\_
7. Were there any visible contusions or wounds on the body of deceased? \_\_\_\_\_
8. What was the nature and extent of the injuries? \_\_\_\_\_
9. What was the date of death? \_\_\_\_\_
10. What was the primary cause of death? \_\_\_\_\_
11. Did any disease or cause, other than the injury referred to, complicate or contribute to the cause of death? \_\_\_\_\_  
If so, what? \_\_\_\_\_
12. Was the injury described above, independently of all other causes, sufficient to cause death? \_\_\_\_\_
13. If a postmortem examination was made, what were the findings as to cause of death? \_\_\_\_\_
14. Give names and addresses of other physicians or surgeons, if any, who attended deceased after the injury \_\_\_\_\_

Date \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP Code \_\_\_\_\_

Attending Physician Sign Here

**Statement of Master Policyholder or Group Administrator**

1. Full name of deceased \_\_\_\_\_ Soc. Sec. No. \_\_\_\_\_ Eff. date of insurance \_\_\_\_\_  
Name of Employee \_\_\_\_\_ Soc. Sec. No. \_\_\_\_\_ Eff. date of insurance \_\_\_\_\_
2. Date employment began \_\_\_\_\_ Occupation at time of death \_\_\_\_\_
3. Date of last active work \_\_\_\_\_ If retired, date retired \_\_\_\_\_
4. Premium for the above deceased has been paid through \_\_\_\_\_
5. If date deceased last worked was more than 31 days prior to death, was deceased:  
totally disabled?  on leave of absence?  on temporary layoff?
6. If benefits are based on earnings, give amount of monthly earnings \_\_\_\_\_  
(Note: We may require supporting documentation of earnings and paid premiums to process the claim.)
7. If your plan has more than one class, show class deceased was covered under \_\_\_\_\_
8. Name of beneficiary shown on your records \_\_\_\_\_ Relationship \_\_\_\_\_  
**Note:** Attach Original Enrollment Record Plus any beneficiary changes.
9. Amount of Benefit: AD&D \$ \_\_\_\_\_ Felonious Assault \$ \_\_\_\_\_ Vol AD&D \$ \_\_\_\_\_  
Common Carrier \$ \_\_\_\_\_ Seat Belt \$ \_\_\_\_\_ Airbag \$ \_\_\_\_\_  
Repatriation (attach bill) \$ \_\_\_\_\_ Repatriation: miles from residence \_\_\_\_\_

Master Policy No. \_\_\_\_\_ Name of Policyholder \_\_\_\_\_

Date \_\_\_\_\_ By \_\_\_\_\_ Signature and Title \_\_\_\_\_

# Group Claim Fraud Statements



The following fraud language is attached to, and made part of this claim form. Please read and do not remove these pages from this claim form.

- \*\* **Alabama:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.
- \*\* **Alaska:** A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.
- \*\* **Arizona:** For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.
- \*\* **Arkansas and Louisiana:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
- \*\* **California:** For your protection California law requires the following to appear on this form. Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.
- \*\* **Colorado:** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.
- \*\* **Delaware:** Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.
- \*\* **District of Columbia:** WARNING: It is a crime to provide false or misleading information to an insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.
- \*\* **Florida:** Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.
- \*\* **Idaho:** Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement containing any false, incomplete, or misleading information is guilty of a felony.
- \*\* **Indiana:** A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.
- \*\* **Kentucky:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.
- \*\* **Maine:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

- \*\* **Maryland:** Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
- \*\* **Minnesota:** A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.
- \*\* **New Hampshire:** Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment of insurance fraud, as provided in RSA 638:20.
- \*\* **New Jersey:** Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.
- \*\* **New Mexico:** ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.
- \*\* **Ohio:** Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.
- \*\* **Oklahoma:** WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.
- \*\* **Pennsylvania:** 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.
- \*\* **Puerto Rico:** Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand dollars (\$5,000) and not more than ten thousand dollars (\$10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances [be] present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.
- \*\* **Rhode Island:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
- \*\* **Tennessee, Virginia, and Washington:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.
- \*\* **Texas:** Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.
- \*\* **If you live in a state other than mentioned above, the following statement applies to you:** Any person who knowingly, and with intent to injure, defraud or deceive any insurer or insurance company, files a statement of claim containing any materially false, incomplete, or misleading information or conceals any fact material thereto, may be guilty of a fraudulent act, may be prosecuted under state law and may be subject to civil and criminal penalties. In addition, any insurer or insurance company may deny benefits if false information is related to a claim by the claimant.